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

Pakel Bowen,

Petitioner,

vs.

NO: 06 WC 31156

Napa Auto Parts,

Respondent.

17IWCC0338

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, credit, maintenance and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

17IWCC0338

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: JUN 1 - 2017
o052517
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

BOWEN, PAKEL
Employee/Petitioner

Case# **06WC031156**

NAPA AUTO PARTS
Employer/Respondent

17IWCC0338

On 11/1/2016, 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 0.50% 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:

0312 BOUDREAU & NISIVACO LLC
ALAN BOUDREAU
120 N LASALLE ST SUITE 2850
CHICAGO, IL 60602

1408 HEYL ROYSTER
DANA HUGHES
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

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

Pamela Bowen
Employee/Petitioner
v.
NAPA Auto Parts
Employer/Respondent

Case # 06 WC 031156

17IWCC0338

An *Application for Adjustment 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 2, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/14/2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$50,615.00**; the average weekly wage was **$973.37**.

On the date of accident, Petitioner was **31** 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 **$13,821.51** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$13,821.51**.

Respondent is entitled to a credit of **$19,654.20** for non-occupational indemnity benefits and **$55,096.08** for medical benefits that have been paid, and Respondent shall hold Petitioner harmless, pursuant to Section 8(j) of the Act, as is set forth in the Conclusions of Law, attached hereto.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $648.91 per week for 29-6/7 weeks, commencing 4/15/2006 – 9/28/2006 and 3/27/2007 through 5/8/2007, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, as is set forth in the Conclusions of Law, attached hereto, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's claim for penalties and attorney's fees is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

October 31, 2016
Date

NOV 1 – 2016

FINDINGS OF FACT

Petitioner was employed by Respondent as an IBS Manager. She was hired in February of 2002. In this position, Petitioner supervised 2 employees and they processed parts orders for City of Chicago vehicles. Petitioner was working in this position for Respondent on April 14, 2006, when she was injured. Petitioner was walking behind a forklift to park it so that it could be plugged in to a charger station. As she was moving the lift, Petitioner's left foot became wedged between the lift and a tire jack. The tire jack was used to hold garbage truck tires. Petitioner's left ankle was crushed between the lift and the jack. Petitioner testified that she then fell and struck her back on the tire jack tines. A fellow employee, "Orlando", helped Petitioner and got the lift off her foot.

Petitioner was taken by CFD ambulance to Mercy Hospital. The CFD records show a history of left ankle was smashed between a forklift and a metal jack. Swelling and deformity of the ankle was observed. There was no other injury reported. (Px 3)

Orlando DeJesus testified at Petitioner's request. He was working in the parts room when Petitioner was injured. He thought that Petitioner tripped and rolled the pallet jack over her foot. DeJesus thought that Petitioner fell on the tire jack because her ankle got stuck. Her back hit the middle forks on the tire jack. He helped Petitioner and called an ambulance. Later, DeJesus told Jeff Rosignol (a supervisor) about the accident. DeJesus did not see the accident. He was an immediate post occurrence witness. The accident occurred because the tire jack was not positioned correctly. Petitioner's vision would be obscured as she back up the lift. She tripped and the lift kept coming, crushing her foot between the tire jack and the lift. Petitioner's back was on the tire jack when DeJesus saw her.

Petitioner was admitted to Mercy Hospital with a fractured left ankle. The diagnosis was: bimalleolar fracture with secondary fibular fracture. She came under the care of an orthopedic surgeon, Dr. Craig Westin. On April 15, 2006, Dr. Westin performed an open reduction, internal fixation of the bimalleolar fracture and fixation of the fibular shaft fracture. Petitioner was discharged from Mercy Hospital on April 17, 2006. There is no mention of any back injury or findings in the Mercy records. (Px 3)

Petitioner said that she called her supervisor, Jeff Rosignol, from Mercy and advised him that her ankle was hurt.

Petitioner testified that she had previously injured her low back in January of 2004. She was at a billiard hall and was hit by a heating duct. She experienced low back pain and left leg pain. She had treatment by Dr. Mekhail, an orthopedic surgeon. She had back surgery on May 28, 2004. The procedure was a L4-L5 microdiskectomy. Petitioner was released from care regarding her back by Dr. Mekhail on August 2, 2004. It was noted that her leg symptoms had completely resolved. Petitioner was advised that there was a chance of recurrence. Petitioner testified that she had no leg pain from August of 2004 to April of 2006. She did not see an orthopedist for back pain during this time. She did see her PCP, Dr. Chen Lin, regarding back pain on a couple of occasions. (Px 1, 2, Rx 20, 23, 24, 25)

Dr. Lin's records show that Petitioner was noted to be "much better" when she was seen on June 25, 2004. On August 12, 2004, she complained of decreased ROM in her low back and a Medrol dospak was prescribed. On September 22, 2005, Petitioner had complaints of low back pain and decreased range of motion. Dr. Lin recommended PT, Flererill and another Medrol dospak. On February 2, 2006, Petitioner complained of low back pain. PT, Vicodin and another Medrol dospak were prescribed. There are several other visits to Dr. Lin where no back complaints were noted. (Rx 25)

Petitioner testified that within a week after the accident, she began to notice low back pain.

Petitioner continued under the care of Dr. Westin. She was seen on April 27, 2006 for a wound check and a cast was applied. There was no mention of back pain. When Petitioner was seen for cast removal on May 25, 2006, she advised Dr. Westin that she had low back pain with sciatica down the right leg to the calf. Dr. Westin charted that the back problems started about a week after Petitioner was released from the hospital. Dr. Westin referred Petitioner back to Dr. Mekhail regarding her low back. Dr. Westin charted: "While it is certainly temporally related to her injury and certainly would be aggravated by her crutch walking and bed rest from the ankle injury, I would defer causal relationship to Dr. McKill [sic] who has treated her in the past." (Px 4)

Petitioner was seen by Dr. Mekhail on June 19, 2006. He diagnosed back pain and right LE radiculopathy. He recommended MRI with gadolinium and that Petitioner remain off work. Petiotioner was already on pain medication for her ankle. Petitioner returned to see Dr. Mekhail on June 29, 2006. He thought that the MRI showed a right protrusion at L5-S1 and some residual scarring at L4-L5. Therapy, epidural injections and continued off work were recommended. The last visit with Dr. Mekhail was September 18, 2006. Petitioner did not feel significant improvement with the recent injections. Slight improvement was noted with therapy. She continues to take Vicodin. Return to work with a sitting job and frequent breaks was recommended. Petitioner was to follow up in 4 to 5 weeks. Petitioner did not follow up with Dr. Mekhail. Dr. Mekhail did not provide any opinion on causation regarding Petitioner's back complaints. (Px 1)

Petitioner continued to receive follow up care from Dr. Westin, through October 6, 2008, when he declared her to be at MMI from an orthopedic standpoint (although with persistent pain-pain management follow up was recommended). Dr. Westin released Petitioner to seated work as of July 20, 2006. He noted that Petitioner was treating with Dr. Mekhail for her back and Mekhail would have to clear Petitioner for return to work as well. (Px 4)

TTD benefits were terminated as of July 31, 2006. There is no evidentiary basis in the Record for stopping TTD as of this date, although it could be speculated that Respondent disputes causation regarding Petitioner's back condition (albeit via Dr. Andersson's reports of 5/17/2010 and forward) and had seated work available for Petitioner in July of 2006. While Petitioner did return to work in a sedentary job after Dr. Westin's second release in September of 2006, there was no evidence that this job was available in July of 2006.

As of September 28, 2006, Dr. Westin released Petitioner to return to work with a 10 pound lifting limit and standing for no more than 3 hours out of an 8 hour shift. Petitioner returned to work with these restrictions on September 29, 2006. (Px 4)

Petitioner began a course of pain management treatment by Dr. Scott Glaser on August 8, 2006. She remains under Dr. Glaser's care. Dr. Glaser has provided treatment consisting of medications, lumbar injections of many kinds, radio frequency lesioning, and has proposed paravertebral sympathetic blocks for what he diagnoses as CRPS of the left foot. Dr. Glaser testified via evidence deposition. (Px 6a &6b, 13a & 13b)

Dr. Westin performed a left ankle hardware removal and tendon release and scar revision procedure on March 27, 2007. (Px 4) Petitioner was off work due to the surgery and was paid TTD from March 27, 2007 through May 8, 2007.

Petitioner returned to work on May 9, 2007 and Respondent has been able to accommodate the restrictions that Dr. Westin has placed. She now works in special account billing regarding the City of Chicago account, providing customer service. She has lost additional time from work (excused by PCP Lin) for which she has received group lost time benefits.

At various times after the accident, Petitioner has "rolled" or sprained her left ankle. It could have occurred at least 12 times, per Petitioner's testimony. Therapy noted that her ankle was swollen after rolling it on a rock at home in June of 2007. In September of 2010, she was walking her dogs (a German Shepherd and a Boxer) on uneven ground and rolled her ankle. She had treatment at Palos Community Hospital and with Dr. Beaty regarding this injury. The last visit with Dr. Beaty for the left ankle condition was on October 8, 2010. The diagnosis was pain and swelling of the left ankle. Fairly good stability of the ankle was appreciated. Petitioner was released, prn. (Px 5, 11)

Petitioner had continued treatment by Dr. Westin through October 8, 2008. He had declared her to be at MMI as of July 30, 2007 (Petitioner did state that she had ankle pain with increased activity {dancing at a wedding}), but not much treatment was anticipated. Thereafter, tarsal tunnel syndrome was considered and an MRI and EMG study was performed (as had been suggested by Dr. Senall. Dr. Westin injected Petitioner's left ankle on February 25, 2008, pending the MRI and EMG. The MRI failed to reveal significant intraarticular pathology, with no torn tendons or ligaments and the EMG was normal. When Petitioner was released from care by Dr. Westin in October of 2008, he instructed her to follow up with Dr. Glaser for pain management. (Px 4)

Respondent sent Petitioner for a §12 exam by Dr. Jeffrey Senall regarding her left foot on January 30, 2008. Petitioner was said to be status post bimalleolar fracture of the left ankle with ORIF on 4/15/2006 and hardware removal on 3/27/2007. Some hardware was still present. Petitioner's ankle condition is causally related to the injury. The work restrictions are appropriate. The treatment to date had been reasonable. Petitioner was not yet at MMI. There was the possibility of a tendon tear, or carpal tunnel syndrome. Accordingly, the MRI and EMG were suggested. (Rx 8)

Dr. Glaser referred Petitioner to Dr. George Miz (orthopedic surgeon) for a consultation regarding her low back in January of 2010. Petitioner was seen by Dr. Miz on January 21, 2010. Dr. Miz's diagnosis was left lumbar radiculopathy related to a recurrent disc herniation at L4-L5. Treatment options were conservative management vs. surgery. Likely surgery would be a microdiscectomy. Petitioner was to call if she wished to pursue the recommended care. Workers' comp would have to approve further treatment. Dr. Miz's records do not contain a causation opinion. (Px 7) Petitioner said that Dr. Miz did not want to deal with workers' compensation issues, so she did not follow up with him. This is not noted in Dr. Miz's chart. (Px 7)

Petitioner then had a consultation with Dr. Michael Zindrick (orthopedic surgeon) on June 2, 2010, again on a referral by Dr. Glaser. Dr. Zindrick's impression was L4-L5 recurrent disc herniation resulting in low back pain with left leg radiculopathy. Treatment options were continued conservative care, L4-L5 laminectomy and discectomy, posterior L4-L5 fusion, spinal stimulator to alleviate leg and ankle pain (Not likely to help with back pain), she can think over her options and return as necessary. Dr. Zindrick

did not review any prior medical records or diagnostic films. He did review the 8/28/2009 lumbar MRI. Dr. Zindrick testified via evidence deposition. (Px 8, 28)

Dr. Gunnar Andersson examined Petitioner at Respondent's request on September 28, 2010 and authored a report regarding the §12 exam. He also authored four other reports. Dr. Andersson testified via evidence deposition. (Rx 17)

Respondent obtained Utilization Review regarding treatment provided by Dr. Glaser and regarding proposed lumbar sympathetic blocks. Certain treatment was certified and other treatment, including the proposed sympathetic blocks (said to be for CRPS) was not certified. Dr. Glaser did not appeal any of the UR determinations. Dr. David Ciochetty, the UR physician, testified via evidence deposition. (Rx 11, 12, 13, 14, 15 & 16)

Petitioner continues to treat with Dr. Glaser, monthly. The injections and medications give her relief, but not 100%. Sometimes the injections last weeks, sometimes months. Dr. Lin provides Petitioner with scripts for medications, including narcotics. It does not appear that Dr. Lin is following any protocol regarding the medications. (Rx 25)

Petitioner continues to work for Respondent. She has had some time off work authorized by Dr. Lin. She has been paid group disability for some of these time periods. Dr. Lin does provide diagnosis such as low back pain, ankle pain and anxiety for the APS documents associated with this lost time. These documents also indicate that the time loss is not due to a work injury. (Px 27, Rx 3, 4, 5, 6, 25, 26 & 37)

Petitioner testified that she has low back pain. It is a sharp, shooting pain down the right buttocks, down the back of her leg to the calf. On the left, she has pain down the back to the upper thigh. Her ankle swells. She has a shooting pain up the leg. She has tenderness and it feels warm. It hurts to wear shoes. She has numbness in her foot. It is stiff and achy upon rising. She can't walk long distances. She can't carry groceries or laundry. Petitioner applies ice, elevates her foot, and takes Vicodin and muscle relaxers daily. She does not sleep well. She was active with hiking, biking and walking before the injury. She does not do so now. She performs less household chores. Some good days, she walks, walks her dogs and does grocery shopping. On bad days, she does not want to go out. She is in pain if she is on her feet too long, or sits for a long period of time. Petitioner played competitive pool before the injury. Now she plays less. She is in less tournaments now and was only in a few tournaments the last few years. (Rx 27, 28, 29 & 30) She does have to alter her position working around the pool table and she rests between shots. Petitioner has been on anxiety medication for years (7 years prior to trial?). She was referred to a psychiatrist in March of 2014. Petitioner did see a psychiatrist on a referral from Dr. Glaser regarding clearance for a neurostimulator. (Px 10) Petitioner feels that she has to be careful bending at work. Sometimes, she leaves work early, due to pain. She is able to complete her work on most days. She can sit or stand as needed at work. Petitioner wants to continue treatment with Dr. Glaser and would like to pursue the surgery that has been offered by Dr. Zindrick. Petitioner has put several of her current bills through group. She has not sought to have the proposed back surgery put through group. Petitioner does go to family functions, but her testimony is that her activity levels have decreased.

Respondent submitted surveillance evidence showing Petitioner's activities on July 21, 2012. Petitioner is seen walking with a slow and deliberate gait at the beginning and later walking and carrying small items with no problems. She gets in and out of her car several times to browse at several garage sales. She is seen picking up and carrying a 20 pound bag of ice. (Rx 33)

The Parties submitted medical testimony via 6 evidence depositions.

Dr. Scot Glaser testified for Petitioner on September 29, 2009 and November 11, 2009. Dr. Glaser is board certified in interventional pain management and anesthesia pain management. He specializes in the diagnosis and treatment of chronic pain. He first saw Petitioner on a referral from Dr. Mekhail on August 8, 2006. Petitioner had low back pain complaints. Medications, Lidoderm patches and a TESI was recommended. After the TESI, Petitioner noted 50% leg pain relief and 20% back pain relief. After the #2 TESI, Petitioner had complete leg pain relief, but still had back pain. Facet injections, medial branch nerve block and radiofrequency lesion procedures were done. Dr. Glaser said that Petitioner complained of ankle pain at her 8/8/2006 visit, although it is not clearly charted. Ankle and back complaints were noted at the 10/6/2006 visit. By January of 2007, Dr. Glaser was diagnosing CRPS of the ankle and recommending lumbar paravertebral sympathetic nerve blocks. In March of 2007, radiofrequency lesioning in the lumbar spine was done. Petitioner had the hardware removal procedure done in her ankle in March of 2007, and she was seen in follow up by Dr. Glaser on October 9, 2007. Petitioner's primary complaints were regarding her ankle at that time. Thereafter, she was seen in March of 2008, with worsening back and ankle pain. Further medications and injections took place in 2008 and 2009. A tarsal tunnel injection was performed on the left foot on August 25, 2009. As of the September 29, 2009 deposition, Dr. Glaser recommended the prescribed lumbar paravertebral nerve block for the ankle pain and another TESI for the radicular pain. If the ankle pain is shown to be sympathetic in nature, a neurolotic sympathetic block and radiofrequency lesioning of the sympathetic plexus would be considered. If the pain is neuropathic in origin, then a spinal cord stimulator would be considered. The next step for the back would be an open discectomy, if TESI procedures did not produce the desired results. Dr. Glaser causally related Petitioner's low back and left ankle complaints to the accidental injuries of April 14, 2006. The prognosis for Petitioner was guarded. She might do better with interventional pain management (long term relief), but she would likely have recurrent pain. (Px 13a, 6a)

The second deposition of Dr. Glaser took place on November 11, 2009. No back complaints were noted in the Mercy Hospital records from April of 2006. Petitioner's degenerative lumbar spine conditions (facet arthropathy, etc.) likely pre-existed the injury. He felt that the temporal relationship between the injury and pain complaints likely established causation. He would not be surprised that Petitioner had occasional flare-ups of back pain after the 2004 surgery and before April 14, 2006. (Px 13b)

Petitioner also presented the evidence deposition of Dr. Michael Zindrick. He is a board certified orthopedic surgeon, with an additional certification in spinal surgery. He saw Petitioner one time (on June 2, 2010). He saw Petitioner for a second opinion regarding her low back. Petitioner was referred to Dr. Zindrick by Dr. Glaser. Dr. Zindrick thought that Petitioner had symptoms from a L4-L5 recurrent disc herniation. He recommended a laminectomy or a laminectomy and fusion at L4-L5, with a consideration of L5-S1 fusion secondary to Petitioner's right leg complaints and the pathology at that level. Dr. Zindrick believed that the accident was a cause of the findings and conditions in Petitioner's low back, because of the onset of symptoms shortly after the accident and perhaps the altered gait after the ankle injury. Dr. Zindrick did not review the records of Dr. Mekhail, Mercy Hospital, Dr. Westin or Dr. Lin. He reviewed just the August 28, 2009 MRI film and not the other films. On cross examination, Dr. Zindrick agreed that the June 19, 2006 MRI report was consistent with degenerative findings at L4-L5. The April, 2008 scan showed a fragmented herniation at L4-L5. The August, 2009 film showed that the L4-L5 disc had deteriorated more. The pathology could be due to ADL's, Petitioner's habitus or the natural progression of DDD. The L3-L4 and L5-S1 levels showed some degeneration, but no dramatic increase in pathology. Dr. Zindrick agreed that it was possible that the degenerative condition alone

could lead to the proposed surgery. The trauma that Petitioner allegedly suffered could be a contributing factor in the progressive disc degeneration. (Px 28)

Respondent submitted the evidence deposition of Dr. Gunnar Anderssen, a board certified orthopedic surgeon with decades of spinal surgery experience. Dr. Anderssen authored four reports regarding this case and examined Petitioner on one occasion. Dr. Anderssen reviewed the MRI films of 1/20/2004, 4/14/2008 and 8/28/2009. He reviewed the report regarding the June 2006 scan. He testified that the August 2009 scan showed progression of the L4-L5 DDD, such that there was a protrusion on the left at that level that was not seen on prior scans. The 2008 scan showed degenerative changes at L3-L4, L4-L5 and L5-S1. There was no herniated disc and no significant stenosis. The disc herniation did not occur between 2006 and 2008. The April 14, 2008 scan was benign and the August 2009 had pathology that supported surgery. The protrusion therefore occurred between April 14, 2008 and August of 2009, as shown in the August 2009 scan. The work accident did not cause or contribute to the L4-L5 pathology noted on the August, 2009 MRI. The basis for Dr. Anderssen's opinion was that there did not appear to be an accident to the spine, the pain complaints Petitioner gave to Dr. Mekhail in June of 2006 were right sided (related to the disc protrusion at L5-S1). The treatment rendered by Dr. Glaser is not related to the April, 2006 accident. The treatment is related to the underlying degenerative condition of Petitioner's lumbar spine. The diagnosis was continued chronic low back pain. There was no causal relationship between the accident and the proposed back surgery. He did not think that an antalgic gait for two years after the accident would cause the L4-L5 disc condition to progress. An antalgic gait does not increase the load on the spine. Crutches tend to unload the spine. (Rx 17)

Respondent submitted two evidence depositions of Dr. David Ciochetty, MD, the physician who authored the UR reports. Dr. Ciochetty's practice is in anesthesia and pain management and he is board certified by the American Board of Anesthesiology. He is licensed in Illinois and two other states. As a UR physician, Dr. Ciochetty examines a case to see if there is enough clinical criteria and medical evidence to substantiate the need for the performance of a procedure or therapy. At the first deposition, Dr. Ciochetty testified regarding his retrospective review of bilateral medial branch nerve blocks at L2. L3, L4 and L5 performed on May 30, 2012 (Dep Ex 2, report of 9/5/12) and of 17 treatments and injections performed from 8/11/2006 through 3/12/2010 (Dep Ex 3, report of 9/7/12). (Rx 15) The May 30, 2012 medial branch blocks were non-certified because there was no current physical exam suggesting concern for facet mediated pain, there was no request for specific levels to be addressed, prior injections and radiofrequency lesioning had been performed and responses to the most recent interventional procedures and expectations for the current procedures were not defined, along with no current evidence of facet mediated pain, leading to the conclusion that medical necessity of the procedures was not evident. Six of the seventeen treatments and injections for the prior period were certified and eleven were non-certified. Dr. Ciochetty relied upon peer-reviewed guidelines in ODG and evidenced-based medicine in coming to his conclusions. The physical exam results set forth in the records don not support the treatment. (Rx 15)

The second Dr. Ciochetty deposition was regarding a prospective UR regarding 5 left lumbar sympathetic blocks to be done weekly regarding Dr. Glaser's proposed treatment for CRPS (Report dated 6/6/2013, Dep Ex 1). There was no obvious sign of CRPS. Petitioner exhibited some signs of CRPS, but did not exhibit several rather obvious signs of the disorder. She did show allodynia and mild hypersensitivity according to Dr. Ciochetty's review of Dr. Glaser's records. However, Petitioner exhibited normal pulses, normal capillary refill, normal skin temperature (no discrepancy, right to left), no loss of skin folds, no contractures, no hair loss, no edema, no skin atrophy and no nail ridging. There is no evidence

of CRPS, therefore the proposed treatment is not certified. Dr. Glaser did not request peer-to-peer review, or otherwise appeal the non-certification. (Rx 16)

CONCLUSIONS OF LAW

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

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT AND WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on April 14, 2006. She gave timely notice of the accident.

These findings are based upon the unrebutted testimony of Petitioner, Orlando DeJesus and the medical records.

WITH RESPECT TO ISSUE (F), IS PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's current condition of ill-being regarding her left ankle (to wit: crush injury with resulting bimalleolar fracture of the ankle with secondary fracture of the fibula, necessitating ORIF and subsequent partial hardware removal resulting in pain and permanent work restrictions as defined by Dr. Westin and Dr. Senall) is causally related to the injury. The Arbitrator does not find that Petitioner has a CRPS condition of the left ankle.

This finding is based upon the report of Dr. Senall and the records of Dr. Westin. Dr. Glaser's CRPS diagnosis is not persuasive, given the lack of objective findings to support the diagnosis, as was described by the persuasive testimony of Dr. Ciochetty.

Petitioner's current condition of ill-being regarding her low back (recurrent L4-L5 herniated disc with resultant back pain and radiculopathy) is not causally related to the accident.

This finding is based upon the persuasive opinion of Dr. Andersson. Dr. Zindrick's opinion regarding causal connection is not persuasive. The tone of Dr. Zindrick's testimony implies that he did not completely endorse his causation opinion. Further, it is noted that Drs. Mekhail and Miz did not render any opinions on causation. Finally, the CFD ambulance report and the Mercy records contain no mention of back complaints or findings. If Petitioner told these medical providers that she had fallen on her back as a result of the accident (an obvious major trauma), the providers would have charted it and comments regarding the exam would have been noted in the records. The medical records do not support a finding of causation regarding Petitioner's low back condition.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner claims $340,827.25 in medical bills. Respondent has paid many of the claimed bills via workers' compensation and group, as is evidenced by the submitted bills and Respondent's Exhibits 2, 35 and 36.

Having reviewed the submitted bills, it does appear that all of the claimed bills are for treatment regarding Petitioner's low back (denied based upon the Arbitrator's finding above regarding causation) or treatment previously paid by Respondent regarding Petitioner's left ankle, or non-certified charges. To the extent that Respondent has paid charges regarding treatment for Petitioner's low back, those payments should remain in effect. To the extent that there are unpaid bills regarding treatment for Petitioner's left ankle (other than treatment related to CRPS) those bills should be paid. Respondent is entitled to a credit for all bills paid, of course. Any medical expense awarded is pursuant to §§8(a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's finding above regarding causation, Petitioner's claim for prospective medical care is denied.

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:

Petitioner claims that she is entitled to TTD benefits for 57-3/7 weeks. Respondent claims that she is entitled to TTD benefits for 20-4/7 weeks. Respondent is entitled to a credit for TTD benefits paid. There is no §8(j) credit for awarded lost time based upon the TTD awarded below (no TTD after May 8, 2007) and Respondent's Exhibit 3 states "unknown" for STD paid during the period after TTD was stopped (July 30, 2006) and through September 28, 2006.

TTD benefits are awarded for 29-6/7 weeks for the time periods of 4/15/2006 – 9/28/2006 and 3/27/2007 – 5/8/2007 based upon the records of Dr. Westin and the other evidence adduced. While it can be argued that Petitioner is not entitled to TTD after Dr. Westin released Petitioner to seated work as of July 20, 2006, Respondent submitted no evidence that such work was available. Therefore, Petitioner is entitled to TTD through September 28, 2006, when Dr. Westin released her to restricted work which was accommodated by Respondent, effective September 29, 2006. The time period of TTD awarded in 2007 is for the time that Petitioner was off work after the hardware removal surgery.

The remaining claimed TTD is for time off work as excused by Dr. Chen and for which Respondent paid Petitioner group disability. This lost time is largely for Petitioner's back condition (not causally related

to the accident), or foot pain complaints not supported by competent medical evidence. The Arbitrator declines to award TTD after May 7, 2007.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's claim for Penalties and Attorney's Fees is denied based upon the Arbitrator's findings above regarding Causation, Medical Expenses and TTD.

Respondent's disputes regarding compensation and medical expenses and treatment are not found to be in bad faith or vexatious. Thus, no award pursuant to §19(k) or §16 is made.

An argument can be made that Petitioner is entitled to §19(l) penalties because of Respondent's failure to pay TTD from July 31, 2006 to September 28, 2006. §19(l) penalties are in the nature of a late payment fee and Respondent did not submit a written explanation of the reason for the termination of payment of benefits, as required by Rule 7110.70(b). On the other hand, Dr. Mekhail's records do not set forth a causal connection opinion. If Respondent does not remedy the underpayment, then the Commission should reverse this portion of the Decision and award the full amount of §19(l) penalties due.

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

Michael Knight,
Petitioner,

vs.

Village of Bartlett,
Respondent.

17IWCC0343

NO: 06 WC 54131

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, permanent disability, temporary disability, jurisdiction, statute of limitations 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 22, 2007, 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: JUN 1 - 2017
o5/25/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0343

MICHAEL KNIGHT
Employee/Petitioner

Case# **06WC054131**

VILLAGE OF BARTLETT
Employer/Respondent

On 10/22/2007, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 4.22% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1869 PRESBREY & ASSOC INC
821 W GALENA BLVD
AURORA, IL 60506

RUSIN MACIOROWSKI & FRIEDMAN L
10 S RIVERSIDE PLAZA
SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)
COUNTY OF COOK)

17IWCC0343

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Case # 06 WC 54131

Michael Knight
Employee/Petitioner

v.

Village of Bartlett
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 Kathleen A. Hagan, Arbitrator of the Commission, in the city of Chicago , on **September 11, 2007** . After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues indicated below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner filed an Application for Adjustment of Claim alleging a date of accident of June 6, 1999 assigned case # 00 WC 4979. The claim was dismissed for want of prosecution on November 6, 2003. A Motion to Reinstate was denied by the Arbitrator, affirmed by the Commission and confirmed by the Circuit Court. Petitioner has re-filed the identical Application for Adjustment of Claim as case # 06 WC 54131.

Section 6(d) of the Act provides, in part, that unless the application for compensation is filed with the Commission within three years after the date of accident, where no compensation has been paid, or within two years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred.

Petitioner has filed his duplicate claim more than seven years after the alleged date of accident. Petitioner argues that payments made to the Petitioner by the Village of Bartlett Police Pension Board constitute compensation under the Section 6(d) and tolls the statute of limitations.

This issue has been previously litigated and the Illinois courts have consistently held that pension boards and villages are separate legal entities and that payments made by a police pension board are not considered payments by the employer under the Act. In the case at bar, Petitioner acknowledges that he received duty related benefits from the Village of Bartlett Police Pension Board and did not receive workers' compensation benefits from the Respondent/employer.

The Arbitrator therefore finds that she has no jurisdiction as Petitioner's rights under the Act for the alleged accident date of June 6, 1999 were extinguished with the dismissal of case # 00 WC 4979 as confirmed by the Circuit Court on April 10, 2007.

ORDER

THE ARBITRATOR FINDS NO JURISDICTION. ALL CLAIMS FOR COMPENSATION ARE THEREFORE DENIED.

- The Respondent shall pay the Petitioner temporary total disability benefits of $ **n/a**/week for **n/a** weeks, from **n/a** through **n/a**, which is the period of temporary total disability for which compensation is payable.
- The Respondent shall pay the Petitioner the sum of $ **n/a**/week for a further period of **n/a** weeks, as provided in Section **n/a** of the Act, because the injuries sustained caused **n/a**.
- The Respondent shall pay the Petitioner compensation that has accrued from **n/a** through **n/a**, and shall pay the remainder of the award, if any, in weekly payments.
- The Respondent shall pay the further sum of $ **n/a** for necessary medical services, as provided in Section 8(a) of the Act.
- The Respondent shall pay $ **n/a** in penalties, as provided in Section 19(k) of the Act.
- The Respondent shall pay $ **n/a** in penalties, as provided in Section 19(l) of the Act.
- The Respondent shall pay $ **n/a** in attorneys' fees, as provided in Section 16 of the Act.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest of 4.22% shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Kathleen A. Hagan

Signature of Arbitrator
Kathleen A. Hagan

October 22, 2007
Date

OCT 22 2007

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
SANGAMON		☐ PTD/Fatal denied
	☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN ONDO,

Petitioner,

17IWCC0349

vs. NO: 08 WC 006504

MONTEREY COAL COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of occupational disease exposure arising out of and in the course of employment, last date of exposure, causal connection, and nature and extent of 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.

Based upon a review of the record as a whole, the Commission modifies the Arbitrator's permanent partial disability award from 10% loss of use of the person as a whole to 17.5% loss of use of the person as a whole under Section 8(d)2. The Commission bases the increased permanent partial disability award upon Petitioner's multiple conditions of coal workers' pneumoconiosis, asthma, and rhinitis related to the exposures as a coal miner. Relying upon Dr. Paul's findings and opinions regarding Petitioner's breathing difficulties, the Commission views Petitioner's permanent partial disability to be more severe than did the Arbitrator.

The Commission further modifies the Arbitrator's Decision to correct a scrivener's error in paragraph 6, the last line on page 11, from "April 6, 2011" to "December 5, 2005."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 20, 2016, is hereby modified for the reasons stated herein, and otherwise

affirmed and adopted. 17IWCC0349

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $494.82 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 17.5% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $24,900.00. 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: JUN 8 - 2017
KWL/bsd
O-04/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0349

ONDO, JOHN
Employee/Petitioner

Case# **08WC006504**

MONTEREY COAL COMPANY
Employer/Respondent

On 4/20/2016, 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 0.35% 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:

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

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST
SPRINGFIELD, IL 62705

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

17IWCC0349

JOHN ONDO
Employee/Petitioner

v.

MONTEREY COAL COMPANY
Employer/Respondent

Case # 08 WC 06504

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **February 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0349

FINDINGS

On **09/29/06**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***was*** last exposed to an occupational disease/***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 **$42,884.94**; the average weekly wage was **$824.71**.

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

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

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

ORDER

Respondent shall pay the Petitioner the sum of **$494.82/week** for a further period of **50** weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused a permanent and partial disablement to the extent of **10 %** MAW.

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

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

Signature of Arbitrator

April 17, 2016
Date

APR 20 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner began working in the coal mines in the 1970's.

The records of Dr. Daniel Wujek were admitted into evidence. The office notes from 1996 through 1999 contain no indications of any breathing problems or any complaints of any breathing problems (PX3).

Petitioner, a patient of Dr. Wujek, presented on June 7, 2001, complaining of "on and off" chest congestion for the last two days. (PX 3, p 36)

Petitioner sustained a right hand injury on October 22, 2001 for which he treated with Dr. Wujek and Dr. McKee. (PX 3)

Petitioner presented to Dr. Wujek on June 25, 2004 after falling five days earlier and hitting his chest on the edge of a door. He complained of worsening breathing and a painful cough accompanied by sinus drainage. He did not complain of any shortness of breath. Petitioner was placed on light duty. (PX 3, p 33)

Petitioner was seen by Dr. Wujek on July 22, 2005 for an insect bite. (PX 3)

Petitioner's next visit with Dr. Wujek was not until December 5, 2005 when Petitioner reported a history of tightness in his chest since before Thanksgiving. He indicated this was worse with exertion. Petitioner indicated that the symptoms had been associated with dizziness, dyspnea, and hypertension. Under review of symptoms, the respiratory portion indicates that Petitioner did not have any decreased exercise tolerance and did not have any difficulty breathing. Under "cardiovascular," the note says Petitioner had chest pain and difficulty breathing on exertion. The diagnosis was unspecified angina pectoris and Petitioner was sent for a chest x-ray and an electrocardiogram. A chest x-ray dated December 5, 2005 was described as "normal." (PX 3)

The medical records do not reflect another office visit to Dr. Wujek's office until April of 2006. The first visit was for a suture removal following a trigger finger surgery performed by a different doctor on April 3, 2006. The second visit, on April 21, 2006, involved skin changes and a cyst on his lower arm that was being removed. There was no mention of any breathing problems in either of those notes. (PX 3)

On April 28, 2006, Petitioner presented to Dr. Wujek complaining of a 3 day cough. Petitioner described the cough as dry and productive of mucoid sputum, albeit scanty. Petitioner's cough reportedly occurred all the time. Petitioner also reported being bitten by an insect while in the woods. The doctor's physical examination revealed a congested pharynx and purulent discharge of the oropharynx. The chest and lung examination was normal. There were no complaints of breathing problems. Petitioner was diagnosed with an insect bite and the physician's assistant prescribed three medications with no refills. (PX 3)

Petitioner's last day at the mine with Respondent was on September 29, 2006.

On December 19, 2007, and at Petitioner's attorney's request, B-reader, Dr. Henry Smith, reviewed a grade 1 chest x-ray dated November 1, 2007. Dr. Smith found mild interstitial fibrosis s/p, mid to lower zones, profusion 1/0. No other chest wall plaques, calcifications or large opacities were seen. There were slight thickened interlobar fissures. Mild chronic parenchymal scarring was seen in the anterior lung base.

Heart size was normal. There was modest lower dorsal spondylosis. Dr. Smith's impression was coal worker's pneumoconiosis (CWP) with interstitial fibrosis, mid to lower zones, profusion 1/0. (PX 2)

Petitioner signed his Application for Adjustment of Claim herein on January 18, 2008. (AX 2)

Petitioner underwent a CT of the brain without contrast dated November 4, 2008 due to left-sided facial pain. Under "Impression", it was noted that the findings were consistent with acute left maxillary sinusitis as well as some ethmoid disease. (PX 3, p 18)

Petitioner presented to the office of Dr. Wujek on December 12, 2008 having last been seen there on April 28, 2006. Petitioner was noted to be 56 years of age and complaining of nasal congestion that had been gradual in onset and occurring in a persistent pattern for three weeks. He described the congestion as increasing and severe. Drainage was noted along with a runny nose and productive cough with yellow phlegm. Petitioner reported his throat was sore in the morning and at night. He was diagnosed with acute sinusitis. (PX 3, p 3)

At Petitioner's attorney's request, Petitioner was examined by Dr. Glennon Paul on May 8, 2008. Dr. Paul issued a report summarizing his "Black Lung evaluation" noting that Petitioner's pulmonary function studies suggested a severe obstruction and a mild restrictive airway disease with marked reversibility after bronchodilation compatible with asthma. He concluded that Petitioner had CWP with lesions in his lungs that might cause early restrictive lung disease along with "a complicating asthmatic condition" and severe hearing loss secondary to noise pollution. (PX 1, ex. 2)

Petitioner presented to Litchfield Family Practice on December 6, 2010 for a physical exam. He reported he felt well with minor complaints. His current problems were noted to be hypertension and sinus problems. He reported that he occasionally couldn't catch his breath and had been under a lot of stress recently which, at times, led to some chest tightness. (PX 4, p 57)

Petitioner presented to Springfield Physicians Center dated December 29, 2010 for a cardiology consultation. Under the "History of Present Illness" it was noted that Petitioner, 59 years of age, had recently been seen by Dr. Wujek's team, who requested a stress test and a consultation. The patient denied any chest pain per se. He did have some shortness of breath, which he has had for many years since working in the mine. He denied any PND, orthopnea, or palpitations. Petitioner managed nearly 7 ½ minutes of a "Bruce protocol" without any symptoms of chest pain and claimed he could have exercised longer if allowed to. Dr. Jennison felt there was little evidence from the stress test to suggest any further cardiac evaluation was necessary at the time. (PX 4)

Petitioner had a stent placed in a coronary artery in early 2011. Medical records regarding that treatment are noted (PX4). At a follow-up on 11/16/11, Mr. Mishkel noted that Petitioner denied complaints of shortness of breath. In a letter dated 2/06/13, Dr. Mishkel indicated that Petitioner remained "extraordinarily active, rebuilding houses." (PX4).

Dr. Wujek re-examined Petitioner on February 21, 2011 for a post-op visit following placement of a stent. (PX 4)

Dr. Peter Tuteur evaluated Petitioner on March 2, 2011 (RX1, p. 3). In his report prepared after the examination Dr. Tuteur noted that Petitioner had retired from the mine because he was able to and had been motorcycling, maintaining a sports car and traveling since then. Dr. Tuteur acknowledged that "Clearly, he was exposed to sufficient amounts of coal mine dust to produce coal workers' pneumoconiosis in a susceptible host." (RX 1, Res. Ex. 2) Petitioner told Dr. Tuteur that towards the end of his mining career he was constantly clearing his throat and he perceived that he had a nasal drip. He

was currently able to walk one-half of a mile without stopping and could climb two flights of stairs. His cough was described as "nagging", mostly nonproductive, occurring daily and related to postnasal drip that was "clear and frothy." Petitioner acknowledged some wheezing but not real often.

Dr. Tuteur personally reviewed Petitioner's chest x-ray taken that day and found no evidence of abnormalities consistent with coal workers' pneumoconiosis. He also reviewed the reports of Drs. Mahon and Smith, the former finding the 2005 film negative while Dr. Smith considered the 2007 film as category "1/0." Dr. Tuteur wrote, "...whatever caused the interval development of findings that allowed Dr. Smith to make his interpretation are no longer present and therefore could not have been coal workers' pneumoconiosis, an irreversible pulmonary process." (RX 1, Res. Ex. 2, p. 2)

Dr. Tuteur reviewed his pulmonary function study dated March 2, 2011 with Dr. Paul's dated May 8, 2008. He described his "current study" as invalid as an assessment of maximum function with respect to spirometry. He noted that the best spirometry revealed no worse than a moderate obstructive abnormality. Due to the lack of reproducibility assessment a response to bronchodilators could not be made. Residual volume was elevated consistent with some airtrapping. Diffusing capacity was normal. There was neither impairment of oxygen gas exchange at rest or with exercise. (RX 1, Res. Ex. 2, p. 2)

Dr. Tuteur went on to comment that Petitioner was "clearly at risk for the development of coal mine dust associated disease." However, he felt there was no evidence to support the presence of simple coal workers' pneumoconiosis of "sufficient severity and profusion to produce clinical symptoms, physical examination abnormalities, impairment of pulmonary function or radiographic change." (RX 1, Res. Ex. 2, p. 3) With respect to the issue of airflow obstruction or COPD due to inhalation of coal mine dust or other factors in the mine, he felt one was limited in making "robust conclusions" because of the invalidity of the pulmonary function studies conducted that day and the numerically worse studies of 2008. Dr. Tuteur wrote, "If one accepts the numerical data as valid, then one would say that [Petitioner] has no worse than a moderate obstructive abnormality improved since the last study." His lung volumes and oxygen gas exchange were essentially normal. Dr. Tuteur recommended a sinus CT scan to further evaluate Petitioner. In the end, due to the "invalidity of current andpast pulmonary function studies, no statement can be made with reasonable medical certainty to indicate the presence of any form of legal coal workers' pneumoconiosis or bronchial reactivity." Dr. Tuteur felt Petitioner's heart disease and need for a stint was not causally related to his work in the coal mine. (RX 1, Res. Ex. 2)

Dr. Paul was deposed on March 14, 2011. (PX 1) Dr. Paul is the senior physician at the Central Illinois Allergy and Respiratory Clinic. Dr. Paul stated that Petitioner gave a history of working 37 years as a coalminer, 29 were above the ground as an electrician. Dr. Paul's diagnosis was pneumoconiosis and asthma. Petitioner on physical examination was found to have shortness of breath, wheezing, and coughing. (PX 1, p 10) Dr. Paul on physical has 3-4 plus wheezes and rhonchi with normal expiration. He attributed this wheezing and rhonchi to asthma. (PX 1, p 11) Petitioner's FVC was found to be 36 percent of predicted and the FEV1 38 percent predicted. Dr. Paul testified that normal is 80 to 120. (PX 1, p 11) Dr. Paul stated that with pulmonary function testing at those numbers Petitioner would not be able to work at that level. (PX 1, p 12) The lung volumes were 76 percent on the total lung capacity. Dr. Paul felt that that number indicated that Petitioner had some additional problems besides the asthma in his lungs known as restrictive lung disease that you can get with coal worker's pneumoconiosis. Petitioner had a diffusion capacity of 50% which Dr. Paul described as quite severe and attributable to the restrictive lung disease, coal worker's pneumoconiosis. (PX 1, p 12 & 13) Dr. Paul stated to a reasonable degree of medical certainty that based on his findings and testing, Petitioner had a diagnosis of coal worker's pneumoconiosis, which was caused by coal dust. Dr. Paul also felt that Petitioner had asthma and there was a "good chance" it was caused by exposures in the coal mine. (PX 1, p 15) According to Dr. Paul, the glues containing TDI and diesel exhaust would also be aggravating factors in the asthma. (PX 1, p 15)

Dr. Paul further testified that asthma and reactive airways disease are the same. Based upon Petitioner's pulmonary function testing, Dr. Paul felt that Petitioner had clinically significant pulmonary impairment. (PX 1, p 16 & 17) Based on all of the data available on Petitioner and in light of his diagnosis of pneumoconiosis and asthma and the severity of the pulmonary function abnormalities, to a reasonable degree of medical certainty, Dr. Paul felt Petitioner was totally disabled from working in the coal mine and that that restriction would be permanent. (PX 1, p 17 & 18) He further felt Petitioner was only capable of sedentary work. According to Dr. Paul, if a person has asthma, his whole life will change. That person will not be able to carry out the activities of daily life as he did before. He won't be able to run without severe shortness of breath or he will be limited from running at all. He won't be able to do heavy labor because of the same symptoms. Every time he gets a cold, he will go into bronchial spasms. He will make thick mucus, which plugs his airways. The airways will get narrow. He won't be able to pass any air through it. He will be uncomfortable. He won't be able to be around irritating chemicals at all, like diesel fumes or gasoline, because he might have the exact same symptomatology. So he will notice a big difference in his lifestyle than from what it was like before he had asthma. (PX 1, p 18 & 19) Dr. Paul testified that in order to have pneumoconiosis; you must have, in addition to coal mine dust deposited in your lungs, a tissue reaction to it. That tissue reaction can be called scarring or fibrosis. The scarring of coal worker's pneumoconiosis cannot perform the function of normal healthy lung tissue. (PX 1, p 20 & 21) By definition if you have pneumoconiosis, it is true that you have some impairment of the function of the lung at the site of the scarring whether it can be measured by spirometry or not. (PX 1, p 21) Dr. Paul explained that coal worker's pneumoconiosis is considered a progressive disease that is considered life threatening. (PX 1, p 25) Generally the progression of coal worker's pneumoconiosis is very gradual and that progression does not end with ending the exposure in the coal mine. (PX 1, p 26)

Petitioner returned to see Dr. Wujek on April 6, 2011 in follow-up from his upper GI study that revealed evidence of esophageal dysmotility with delayed transit. (PX 4, p 103) An operative report dated March 7, 2011 included a pre-operative diagnosis of dysphagia. The post-operative diagnosis was Gastritis and Duodenitis. Petitioner had undergone an esophagogastroduodenoscopy. (PX 4, p 110)

On April 16, 2011, Dr. Smith, a B-reader, interpreted a grade 1 chest x-ray dated December 5, 2005. Dr. Smith found interstitial fibrosis, p/s, bilateral mid to lower zones of a profusion 1/0. No chest wall plaques or calcifications are seen. There were thickened interlobar fissures. Heart size was normal. There was calcified thoracic aorta and modest lower dorsal spondylosis. Dr. Smith's impression was simple coal worker's pneumoconiosis with small opacities, primary p, secondary s, bilateral mid to lower zones of a profusion 1/0. (PX 2)

In an office visit with Dr. Wujek dated May 11, 2011 occasional dysphagia was noted and the doctor suspected Petitioner had quite a bit of postnasal drip and allergies. Given his normal esophageal manometry exam he suspected that might be part of the sinusitis. The doctor felt that once Petitioner's chronic postnasal drip had cleared, he expected his upper dysphagia to clear as well. If it didn't he wished to see Petitioner in follow up. (PX 4, p 102)

On June 22, 2011, Dr. Shipley, a certified B-reader, reviewed chest x-ray films taken on March 2, 2011. He found no evidence of coal workers' pneumoconiosis. He described the film's quality as "2" noting it was under inflated and had improper positioning. He further noted that it was a digital radiograph and not an analog exam and the ILO classification system was initially based on analog technique but the revised edition stated that whether the radiograph was good rested ultimately with the physician classifying the radiograph. While Dr. Shipley felt the exam quality was a "2" he noted that the overall study was acceptable and readable for the purposes of detecting coal workers' pneumoconiosis. (RX 2)

On March 8, 2011 Petitioner was seen at Prairie Cardiovascular. Petitioner reported remaining relatively active working on rental houses but denied any formal exercise program. Petitioner specifically reported

significant improvement in his shortness of breath. He was to return in six months. (PX 4)

On May 11, 2011 Petitioner was examined by Dr. Blaser in follow-up from his esophageal manometry that had been done in Springfield and read as normal. Dr. Blaser noted that Petitioner reported occasional difficulty with swallowing and quite a bit of postnasal drip and allergies. He recommended follow up for possible allergic rhinitis v. chronic sinusitis. The doctor suspected the difficulty swallowing would improve when the postnasal drip cleared. (PX 4)

Petitioner was seen at Litchfield Family Practice on September 13, 2011 for hypertension management. No problems with breathing were noted. (PX 4)

At a follow-up visit on November 16, 2011 with Petitioner's cardiologist, Dr. Mishkel, Petitioner denied complaints of shortness of breath. (PX 4)

Petitioner presented to Litchfield Family Practice on January 19, 2012 due to back pain and a cough. Petitioner reported difficulty walking due to his back pain which had begun three days earlier. He complained of a cough, wheezing, runny nose, stuffy nose and sore throat. His symptoms did not include chills, fever, chest pain or vomiting. The cough was described as hacking and productive and green in color. The cough reportedly began one week earlier and his symptoms were worsening. He was diagnosed with acute pharyngitis. (PX 4)

Petitioner underwent his annual exam at Litchfield Family Practice on April 12, 2012. He had no complaints, reporting that he felt well with good energy. He denied any regular exercise program. No coughing or difficulty breathing was noted. (PX 4)

Petitioner was seen at Litchfield Family Practice on April 14, 2012 for problems with eye pain. Petitioner reported cutting wood two days earlier and believing some wood got in his eye. (PX 4)

During an office visit with Dr. Wujek dated December 5, 2012, Petitioner reported cold symptoms including sneezing, nasal congestion, runny nose, postnasal drainage, scratchy throat, sore throat, productive cough, facial pain and headache. The onset was reportedly two weeks earlier and Petitioner described them as worsening. Associated symptoms include wheezing, shortness of breath, fatigue, weakness, fever and chills, while associated symptoms did not include plugged ear(s), ear pain, vomiting or diarrhea. He was diagnosed with a cold and cough. (PX 4)

Petitioner returned to Dr. Wujek's office on December 11, 2012, with a cough. His symptoms included a cough and runny nose, but no dyspnea, wheezing, chills, fever, stuffy nose or sore throat. The onset date was two weeks earlier. Petitioner's symptoms were described as improving. Note for "cough". He was diagnosed with an acute respiratory infection. (PX 4, p 27)

Petitioner had an appointment at Litchfield Family Practice Center on December 31, 2012 in follow-up for management of his hypertension. Petitioner denied any dyspnea. No cough or difficulty breathing was noted. (PX 4)

In a letter dated February 6, 2013, Dr. Mishkel, of Prairie Cardiovascular, indicated that Petitioner remained "extraordinarily active, rebuilding houses. He was up on a roof without any issues related to his heart." He did not need to see Petitioner for another year unless there were problems. (PX4).

Dr. Tuteur was deposed on May 23, 2013. Dr. Tuteur testified that he is board certified in internal medicine and pulmonary diseases (RX1, p. 4). With regard to Petitioner spending 29 years working above ground as an electrician, Dr. Tuteur indicated that he, in general, would have fewer exposures than

underground coal miners (RX1, p. 6). Dr. Tuteur indicated that Petitioner seemed to be an active individual. He did fall into the obese category but his weight was not such that it would likely impair pulmonary function. Dr. Tuteur noted Petitioner's history of a nagging cough associated with post- nasal drip. He found significant findings on the physical examination of the nasal passages including inflammation and scabs from previous bleeding (RX1, pp. 7-8). There were no findings consistent with an allergic rhinitis (RX1, p. 8). Dr. Tuteur noted that when there are nasal secretions, they can drip down the posterior pharynx into the lungs and cause a cough. Dr. Tuteur noted early inspiratory crackling sounds on physical examination of the chest. This would suggest secretions or inflammation in the larger airways which open up in early inspiration. Petitioner also cleared with cough suggesting that it was a secretion problem (RX1, p. 9). Dr. Tuteur noted that Petitioner had a cardiac work-up and stent placement about two months prior to the evaluation.

Dr. Tuteur testified that he reviewed chest x-ray films dated March 2, 2011 and found them to be "totally normal." (RX 1, p. 11)

With regard to the arterial blood gas study, the "at rest" values were within the normal range (RX1, p. 13). The oxygen saturation level was also measured within the normal range at rest. It remained normal during exercise. With regard to the pulmonary function study, when looking at the graphic data, there was inadequate reproducibility which meant the values did not accurately reflect maximum pulmonary function. Therefore, Dr. Tuteur could only state that Petitioner had no worse than a moderate obstructive abnormality but it could very well be much better (RX1, p. 13). Dr. Tuteur explained that the exercise arterial blood gas was not obtained because Petitioner became light-headed while pedaling. Dr. Tuteur noted that criteria for reproducibility is the two best test results in numerical values are within 5% of each other and he was not close (RX1, p. 14). Dr. Tuteur indicated that the pulmonary function results from Dr. Paul's evaluation also reflected a problem with reproducibility, the same sort of problem found at his exam. Dr. Tuteur indicated that Petitioner did not have coal workers' pneumoconiosis because he noted there were no restrictive abnormality and no impairment of gas exchange either at rest or during exercise. He also noted the negative chest x-ray (RX1, p. 15).

Dr. Tuteur also testified that Petitioner had no physical findings consistent with an interstitial pulmonary process. Dr. Tuteur noted that Petitioner's total lung capacity was 87% of predicted, within the normal limits. Dr. Tuteur indicated based upon the invalidity of the pulmonary function study, he was unable to determine whether there was an obstructive problem or chronic obstructive pulmonary disease. Additionally, there was no way to make a determination regarding reactive airways disease (RX1, p. 17).

On cross-examination Dr. Tuteur acknowledged that the inhalation of coal mine dust over many years can aggravate rhinitis, sinusitis, and bronchitis. (RX 1, p. 18) He also acknowledged that exposure to adhesives and plant glues could aggravate those conditions and Petitioner was exposed to those products. (RX 1, p. 19) He acknowledged that an above-ground electrician might have certain exposures that were harmful to them greater than those experienced by some underground miners. (RX 1, pp. 20-21)

Dr. Tuteur further acknowledged that Petitioner's history reflected progressive exercise intolerance over his lifetime. (RX 1, p. 26) Petitioner had a nagging cough and problems with excess mucus. He did not feel Petitioner had chronic bronchitis because such a condition would result in a cough most days three months out of the year in two successive years with no other explanation. If it's a cough initiated by rhinorrhea and rhinitis, it's not chronic bronchitis. (RX 1, p. 26) He agreed that Petitioner has rhinitis, noting he refused a CT scan to evaluate it. He also refused a CT scan to evaluate if there was bronchial mucosal thickening. Petitioner was unable to perform in both his and Dr. Paul's lab a valid way to assess airflow obstruction and all the effort-independent tests on pulmonary functions were normal. The bottom line, according to Dr. Tuteur was that Petitioner has inflammation of his nose; however, he didn't feel it was a coal mine dust-related disease. He acknowledged, however, that it could be aggravated by the coal

dust. (RX 1, p. 28)

Dr. Tuteur testified that Petitioner retired because he was able to do so in terms of retirement funds and he had been very active post-retirement and then developed symptoms along with cardiac arrhythmia and, incidentally, "he has a bad nose." (RX 1, p. 29)

Dr. Tuteur testified that a moderate obstructive ventilator defect could "remotely" put an extra burden on the functioning of the heart but "typically" and "with reasonable medical certainty" does not. (RX 1, p. 29) He later testified, "...it is not unlikely that the coal dust produced his COPD, with the key additional information that you provided was that it was a non-smoking coal miner, and I assume by that you mean never-smoking." (RX 1, p. 30)

Dr. Tuteur testified that some objective data is missing in Petitioner's case because he couldn't perform his pulmonary function studies properly for either himself or Dr. Paul. He acknowledged that it is possible some people could have problems with their pulmonary function to the extent that they aren't able to perform valid, consistent testing. (RX 1, p. 33) He noted that Petitioner reportedly had difficulty following directions on all tests and especially those requiring maximal inspiratory effort. (RX 1, p. 34) The notations with regard to the pulmonary function study indicated that Petitioner had difficulty following directions of all tests. ATS criteria were not met for most tests due to submaximal and erratic effort, combined with frequent cough. Petitioner especially had difficulty performing tests requiring maximum inspiratory effort (RX1, p. 34). With regard to the exercise study performed by Petitioner, Dr. Tuteur indicated this would not preclude him from doing heavy manual labor for a full work day (RX1, p. 37-38). Dr. Tuteur noted that Petitioner had obstruction of his coronary arteries and was taking four medications. He also noted that the part of pulmonary function testing that was valid was normal. He also mentioned nasal mucosa problems (RX1, p. 40). Dr. Tuteur acknowledged that the inhalation of coal mine dust can result in shortness of breath and a cough. (RX 1, p. 41) He also agreed that once a person has radiographically significant coal workers' pneumoconiosis he should not have further exposure to coal mine dust. (RX 1, p. 43) One can also have radiographically significant coal workers' pneumoconiosis (CWP) and still have normal pulmonary function testing. (RX 1, p. 44) He agreed that if Petitioner had simple CWP he would not expect him to be experiencing any symptoms that would cause him to complain to his doctor. (RX 1, p. 45)

Dr. Tuteur acknowledged that he used Knudson's predicted normals in his testing while the American Thoracic Society and American Medical Association recommend the use of Crapo normals. (RX 1, p. 48)

Dr. Tuteur was asked various questions about CT scans and their role in CWP. (RX 1, pp. 62 – 69)

Dr. Tuteur acknowledged that he took the B-reader exam but didn't pass. (RX 1, p. 69)

Dr. Tuteur indicated he found no obvious reason why Petitioner could not perform the spirometry in a valid way. This spirometry was invalid at the baseline and with the administration of the bronchodilator (RX1, p. 73). On redirect examination Dr. Tuteur testified that Petitioner's cough could be due to a bad nose. He has not diagnosed Petitioner with chronic bronchitis or sinusitis due to the testing problems. There was no valid objective data to support an obstructive abnormality. There was no diagnosis of chronic bronchitis and no diagnosis of sinusitis (RX1, p. 74).

Petitioner treated at Litchfield Family Practice in January, April, June, July and September of 2013. Petitioner's problems included acute right knee pain, cellulitis, foreign bodies in his eye, and a general health exam. (PX 4) Petitioner's right knee pain followed a specific injury involving Petitioner's dog and a fall. (PX 4) When Petitioner reported for his general health exam on April 24, 2013 he reported feeling well with minor complaints, a good energy level, and no problems sleeping. His appetite was normal and

he reported no exercise during the week. He denied any current medical problems. His breathing was normal as was his heart.

Petitioner was seen at the Springfield Clinic in September of 2013 for right knee problems associated with the earlier episode involving his dog followed by two further injuries to his knee when he stepped in potholes wrong. Petitioner reported pain when going up and down his ladder, noting that he was redoing the siding on his house and going up and down it all day long. Conservative treatment was recommended. (PX 4)

Petitioner presented to Litchfield Family Practice Center on July 1, 2014 for a physical examination. He reported feeling well with minor complaints and good energy. He denied any chest pain or shortness of breath. He did note a cough and sputum production in the early morning. He also had some left heel pain of three weeks duration. (PX 5)

On August 8, 2014, Dr. Tarver, a certified B-reader, reviewed chest x-ray films taken on March 2, 2011. In his report he found no evidence of coal workers' pneumoconiosis. He described the film's quality as "1." He further noted that it was a digital radiograph and not an analog exam and the ILO classification system was initially based on analog technique but the revised edition stated that whether the radiograph was good rested ultimately with the physician classifying the radiograph. (RX 2)

Petitioner is a non-smoker. (PX 3, 4, 5)

Petitioner's case proceeded to arbitration on February 19, 2016. Petitioner was the sole witness testifying at the hearing.

Petitioner lives in Sawyerville, Illinois and was 64 years of age at the time of arbitration with a date of birth of December 21, 1951. He is married to Sandra Ondo. Petitioner graduated from Gillespie High School and thereafter continued his education at Lewis and Clark Community College where he received a certificate as an electrician. Petitioner testified that he worked 37 years in the coal mining industry with approximately the first 6 or 7 of those being underground. Petitioner further testified that, in addition to coal dust, he was exposed to silica, rock dust and roof bolting glue fumes.

Petitioner testified that he last worked in the coal mine in September of 2006. On that day, he worked for Respondent at their #1 mine. He was 54 years of age, worked in the classification of a surface electrician, and was exposed to and breathed coal mine dust. According to Petitioner, this was his last day of work in the mine because he was having health issues "with breathing and stuff." He had never smoked and was able to retire at that time so he decided it might be in his best interests. He further noted that his wife wanted him out of there.

Petitioner testified to no subsequent mining employment.

Petitioner testified regarding his employment history. In 1970, Petitioner worked for a contractor named "Allen & Garcia." This contractor actually built the Monterey mine. After approximately 2 years of building the mine, he hired on with Monterey. In 1972, Petitioner hired in as a general laborer. Petitioner worked, approximately his first 7 years underground, at the face of the mine. Petitioner worked in a unit, which included roof bolting, running a continuous miner machine and repairmen. Petitioner testified that working at the face of the mine is generally considered one of the dustiest areas of the mine. Petitioner went to the surface of the mine around 1979-1980. He went with the job classification of electrician. Petitioner primarily worked around the prep plant where the processed coal is dried and shipped. Petitioner also ran a 770, 350 ton truck a few days a week when somebody was off or when they were short-handed. He described the truck as pulling under a 100-ton bin were 50 tons of "gob" were put in the

truck and you hauled that to a hill where it was disposed of. Petitioner testified that "gob" was the stuff that is thrown away in the coal process. Petitioner testified that he felt that up on the surface, on the first and second floor under the silos, there was more dust exposure than underground in the early days because there was no water that got sprayed on the coal. Petitioner testified that he was continually exposed to coal dust on the surface of the mine.

Petitioner also testified to exposure to diesel fumes as they were present in the "prep plant." The fumes would come up through the "gob" bin and go into the entire plant.

Petitioner was asked when he first began noticing breathing problems at work and he explained that when he first started there they didn't have very good sprays on the miners or anything but it has continuously gotten better. He could tell a difference from when he first started until he went to the surface and he was sure it was better now (the dust control). However, when he first began there wasn't much protection for coal dust. His attorney then asked him if ten years prior to his retirement sounded about right and Petitioner replied, "Oh, yeah." At that time he was working on the surface.

Petitioner testified that his breathing has worsened since leaving the mine. He also testified that from the first time he noticed it until he left the mine it got worse because he would have more trouble breathing and more colds and coughing.

Petitioner testified that his daily living is affected by his breathing difficulties. Petitioner testified that he used to do a tremendous amount of walking and hunting but he has had to quit the hunting and can't walk near as far as he used to. Petitioner also gave testimony that he rehabbed houses but has had to almost give that up because of his breathing.

Petitioner also testified that he was given an inhaler after his doctor's deposition and he uses an emergency inhaler called ProAir HFA. He uses it several times a week. Petitioner's treating doctor is Dr. Wujek and Petitioner testified that he has discussed his breathing problems with him, especially in the last five years since it has gotten quite a bit worse. Petitioner has never smoked cigarettes. In addition to breathing problems, Petitioner has had a stent put into his heart and takes medication for hypertension.

On cross-examination Petitioner acknowledged that the mine closed in 2007. He was asked about his rehabbing of houses and explained that his dad left him some houses and he usually hires someone to go in and take the stuff out of the house and then he and his son go in and re-insulate, wire, and hang drywall. He doesn't want to do all of the removal work as he has worked every day and wants to hire someone to do that. Petitioner testified that he is getting rid of the houses because he is getting to a point where he can't do it.

The Arbitrator notes that throughout the hearing Petitioner was coughing a great deal.

The Arbitrator concludes:

Issue (C and O): Did Petitioner suffer a disease which arose out of and in the course of his employment by Respondent?

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

The Arbitrator resolves the issue of occupational disease in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from coal workers' pneumoconiosis, asthma, and rhinitis related to his exposures as a coal miner, the CWP being caused by the exposures and the remaining conditions being aggravated by them. Petitioner is a non-smoker, having never smoked in his life. He worked as a coal

miner for 37 years and, indeed, helped construct the mine. During his coal mine work, in addition to coal dust, he was exposed to silica, diesel fumes, roof bolting glue fumes, and fumes from adhesives used to repair coal chutes.

Dr. Paul, Petitioner's examining expert, diagnosed CWP and asthma, both caused by his coal mining exposures, (PX 1, pp. 14-15) His testing also showed a severe obstructive ventilatory defect and a mild restrictive defect. (PX 1, p. 13) On physical examination of the chest, Dr. Paul found 3 to 4+ wheezes and rhonchi with normal expiration, "That's quite a bit." He attributed the wheezing and rhonchi to asthma. (PX 1, p. 11) He found there was a good chance that coal mine exposures cause asthma, specifically, "any of the chemicals that are used in the coal mine such as glues that contain TDI," and also diesel exhaust. (PX 1, pp. 14-15, 45) He testified that CWP can cause either obstructive or restrictive defects. (RX 1, p. 24) He testified that coal mine dust can result in shortness of breath, chronic cough, emphysema, chronic bronchitis, and occupational asthma, and that coal mine exposures can aggravate emphysema, chronic bronchitis, and asthma. (PX 1, p. 30)

Dr. Paul testified that in addition to shortness of breath, wheezing and coughing, Petitioner told him about nasal congestion, rhinorrhea, and post-nasal drip. Dr. Paul further testified that those are not suggestive of some type of allergy. "No, that's suggestive of reactive upper airway tissues." It has to do with rhinitis. (PX 1, p. 46) He said that the same things that cause reactivity of the lower airways can cause reactivity of the upper airways. "...so the same things that affect the lower airways affect the upper airways...It doesn't mean that it's part of allergy. It just means it's reactive. That doesn't mean that allergy doesn't play a role here, too." (PX 1, p. 46) Dr. Tuteur agreed with Dr. Paul, saying that rhinitis, sinusitis, and bronchitis are all related in that they have to do with problems with the mucosa, excess mucous. (RX 1, p. 18) He also testified that the inhalation of coal mine dust over many years can aggravate rhinitis, sinusitis, and bronchitis. (RX 1, p. 17) Dr. Paul further clarified that the cause of Petitioner's asthma would also have been a causative or aggravating factor in his rhinitis. (PX 1, p. 51)

Dr. Tuteur disagreed with Dr. Paul, determining that both his pulmonary function testing and that of Dr. Paul were invalid. (RX 1, pp. 13-15) Nonetheless, he testified that based on the best numerical data from his testing, Petitioner has no worse than a moderate obstructive abnormality. (RX 1, p. 13)

The Arbitrator specifically notes that Dr. Tuteur testified that based on the invalidity of the testing, he was unable to determine either that there was or was not any obstructive problem or any COPD. (RX 1, pp. 16-17) He further testified that it could be said that there was no worse than a moderate obstruction, but due to the invalidity of the testing, one cannot make an assessment of the presence or absence of a COPD picture which can be seen in response to the inhalation of coal mine dust. (RX 1, p. 17) He also could not make a determination one way or the other as to whether Petitioner has any reactive airways problem. (RX 1, p. 17)

Dr. Tuteur testified that if a person were exposed to TDI while working with the adhesives used to repair coal chutes, sometimes called plant glue, sometimes called Strong Seal, that could cause and aggravate rhinitis, sinusitis, and bronchitis and that it could also cause and aggravate reactive airways disease. He further opined that it appears that Petitioner was exposed to that. He added that "It's not the first miner I've evaluated from this mine and those who are so exposed have the possibility of developing reactive airways disease to that material." (RX 1, p. 19) He also testified that the burning, smoldering smoke and fumes from overheated cables and electric devices in an above ground mine can be something that can cause and aggravate reactive airways disease. "The potential is there..." He added that personally he would expect that Petitioner would have been regularly called on to work on electrical parts, electrical machinery and electrical cables that were having problems and may have been overheated and had fumes and smoke. (RX 1, pp. 20-21) Dr. Tuteur explained that once a person has a reactive airways disease, repeated exacerbations can worsen it, and also that "A miner could be exposed to the

agents that can cause and aggravate reactive airways disease but have it as an onset over a long period of time, what I think of as not-so-sudden onset." (RX 1, p. 22)

Again, Dr. Tuteur testified that if the testing in his lab actually did represent the best that Petitioner could do, it would show a moderate obstructive defect, and that from time to time, persons with bronchial reactivity will have testing that demonstrates an obstructive abnormality. (RX 1, pp. 23-24)

Dr. Tuteur offered that a coal miner can absolutely be exposed to the fumes from roof-bolting glues yet not be a roof bolter, and that based on the data set he had, he could not rule out that Petitioner was exposed on occasion to broken tubes of roof bolting glue. (RX 1, pp. 25-26) Dr. Tuteur admitted that over his lifetime, Petitioner has had progressive exercise intolerance; that his cough was a nagging cough; that he has great problems with excess mucous; and that it's possible that a definition of chronic bronchitis could be applied to this case. (RX 1, p. 26) He also said that if you see a coal miner walking down in a coal mine who's a non-smoker coughing and having the same symptoms as Petitioner and he says, "Boy, I've got COPD." You would not say, "That's atypical." That's something that can happen from this environment. (RX 1, p. 30) In addition, he admitted that Petitioner had sufficient exposure to cause legal pneumoconiosis, sufficient exposure for obstructive airways disease, that the inhalation of coal mine dust can result in shortness of breath, and that it can result in cough. (RX 1, pp. 40-41)

Dr. Tuteur disagreed with Dr. Paul and with the primary care physicians as reflected in their records, saying "There were no findings consistent with an allergic rhinitis. There was no bogginess. Mucosa wasn't pale. The secretions weren't water-like." (RX 1, p. 8) However, he also provided the following contradictory testimony, "The point is, he has inflammation of his nose. That, we know for sure. That's not a coal mine dust-related disease process, "but it can be caused and aggravated by it." (RX 1, p. 28)

Dr. Tuteur testified that he disagreed with the American Thoracic Society (ATS) which has published its position statement which finds a much greater risk from coal mine dust than he does. (RX 1, p. 54) He also testified that he disagreed with NIOSH and the Department of Labor (DOL) which find a greater risk from coal mining than he does. (RX 1, p. 56)

Regarding CWP, Dr. Paul found fibronodular areas throughout the lower and middle lung fields consistent with CWP. He is not a B-reader but has read 100 chest x-rays per week for the past 35 years, more than radiologists at local hospitals, because those radiologists read x-rays of other parts of the body, while Dr. Paul reads only chest x-rays. (PX 1, p. 7) He confirmed that of all of the chest x-rays sent to him by Petitioner's counsel, he has failed to find pneumoconiosis in a majority of them. (PX 1, p. 37) His readings were consistent with those of Dr. Smith, Petitioner's B-reader, who also found CWP in the mid and lower zones.

On the other hand, Respondent's two B-readers disagreed with each other on their interpretation of the x-ray of March 2, 2011, with Dr. Shipley finding it quality 2 due to improper position and underinflation (RX 2) and Dr. Tarver finding it to be quality 1. (RX 3) The reading of Dr. Shipley was, in fact, equivocal. He wrote that the film showed no upper zone predominant small or large rounded opacities to suggest CWP. By the plain wording of that report, Dr. Shipley found no CWP because he saw no rounded opacities predominantly in the upper zones; however, there is nothing in the record to prove or even support the contention that for there to be CWP, the opacities must be round or that they must be upper zone predominant. Both Dr. Paul and Dr. Smith, in fact, found CWP based on abnormalities in the mid and lower zones. Dr. Tarver did not indicate a need to find upper zone predominant round opacities. Dr. Teuter is not a B-reader. Respondent did not have B-readers review the November 1, 2007 and April 6, 2011 chest x-rays.

Based on the inconsistencies between Respondent's B-readers, the Arbitrator gives greater weight to the readings of Dr. Paul and Dr. Smith on the issue of CWP. Based on the equivocal testimony of Dr. Tuteur that he was unable to determine either that there was or was not any obstructive problem or COPD, (RX 1, pp. 16-17) and that he also could not make a determination one way or the other as to whether Petitioner has any reactive airways problem, (RX 1, p. 17) the Arbitrator gives greater weight to the testimony and findings of Dr. Paul.

Dr. Tuteur testified that the pulmonary function testing from his lab as well as that from Dr. Paul's lab was invalid. However, Dr. Paul did not find his tests to be invalid, and Dr. Tuteur did not sufficiently describe the basis of his opinion that all of the testing was invalid. Even if the testing from Dr. Tuteur's lab was not valid, Dr. Tuteur admitted that some people can have problems with their pulmonary function to the extent that they're not able to perform valid, consistent pulmonary function testing. (RX 1, p. 33) It is clear from the description of Petitioner's testing by Dr. Tuteur's lab that Petitioner had physical difficulty in performing the testing. "Patient had difficulty following directions of all tests. ATS criteria not met for most tests due to submaximal and erratic effort, *combined with frequent cough*...Patient especially had difficulty performing all tests requiring maximal inspiratory effort." (RX 1, p. 34) (emphasis added) This lack of physical ability to perform better was consistent with the lab's reporting of the exercise testing: "Rest and arterial blood gas exercise not obtained. Patient became lightheaded at peak exercise, was immediately moved to recliner. Nebulized (ph) 2.5 mg of albuterol given. *Postbronchodilator patient effort improved despite cough.*" (RX 1, p. 34) (emphasis added) Even Dr. Tuteur admitted that it was not his opinion that Petitioner was giving less than his best effort: "I didn't say he was dogging it. That's why I quoted what was said." (RX 1, p. 34)

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the credible evidence that Petitioner's heart problems are causally related to his work as a coal miner.

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

Dr. Paul was of the opinion Petitioner should only be working in a sedentary capacity. However, evidence found in the medical records subsequent to September 29, 2006 reveals someone engaged in much more than sedentary activity. The Arbitrator notes that following his retirement from Respondent on September 29, 2006 Petitioner continued his work rebuilding houses. The Arbitrator further notes the medical records from Petitioner's cardiologist. In a letter dated 2/06/13, the doctor indicated that Petitioner remained "extraordinarily active, rebuilding houses" (PX4). He was climbing up and down ladders reporting the only problem was with his knees. As of the date of arbitration, he was still doing that, although he indicated he had cut back. The medical records from Dr. Wujek, Petitioner's family doctor, do not reflect an ongoing problem with shortness of breath. Based upon all of the evidence, Petitioner has sustained a 10% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martin Wright,

Petitioner,

vs.

NO: 08 WC 14739

17IWCC0345

Clearwater Technology & Illinois
State Treasurer Ex-Officio Custodian
Injured Workers' Benefit Fund,

Respondent,

DECISION AND OPINION ON REVIEW

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

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

17IWCC0345

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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 6 - 2017
o052517
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WRIGHT, MARTIN
Employee/Petitioner

Case# **08WC014739**

CLEARWATER TECHNOLOGY & ILLINOIS STATE TREASURER EX-OFFICIO CUSTODIAN INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0345

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:

0147 CULLEN HASKINS NICHOLSON ET AL
ERIC A LOPEZ
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0000 CLEARWATER TECHNOLOGY
11426 S PERRY AVE
CHICAGO, IL 60628

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0345

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

Martin Wright
Employee/Petitioner

Case # **08 WC 14739**

v.

Clearwater Technology, & Illinois State Treasurer, *ex-officio* custodian, Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **March 2, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD

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

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

N. ☒ Is Respondent due any credit?

O. ☒ Other: **Was Respondent insured?; Was Respondent given proper notice?**

FINDINGS

On **07/31/2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**4,552.50**; the average weekly wage was $**400.00**.

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

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

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

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

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

ORDER

Respondent, Clearwater Technology, shall pay Petitioner a total of **$191.00** for reasonable and necessary medical services pursuant to § 8(a) of the Act: Ingalls Memorial Hospital, $67.00; Radiology Imaging Consultants, $26.00; and St. Bernard's Hospital, $98.00, adjusted in accord with the fee schedule provided in §8.2 of the Act.

Respondent shall hold Petitioner harmless for payments made by Harmony Health Plan.

Respondent, Clearwater Technology, shall pay the Petitioner temporary and total disability benefits at the rate of **$266.64/week** for a total of **3** days, because the injured sustained caused Petitioner to be temporarily totally disabled from August 1, 2007 through August 3, 2007.

Respondent, Clearwater Technology, shall pay Petitioner permanent partial disability benefits for a total of **12.65** weeks, because the injuries sustained caused **5%** loss of use of left arm, as provided in § 8(e) of the Act.

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

November 4, 2016
Date

ICArbDec p. 2

NOV 7 - 2016

Martin Wright v. Clearwater Technology and Illinois State Treasurer, *ex officio* custodian, Injured Workers' Benefit Fund
08 WC 14739

INTRODUCTION

This matter proceeded to hearing before Arbitrator Steven Fruth. All issues were disputed. Petitioner was present and represented by counsel. The Illinois Attorney General's Office appeared on behalf of the Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund. Respondent Clearwater Technology was not present but had received notice of the hearing.

STATEMENT OF FACTS

Petitioner Martin Wright testified that he was employed by Respondent Clearwater Technology, Inc. as a laborer for seven years. His job duties included cleaning up waste at industrial sites by using water transmitted through a vacuum hose connected to a diesel truck. Tools utilized included scrapers, picks and shovels. Petitioner testified that the tools were provided by Respondent.

Petitioner testified that sometime before 2007 John Di Mari purchased the company. Work schedules were set by Mr. Di Mari. Petitioner explained that his supervisor, John Reardon, controlled his job duties. Petitioner would be sent to different job sites, sometimes traveling in a company van and sometimes driving his own car. All tools, machinery and vehicles he used in his occupation were provided by the Respondent. Additionally, Petitioner stated that the trucks and vans that transported the industrial vacuums had Clearwater Technology decals on them.

Petitioner earned $10.00 an hour, working 40 hours a week. He stated that he was paid by check although he did not produce any of those checks at trial. He produced an IRS W-2 (PX #5) from Respondent for the year 2007 with wages of $4,552.50. He explained that the W-2 reflects his wages through the date of accident as he did not return to work after the accident. He testified that he was 38 years old, not married but had one dependent child.

On July 31, 2007, Petitioner was working with a vacuum hose, cleaning waste under a tank when he bumped his left elbow. He had a tingling, "funny-bone" feeling in his elbow. He mentioned the bump to his supervisor Mr. Reardon during his break but continued working the remainder of the day. At the end of that day, he had pain with numbness and tingling feeling into his hand and fingers.

Petitioner sought treatment at Ingalls Memorial Hospital the same day (PX #6). He gave a history of hitting his left elbow on machinery, causing 5/10 pain. He also complained of numbness in 3rd, 4th, and 5th fingers. X-rays were negative. Petitioner was discharged with diagnoses of probable neurapraxia, elbow contusion, and ulnar palsy. He was taken off work through August 3. He was advised to follow up with a physician.

Petitioner notified Mr. Reardon that he had been injured the next day, August 1. Mr. Reardon told him to come to the office to talk to Mr. Di Mari. He reported his accident and elbow injury to Mr. Di Mari. He gave Mr. Di Mari his ER note.

Petitioner saw Dr. Lisa Green at Family Christian Health Center on August 8, 2007 (PX #7). She referred him to a specialist, Dr. Richard O'Young. Petitioner saw Dr. O'Young August 23, 2007 at St. Bernard Hospital (PX #8 & PX #9)). Dr. O'Young diagnosed left elbow neuritis and recommended physical therapy. Dr. O'Young noted that Petitioner may need surgical transposition of the ulnar nerve. Petitioner testified that Dr. O'Young in fact recommended surgery and advised Petitioner to remain off work. He also testified that he had four physical therapy sessions, although no records or billing for therapy were offered in evidence.

Petitioner testified that he was unable to work from July 31, 2007 through his last received medical visit, August 23, 2007, due to pain and numbness in his left arm and fingers Petitioner testified that he did not quit his job but just never returned. He learned through a buddy that Clearwater subsequently went out of business in July 2008.

Petitioner also testified that he continues to experience a slight pain but only when doing repetitive work. He has sought no further treatment and has no permanent restrictions. He is currently employed at shipping and handling facility, since 2015. His duties include working on an assembly line pushing boxes weighing up to 50 pounds.

The admission of Petitioner's Exhibit #5 was reserved. All other exhibits offered by Petitioner were admitted.

CONCLUSIONS OF LAW

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

The evidence established that Respondent Clearwater was operating under and subject to the Illinois Workers' Compensation Act.

B: Was there an employee-employer relationship?

Petitioner's testimony regarding his employment by Respondent Clearwater was unrebutted. Furthermore, Petitioner's Exhibit #5, IRS W-2 for 2007 clearly established that an employee-employer relationship existed at the time of the accident.

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

The evidence established that Petitioner was injured in an accident that arose out of and in the course of his employment by Respondent Clearwater.

D: What was the date of the accident?

The evidence established that the accident occurred on July 31, 2007.

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

The evidence established that Petitioner gave timely notice of the accident to Respondent Clearwater.

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

Petitioner testified credibility that he hit his left elbow on machinery while at work on July 31, 2007. He had immediate pain and numbness in the arm. He sought emergency care on the date of the accident. He followed up with several physicians. He was diagnosed with left elbow neuritis. Dr. O'Young discussed possible surgery but Petitioner did not follow up with Dr. O'Young. Petitioner recovered sufficiently to return to full time work which involved repetitive arm and hand movements.

Petitioner proved that his condition of ill-being was casually related to the accident.

G: What were Petitioner's earnings?

The evidence established that Petitioner's average weekly wage was $400.00 at the time of the accident.

Petitioner testified that he worked 40 hours/week at $10.00/hour. Petitioner's Exhibit #5, IRS W-2, reflected Petitioner's 2007 earnings from Respondent Clearwater. However, there was no evidence of what was the period of time over which those wages were earned. It would be speculative to calculate average weekly wage from the W-2.

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

The evidence established that Petitioner was 39 (36.5/21) years old at the time of the accident.

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

The evidence established was single at the time of the accident. The evidence also established that Petitioner had one child under the age of 18 at the time of the accident.

K: What temporary benefits are in dispute? TTD

Petitioner testified that he was off work from the day after his accident until August 23, 2007, 3 1/7 weeks. The only evidence of was a note in the Emergency Room from Ingalls Memorial Hospital which stated, "Please excuse this patient from work Wed. August 1 through Fri. August 3." The remainder of the medical records admitted in evidence are silent as to Petitioner being medically authorized off work.

As such, the Arbitrator finds that Petitioner is entitled to 3 days of temporary total disability.

J: Were 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 sought treatment at Ingalls Memorial Hospital Emergency Department, and then followed up with his primary care physician who in turn referred him to a specialist. He testified to four physical therapy treatments no records or bills for those services were introduced. The Arbitrator finds the medical treatment provided was reasonable and necessary.

Petitioner submitted medical bills from Ingalls Memorial Hospital (PX #6), Dr. Lisa Green at Family Christian Health Center (PX #7), Dr. Richard O'Young (PX #8), St. Bernard's Hospital (PX #9), Walgreens (PX #10), and Radiology Imaging Consulting (PX #11). There are zero balances with respect to Dr. Green and Walgreens.

The Ingalls billing includes $338.24 for August 24, 2007 Emergency Services. There were no medical records submitted which correspond to that date for Emergency Services. The $338.24 Ingalls charges for August 24 are denied for failure of proof.

The $250.00 bill from Dr. O'Young for $250.00 for August 23, 2007 (PX #8) lacks CPT coding. 50 Ill. Admin. Code, Rule 7110.90(h)(6)(D) requires medical expenses incurred on or after February 1, 2006 that services be reported with the HCPCS Level II or Current Procedural Terminology codes that most comprehensively describe the services performed and requiring providers to identify the DRG code on each bill. The bill from Dr. O'Young does not comply with the foundational requirements established under Rule 7110.90(h)(6)(D). Therefore, the Arbitrator denies the medical bill of Dr. O'Young.

The Arbitrator does award any unpaid balances of bills of Ingalls Memorial Hospital from July 31, 2007, Radiology Imaging Consulting from July 31, 2007, St. Bernard's Hospital from August 23, 2007, to be adjusted in accord with the fee schedule provided in §8.2 of the Act.

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

Petitioner received emergency medical care on the date of his accident. He followed up with his primary physician who referred him to a specialist, Dr. O'Young. Dr. O'Young diagnosed with neuritis of the left elbow and as discussed the possibility of surgical transposition of the ulnar nerve. Petitioner testified that her had four physical therapy sessions but submitted no other evidence in support of his testimony.

Petitioner discontinued medical care without being discharged. He is now employed in work that requires repetitive arm and hand motion. Despite minor continuing complaints Petitioner has apparently reached MMI. As a result, the Arbitrator awards 5% loss of use of the left arm, 12.65 weeks.

O: Was Respondent Clearwater Technology insured? Did Respondent Clearwater Technology receive proper notice of the arbitration hearing?

Petitioner's Exhibits #3 & #A, November 18, 2014 letter from National Council on Compensation Insurance and certification, established that Respondent Clearwater did not have valid workers' compensation insurance effective on July 31, 2007. Petitioner's Exhibits #1 & #2 established that Petitioner complied with due process obligations in attempting to notify Respondent Clearwater of the arbitration hearing.

Steven J. Fruth, Arbitrator

November 4, 2016
Date

17IWCC0345

3/2/16

Medical Bills
Martin Wright
v.
Clearwater Technology & IW BF
08 WC 014739

Provider	Charges	Balance
Ingalls	$876.24	$338.24
Radiology Imaging Consulting	$26.00	$26.00
Dr. Lisa Green	$110.00	$0.00
St. Bernard's Hospital	$98.00	$98.00
Dr. Richard O'Young	$250.00	$250.00
Walgreens	$42.68	$0.00

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

Estate of Gyula Kormany,
Petitioner,

vs.

A-Tech Stucco Eifs Company and
The Injured Workers' Benefit Fund,
Respondent.

17IWCC0342

NO: 08 WC 15587

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent Injured Workers' Benefit Fund herein and notice given to all parties, the Commission, after considering the issues of accident, causation, notice, employment relationship, average weekly wage, temporary total disability benefits, permanent partial disability benefits, medical expenses, statute of limitation, liability of the Fund, and the propriety of entering an award against a bankrupt employer and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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.

17IWCC0342

Bond for 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: JUN 1 - 2017
o5/18/17
DLS/rm
046

David L. Gore

Stephen J. Mathis

DISSENT

I respectfully dissent from the opinion of the Majority. I would have reversed the Decision of the Arbitrator, found that the Injured Workers' Benefit Fund (hereinafter "Fund" or "IWBF") is not liable for the instant award, and granted its motion to be dismissed from the claim.

By way of background, I believe that it is important to outline certain facts that were adduced at arbitration. Petitioner, Kristina Kormany, testified her father was born on September 16, 1961 in Hungary and died October 25, 2014, in an accident unrelated to the work injury that is the subject of this claim. On March 19, 2007, the date of her father's work-related accident, she was 16 years old and lived with him and her disabled grandfather. She did not notice her father had any problems with his left leg or ankle prior to the date of the accident.

Submitted into evidence was a copy of the workers' compensation insurance policy the Respondent employer had in effect on March 19, 2007. On June 9, 2009, Respondent employers' workers compensation insurance carrier was granted summary judgment determining that it had no duty to defend or reimburse the Respondent employer because of the employer's failure to timely notify the insurer of the accident and because it paid out some benefits on the claim. The Circuit Court found that these actions were both in violation of the contract of insurance. The summary judgement order specified that "Defendant Kormany [was] bound by this decision."

Petitioner also submitted various other documents into evidence. The documents establish that Respondent employer was incorporated on August 18, 2004 and was dissolved involuntarily on January 11, 2008. On October 15, 2008, Respondent employer filed for Chapter 7 bankruptcy. On December 16, 2008, the case was closed and the trustee in bankruptcy was dismissed. On February 3, 2009, Respondent employer's owners, John Bagjas and Kama Bagjas were personally discharged from creditors through bankruptcy.

Also submitted into evidence were two amended applications, both of which bear the signature of Mr. Kormany and dated April 8, 2008, the date of the original filing. The first amended application appears to be a copy of the original application with IWBF typed in as a second party Respondent. That application was filed on April 16, 2010. The second amended

application was filed on October 19, 2015, and appears to be a copy of the first amended application with the Petitioner then listed as the Estate of Gyula Kormany. The attorney of record in all the applications is listed as Stewart Orzoff, who clearly did not represent any Petitioner at any time after March 22, 2010, the date he sent correspondence to Petitioner's current lawyer noting he no longer represented Petitioner and would not seek any fees or expenses.

At Arbitration and in its brief, the Fund presented two alternative theories on why it should not be held liable for the instant award. First, the claim against the Fund is barred by the statute of limitations, and second the Fund is not liable because the statutory basis for its liability has not been met. At oral argument, IWBF "withdrew" the issue of the statute of limitations. Nevertheless, that issue has been successfully preserved and not specifically waived. In addition, the Commission is obliged to address any issue which becomes manifest upon considering the entire record, even if an issue has been specifically waived. *See, Klein Construction/Illinois Insurance Guaranty Fund v. I.W.C.C.*, 384 Ill. App. 3d 233 (1st Dist. WC Div. 2008).

Statute of Limitations

The Act provides in pertinent part (820 ILCS §305/6(d)): "In any case, other than one where the injury was caused by exposure to radiological materials or equipment or asbestos unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred."

The Arbitrator found that Petitioner timely filed the amended application naming the IWBF. He noted that the amended application naming the IWBF was filed "exactly three years and four weeks after the date of accident." He also noted the legislative intent that the IWBF pay injured workers who are not covered by workers' compensation insurance and the Act does not specify a statute of limitations for adding the IWBF as a party because it is not an employer under the Act. IWBF argues the claim against it is barred by the statute of limitations because it was only added as a respondent more than three years after the accident.

The Fund acknowledges that there does not appear to be any legal ruling specifically supporting its argument, but it cites what it deems an analogous case, *IPF Recovery Co. v. Illinois Insurance Guaranty Fund*, 356 Ill. App. 3d 658 (1st Dist. 2005). There, the court dismissed a claim against the Guaranty Fund based on the general 5-year statute of limitations in the Code of Civil Procedure. The *IPF* court found "the 5-year statute of limitations, applicable to plaintiff's cause of action was not tolled from the time plaintiff's cause of action accrued until the time that defendant first denied plaintiff's claim for unearned premiums." Therefore, the claim against that guaranty fund was dismissed.

While the Workers' Compensation Act does not specify a separate statute of limitations for including the Fund in a claim, it does place IWBF in the position to advance all defenses the employer can assert. The Appellate Court in *IPF* held that a general statute of limitations applies

with equal force regarding a complaint against a state fund similar to the IWBF. Therefore, it is my interpretation that the intent of the Act is that IWBF shall be afforded the same protections as employers, including protections of the statute of limitations. The same factors intended to protect employers and allow them to offer a legitimate defense against a workers' compensation claim would appear to apply equally to IWBF. If the statute of limitations does not apply to IWBF, it could be in a position to have to defend against stale claims for which it cannot mount a reasonable defense.

The Arbitrator seemed to have applied an analysis similar to determining whether notice of accident to an employer is timely. Under such analysis, a technical violation of the notice requirement can be overlooked if the delay did not result in prejudice against the employer. However, the statutory language of the notice and statute of limitations sections are substantially different. The 90-day notice requirement includes the provision (820 ILCS §305/6(c)(2)): "no defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." On the other hand the statute of limitations provision specifies that if the application is not timely filed "the right to file such application shall be barred." Therefore, the legislature clearly intended that the statute of limitations requirement be more absolute than the notice requirement.

It could be interpreted that the Arbitrator effectively applied an equitable tolling of the statute of limitations. The Arbitrator stressed the efforts of Petitioner to collect benefits prior to filing the amended complaint. The *IPF* court did not address this specific issue because the plaintiff did not advance the argument in the Circuit Court and therefore it was deemed waived. A problem I have with such an analysis is that the Summary Judgment granted to the workers' compensation insurer was entered on June 9, 2009. Mr. Kormany would have been aware of the order because he was a defendant and the order provided specifically that he was subject to, and bound by, the judgement. Nevertheless, the amended complaint naming IWBF was not filed until 10 months later. Petitioner had about nine months to join IWBF to be within the three-year statute of limitations and there is no indication that IBWF had any pre-knowledge of the claim prior to the amended complaint.

In this regard, I am aware of a prior decision of the Commission in *Wold v. Sun Towing & IWBF*, 16 I.W.C.C. 535 (filed Sept. 30, 2016). There, the Commission affirmed and adopted the Decision of the Arbitrator who held simply "Petitioner's claim against the IWBF is not time barred because the Application naming Sun [employer respondent] was timely filed." However, in *Wold* there is no indication Petitioner had prior notice that insurance coverage was not available prior to running of the statute of limitations. In that regard *Wold* is distinguishable from the instant claim because as noted above the injured employee had notice that he was not protected by workers' compensation insurance coverage nine months before he had to join the Fund within the normal three-year statute of limitations. Therefore, I would find that because Petitioner failed to name and failed to join the Fund within the three-year statute of limitations despite sufficient notice to do so, her action against IWBF is barred.

17IWCC0342

Liability of IWBF

The Act provides in pertinent part (820 ILCS §305/4(d)): "Moneys in the Injured Workers' Benefit Fund shall be used only for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage as determined under this paragraph (d) and has failed to pay the benefits due to the injured employee." The Arbitrator denied IWBF's motion to dismiss it from the claim and found it to be liable for the award under the Act.

The Arbitrator found IWBF liable because of his determination that the employer effectively did not "provide" workers' compensation coverage because it apparently did not comply with the contractual requirements of the policy. The Arbitrator stressed the legislative intent for establishment of the IWBF to pay awards to claimant by employers which "fail to provide coverage" and Respondent employer had workers' compensation insurance in effect at the time of the accident.

Clearly, the IWBF was established to provide protection to injured workers whose employers do not maintain workers' compensation insurance coverage. Here, the record is also clear that Respondent employer indeed did maintain a workers' compensation insurance policy at the time of the accident. Nevertheless, for reasons unknown to the Commission, Respondent employer did not comply with the provisions of the policy contract and therefore neither the employer nor the employee received any benefits from the insurance policy coverage. While the Appellate Court appears not to have addressed this issue, it did interpret the above cited language to mean that the sole purpose of the Fund was to pay awards against employers which failed to carry workers' compensation insurance. *See, Illinois State Treasurer v. I.W.C.C.*, 12054WC (1st Dist. 2013).

It is important to understand that the establishment of the Fund is part of a larger legislative scheme. IWBF is funded exclusively from fines imposed on businesses that unlawfully fail to carry workers' compensation insurance collected either through citation issued by the Insurance Compliance Division of the Commission or by order of the Commission itself upon petition from the Insurance Compliance Division. In this matter, Respondent employer could not have been fined under §4(d) because it did in fact have workers' compensation insurance at the time of the accident. Therefore, the Respondent employer could not have been forced to contribute to the fund through fines. The decision of the majority would effectively sever the link between funding the IWBF through fines imposed against uninsured employers and payments to injured employees of such uninsured employers established in the Act.

In addition, according to the plain words of the statute, simply not "providing workers' compensation insurance" is not in itself sufficient to establish liability of IWBF. The statute also requires that the uninsured employer failed to pay benefits due the injured worker. Therefore, if the employer decides to pay benefits instead of submitting a claim to its insurer, the Fund would not be liable for payment of the award. The record before us indicates that at least initially, the Respondent employer began to pay some benefits on behalf of the injured employee. The insurance carrier argued that such payments were a violation of the insurance policy and such

alleged violation became a basis for the insurer's successful argument that it was not bound to defend the claim.

I understand that the result I advocate here may appear harsh because the descendent of the deceased employee may not have any way to recover for decedent's injury. However, it also must be recognized that the IWBF has often not had sufficient funds to pay 100% of the awards against it. Therefore, the money has to be distributed on a *pro rata* basis to all recipients for the preceding year, as specified in the Act. Accordingly, any result that improperly imposes liability on the Fund could be considered unfair to the other recipients whose awards thereby may be reduced.

Therefore, for the reasons stated above I respectfully dissent from the Decision of the Majority. I would have found that the claim against the Fund was barred both because the Fund was not joined before the expiration of the statute of limitations and because the statutory basis for liability of the Fund has not been met.

DLS/dw
O-5/18/17
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Deborah L. Simpson
Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0342

ESTATE OFKORMANY, GYULA
Employee/Petitioner

Case# **08WC015587**

A-TECH STUCCO EIFS COMPANY AND THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 3/14/2016, 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 0.47% 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:

0412 RIDGE & DOWNES
MEGAN O'BRIEN
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

0000 A TECH STUCCO EIFS CO
1001 AURORA AVE
AURORA, IL 60505

5472 ASSISTANT ATTORNEY GENERAL
BETSY FERGUSON
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0342

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Estate of Gyula Kormany
Employee/Petitioner

v.

A- Tech Stucco Eifs Company and the Injured Workers' Benefit Fund
Employer/Respondent

Case # 08WC 15587

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **January 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 **1. Respondent's Motion to Dismiss the Injured Workers' Benefit Fund; 2. Is Respondent IWBF Liable; 3. Was Notice Proper; 4. Can an award be entered against Respondent employer when it has been discharged in bankruptcy; 5. Was Amended Application against Fund Timely Filed**

FINDINGS

On **March 19, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,414.35**; the average weekly wage was **$800.30**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** child 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.

ORDER

Respondent shall pay reasonable and necessary medical services of **$19,970.80**, as provided in Section 8(a) of the Act. Said payment shall be made consistent with the medical fee schedule. Respondent shall further reimburse Petitioner's union health and welfare fund, Administrative District Council 1 Welfare Fund, in the amount of **$2,038.28.**

Respondent shall pay Petitioner permanent partial disability benefits of **$480.18**/week for **41.75** weeks, because the injuries sustained caused the **25 %** loss of the **foot**, as provided in Section 8(e) of the Act.

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

Respondent Injured Workers' Benefit Fund Motion to Dismiss 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

3/11/16
Date

ICArbDec p. 2

MAR 14 2016

FINDINGS OF FACT:

Gyula "George" Kormany ("Petitioner") was born on September 16, 1961 and passed away on October 25, 2014. (PX 17 and 18) On March 19, 2007, he was single, and had one dependent daughter, Kristina Kormany ("Petitioner's daughter"), whose date of birth was May 29, 1990. On this date, Petitioner worked for Respondent A-Tech Stucco Eifs Company ("A-Tech"), owned by John Bajas ("Bajas"). On this date, A-Tech had a workers' compensation policy with West Bend Mutual Insurance Company ("West Bend"). (PX 9)

Petitioner filed an Application for Adjustment of Claim ("Application") on April 9, 2008, case number 08 WC 15587. (PX 20) On July 15, 2008, West Bend filed a Complaint for Declaratory Judgement against A-Tech alleging that A-Tech violated the terms of its workers' compensation policy with West Bend because it did not report Petitioner's accident to West Bend for over twelve months after the accident. (PX 11)

On October 15, 2008, A-Tech filed a Petition for Chapter 7 Bankruptcy. (PX 12) A-Tech listed Petitioner Kormany as a debtor in connection with its bankruptcy hearing. (PX 13) On December 16, 2008, A-Tech's Bankruptcy Petition was closed. (PX 12) On February 3, 2009, A-Tech's owner, Bajas, and his wife, Kama Bajas, were personally discharged from bankruptcy by the United States Bankruptcy Court of the Northern District of Illinois. (PX 13)

On June 9, 2009, Judge Mary K. Rochford granted West Bend's Motion and found that West Bend had no duty to defend or indemnify A-Tech in workers' compensation case 08 WC 15587 and that Petitioner Kormany was bound by such order. (PX 15)

On April 16, 2010, Petitioner amended his Application to include the Illinois State Treasurer as ex-officio custodian of the Injured Workers' Benefit Fund as a party Respondent to case 08 WC 15587. (PX 20) After Petitioner's death, Petitioner's daughter completed a Small Estate Affidavit. (PX 19) Thereafter, Petitioner's Application was amended to change the name on the Application from Gyula Kormany to the "Estate of Gyula Kormany". (PX 20)

Prior to the hearing on January 25, 2016, Petitioner sent notice of the hearing to A-Tech to two different locations, both of which were listed on different check stubs of Petitioner. (PX 2) Petitioner's attorney called out the name of Bajas prior to commencement of the hearing and he was not present.

As Petitioner was not alive at the time of the hearing on January 25, 2016, Petitioner's case in chief came from the direct testimony of Petitioner's daughter and Petitioner's former boss, John "Jack" Lorezal ("Lorezal").

In 2005, Petitioner's daughter, at the age of 14, moved in with her father and her disabled grandfather at 428 West Touhy, Des Plaines, Illinois 60018. Prior to this time she lived with her mother in the Chicago-area. On March 19, 2007, Petitioner's daughter continued to live with her father and she was 16 years old at the time of his accident.

Lorezal worked as a superintendent for A-Tech from 2006 until 2009. He reported directly to owner Bajas and served as a liaison between other employees of A-Tech and Bajas. As superintendent he looked at blue prints, ordered materials for projects, delivered material and supervised employees. In March of 2007

Lorezal served as Petitioner's supervisor. Lorezal testified Petitioner worked as a plasterer and plastered walls. To perform this job, Petitioner had to climb up and down scaffolds and ladders as well as mix and apply plaster.

Petitioner's daughter testified that she regularly noticed her father deposit his paystubs from A-Tech into the bank. Lorezal testified A-Tech paid Petitioner on an hourly basis. On Fridays, Lorezal would drop off paychecks to Kormany at his job sites. He also dropped off a check to Petitioner at his house on Touhy Avenue the week after his accident.

Upon his death, Petitioner's daughter found old paystubs from the years 2006-2007 in the top drawer of his dresser at their house Touhy Avenue. Petitioner's daughter brought copies of the paystubs she located from A-Tech to trial on January 25, 2016 from pay periods of March 24, 2006 through March 17, 2007. There were a total of 48 weekly pay stubs. (PX 8) Each pay check listed the name of the employer in the top left-hand corner as "A-Tech Stucco EIFS Co." and the employee name as "Gyula Kormany". Each check listed "regular pay" and deduction for applicable taxes and union dues. (PX 8)

Prior to March 19, 2007, Petitioner did not have any known problems with his left leg or ankle. On March 19, 2007, while working for A-Tech, Petitioner fell off a six foot, four inch, scaffold and was taken to the emergency room at Advocate Condell Medical Center via ambulance. (PX 3) He complained of pain in his left ankle. Lorezal testified that he saw Petitioner in the emergency room at Advocate Condell Medical Center and Petitioner's foot was wrapped. Lorezal provided that he informed Bajas that he saw Petitioner in the emergency room.

Petitioner came under the care of Dr. Zoellick in the emergency room. The doctor diagnosed Petitioner with "left posterior talus fracture with left calcaneal anterior process fracture with mild displacement. Lateral calcaneal fracture at the calcaneocuboid joint, not displaced. Left knee strain/contusion." (PX 3) Dr. Zoellick opined that Petitioner could have problems with arthritis and need an ankle fusion in the future. Dr. Zoellick placed his left ankle in a cast and he was discharged the next day. (PX 3)

Petitioner followed up with Dr. Zoellick on March 23, 2007. Dr. Zoellick mailed all treatment notes to Bajas. (PX 4). X-rays from March 23 showed a fracture of the anterior process of the calcaneus with slight displacement and an avulsion fracture of the talus by the fibula. Dr. Zoellick recommended Petitioner be seen by a foot and ankle specialist. Petitioner strongly advised he did not want any surgical intervention. Petitioner received a cam-boot and was advised to remain non-weight bearing. (PX 4) At his follow up with Dr. Zoellick on April 2, Petitioner again indicated he did not want surgical intervention; and, as such, Dr. Zoellick indicated he would continue with conservative care, keep Petitioner off work, keep him in the cam boot and be non-weight bearing for six weeks. At this appointment the doctor once again warned about the possibility of development of arthritis, decreased range of motion and the need for surgical intervention in the future. (PX 4)

Petitioner continued to treat with Dr. Zoellick and he prescribed physical therapy. On June 18, 2007, Dr. Zoellick indicated that Petitioner could try to return to work light duty, with a restriction of no lifting more than 20 pounds and no climbing ladders. On August 13, 2007, Petitioner still felt like he had broken glass in his ankle when walking. Dr. Zoellick indicated Petitioner could return to work full duty; however, he recommended an evaluation with Dr. Kodros or Dr. Kelikian, orthopedic foot and ankle specialists. (PX 4)

Petitioner presented to Dr. Kodros for a second opinion on August 16, 2007, complaining of pain over the lateral aspect of the ankle, hindfoot and heel. He indicated the pain was aggravated by weight-bearing. Dr. Kodros opined that Petitioner may have some posttraumatic arthritis of the hindfoot and prescribed a custom molded brace for his weightbearing activity. The doctor recommended activity modification, prn use of ice and anti-inflammatory medications and periodic corticosteroid injections (which Petitioner declined at the visit). Petitioner started using the custom molded brace. (PX 6)

The custom molded brace only provided relief for a short time. Petitioner returned to Dr. Kodros' office on April 9, 2008 and came under the care of Dr. League at the same office. Examination on that date revealed that Petitioner had only approximately 25 percent of the inversion-eversion hindfoot motion on the left side when compared to the non-injured right foot. At this appointment, Petitioner agreed to a steroid injection. (PX 6) The relief from the steroid injection only lasted for 24 hours; as such, Dr. League recommended an MRI on April 30, 2008. The MRI revealed patchy edema throughout the lateral process of the talus that likely indicated post-traumatic degenerative healing pattern and a slight tear of the Achilles tendon. Dr. League prescribed an additional course of physical therapy and consideration of excision of the lateral process of his talus. Petitioner continued to wear his custom molded brace. (PX 6)

At his initial physical therapy evaluation on May 7, 2008, Petitioner indicated that "if he works one day, the next he cannot walk, because it is so painful" and that "his heel feels like a broken glass when he walks". He further stated that he could not move his ankle sideways and that he had a constant sharp/burning pain in the bottom of the heel and lateral foot. (PX 6)

Petitioner stopped attending physical therapy on his own on June 30, 2008 and cancelled his follow up appointment with Dr. League on July 7, 2008.

During the course of his treatment with the orthopedic physicians, Petitioner also treated his ankle through chiropractic treatment at Community Health and Rehabilitation Center from May 3, 2007 through June 29, 2012. (PX 5)

Petitioner did not sustain any new accidents after March 19, 2007. Petitioner used one crutch and a cane after his accident. He used the cane until the date of his death. After he completed his medical treatment, Petitioner's daughter noticed that cold weather caused him pain and she sometimes saw him in tears. She also noticed that during rainy weather, her father had a hard time getting out of bed. Petitioner's daughter noticed that he would take pain medication at the dinner table (sometimes prescribed pain medication and sometimes samples given to him from his physician). She specifically remembers that he took Hydrocodone.

Similarly, Petitioner's daughter indicated that after he finished his medical treatment related to his accident, Petitioner no longer played soccer or gymnastics with her. She stated that prior to his accident, he would play soccer with her in their front or back yard. They also used to take long walks around their neighborhood together before the accident. After the accident, they did not take these walks as frequently. If they did, they did not walk for more than a half hour, they walked at a slower pace and Petitioner needed to take frequent stops and use his daughter's arm for stability.

At the time of trial, several medical bills remained unpaid and were entered into evidence as Petitioner's group exhibit 7A-7G. The bills are as follows: Adult and Pediatric Orthopedics ($3660.00); Lake County Radiology Assoc. ($433.00); Illinois Bone and Joint ($4851.00); Community Health and Rehabilitation Center ($2538.00); Condell Medical Center ($8234.80); Dr. Spiros Stamelos ($254.00); and, Administrative District Council 1 Welfare Fund, seeking reimbursement to union for group health payments made on behalf of Petitioner ($2038.28).

With respect to (A.) Was Respondent operating under and subject to the Illinois Workers' Compensation Commission or Occupational Disease Act, the Arbitrator finds as follows:

The Arbitrator finds that Respondent A-Tech was operating under and subject to the Illinois Workers' Compensation Act on March 19, 2007. Respondent was in the business of plastering and stucco work. The Arbitrator finds there to be automatic coverage under Section 3 of the Act.

With respect to (B.) Was there an Employee-Employer relationship, the Arbitrator finds as follows:

The Arbitrator finds that there was an employee-employer relationship between A-Tech and Petitioner. In coming to this conclusion, the Arbitrator relies on the testimony of Superintendent Lorezal, who served as a supervisor to Petitioner and confirmed he was employed by A-Tech at the time of the accident. The Arbitrator also relies on Petitioner's pay stubs that state the name of the employer as "A-Tech" and name of employee "Gyula Kormany".

With respect to (C.), (D.) & (E.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; What is the date of the accident; Was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

The Arbitrator finds that an accident occurred on March 19, 2007 that arose out of and in the course of Petitioner's employment. Petitioner arrived at Advocate Condell Medical Center via ambulance after falling off a scaffold while working for A-Tech on March 19, 2007. Petitioner injured his left foot and ankle. Petitioner gave a history of his accident occurring at work to every physician he saw, including, the emergency room physicians, Dr. Zoellick, Dr. Kodros, Dr. League and the treaters at Community Health and Rehabilitation Center.

Regarding notice, the Arbitrator finds that timely notice of the accident was given to Respondent. Petitioner advised Supervisor Lorezal of the accident on March 19, 2007. Furthermore, on March 19, 2007, Lorezal saw Petitioner in the Emergency Room at Advocate Condell Medical Center with his foot wrapped. Lorezal informed the A-Tech owner Bajas of the accident. Finally, all of Dr. Zoellick's treatment records indicating that Petitioner injured his left foot when he fell from a scaffold while working for A-Tech were sent directly to Bajas.

With respect to (F.) Is Petitioner's current condition of ill being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner's left foot condition of ill-being at the time of his death on October 25, 2014 was related to his work accident of March 19, 2007.

Petitioner's daughter testified that Petitioner had no known problems with his left foot or ankle prior to March 19, 2007. Lorezal testified Petitioner was always able to perform his job prior to the date of the accident. All of the medical records indicate Petitioner's left foot/ankle was in fine condition until his injury of March 19, 2007.

Beginning with the date of the accident, Dr. Zoellick warned Petitioner that his injury was serious enough that it would lead to future arthritis and the need for a potential fusion. All of Petitioner's treatment from the date of the accident through the date of his death dealt with the initial treatment of his left foot/ankle or therapy and by April 2008 (one year after the accident) an MRI revealed post-traumatic arthritis.

Finally, Petitioner did not suffer any additional accidents to his left foot/ankle after March 19, 2007. In light of the above, the Arbitrator finds all of Petitioner's medical treatment to be causally related to his March 19, 2007 work accident.

With respect to (G.) What were Petitioner's earnings, the Arbitrator finds as follows:

The Arbitrator calculates Petitioner's average weekly wage to be $800.30. In coming to this conclusion, the Arbitrator used the paystubs entered into evidence as Petitioner's Exhibit 8.

Petitioner's daughter regularly noticed her father deposit his paystubs from A-Tech into the bank and she brought copies of his pay stubs to trial. Lorezal testified A-Tech paid Petitioner on an hourly basis. On Fridays, Lorezal would drop off paychecks to Kormany at his job sites. He also dropped off a check to Petitioner at his house on Touhy Avenue the week after his accident.

Upon his death, Petitioner's daughter found several old paystubs from the years 2006-2007 in the top drawer of his dresser at the house where they lived together on Touhy Avenue. Petitioner gave a detailed description of the dresser where she found the pay stubs and indicated that her father kept his television on the dresser. Each pay check listed the name of the employer in the top left-hand corner as "A-Tech Stucco EIFS Co." and the employee name as "Gyula Kormany". Each check listed "regular pay" and deduction for applicable taxes and union dues.

Petitioner's daughter brought copies of the paystubs she located from A-Tech to trial on January 25, 2016 from pay periods of March 24, 2006 through March 17, 2007. There were a total of 48 weekly pay stubs. The Arbitrator totaled the 48 pay stubs and found Petitioner's salary for the dates of March 24, 2006 through March 17, 2007 to be $38,414.35. That total divided by 48 weeks, equates to an average weekly wage of $800.30.

With respect to (H.) & (I.) What was Petitioner's Age at the time of accident and What was Petitioner's Marital Status at the time of the accident, the Arbitrator finds as follows:

Petitioner was 47 years old at the time of the accident, single and never married. (PX 17 and18)

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Having found the requisite causal relationship, the Arbitrator finds that the medical services that were provided to Petitioner were reasonable and necessary.

Petitioner arrived at Advocate Condell Medical Center emergency room via ambulance where he came under the care of Dr. Zoellick. After Dr. Zoellick felt he could no longer help Petitioner, he referred him to foot/ankle specialist, Dr, Kodros. Dr. Kodros treated Petitioner for some time, until he changed offices, at which time Petitioner came under the care of Dr. League at Dr. Kodros' former office. Petitioner attended physical therapy throughout the pendency of his treatment at Community Health and Rehabilitation Center.

All of the medical treatment received by Petitioner was reasonable and necessary and were within the allowed chain of medical providers. The Arbitrator finds that A-Tech did not pay all appropriate charges for this reasonable and necessary medical treatment. At the time of trial, the following bills remained outstanding (P. Ex. 7A-7G):

Adult and Pediatric Orthopedics	$3,660.00
Lake County Radiology Associates	$433.00
Illinois Bone and Joint	$4851.00
Community Health and Rehabilitation Center	$2538.00
Condell Medical Center	$8234.80
Dr. Spiros Stamelos	$254.00

The Arbitrator finds Respondent liable for the above stated medical bills, which total $19,970.80. Additionally, Petitioner's union paid $2038.28 in work- related medical bills. The Arbitrator finds Respondent shall reimburse Administrative District Council 1 Welfare Fund in the amount of $2,038.28.

With respect to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

The Arbitrator finds Petitioner reached maximum medical prior to his death on October 25, 2014 and that the Estate of Gyula Kormany is entitled to a permanency award in the amount of 25% loss of use of the left foot.

Petitioner sustained fractures of the left posterior talus with a left calcaneal anterior process fracture as well as a lateral calcaneal fracture at the calcaneocuboid joint. From his very first trip to the emergency room, doctors advised Petitioner that he would have arthritis in the future as well as the potential need for an ankle fusion.

Although Petitioner was not able to testify at trial, it is very clear from the medical records that he was very resistant to anything more than conservative treatment, even though he was in a tremendous amount of discomfort. Throughout his treatment records, Petitioner described tremendous pain with weight-bearing. Doctors Zoellick, Kodros and League all recommended eventual surgical intervention which Petitioner was strongly opposed to. Petitioner's objection to surgery was evident when he fact did not even agree to a cortisone injection until a year after the accident.

By April 2008, Dr. League confirmed (via an MRI) that Petitioner had post traumatic arthritis. At a physical therapy appointment on May 7, 2008, Petitioner indicated that, "if he works one day, the next he cannot walk, because it is so painful" and that "his heel feels like a broken glass when he walks." He further stated that he could not move his ankle sideways and that he had a constant sharp/burning pain in the bottom of his heel and lateral foot. This description of pain was corroborated by Dr. League's April 9, 2008 examination, which showed that Petitioner had only approximately 25 percent of the inversion-eversion hindfoot motion on the left side when compared to the non-injured right foot. In April 2008, Dr. League recommended one more course of physical therapy and indicated the only other option for Petitioner would be surgical intervention if it did not work.

Petitioner stopped treating for his ankle on his own accord in July 2008. At that point, he had a current physical therapy prescription as well as a follow up appointment scheduled with Dr. League. Petitioner was not able to testify at trial on January 25, 2016, as such, the Arbitrator cannot speculate why Petitioner stopped treatment. Whatever the reason Petitioner stopped treatment, it is clear that he had continuing complaints at the time he stopped treatment. He continued to use a cane, one crutch, and the custom boot after his treatment stopped. Petitioner's daughter testified that he used the cane until the date of his death. Petitioner's daughter also testified that his ankle caused him pain during cold weather and/or rainy weather and that he had difficulty getting out of bed. He continued to take pain medication after his treatment ceased. On a personal level, he used to play soccer with his daughter and take long walks before the accident. After the accident, he no longer was able to play soccer with his teenage daughter and, if they took walks, they were less frequent, slower, and he needed to use his daughter for stability during the walk.

In light of the above, the Arbitrator finds Petitioner's Estate entitled to an award of 25% loss of use of the left foot.

With respect to (O.) (1 and 2) Respondent's Motion to Dismiss the Injured Workers' Benefit Fund and Is Respondent IWBF liable, the Arbitrator finds as follows:

The Arbitrator denies party Respondent Injured Workers' Benefit Fund's Motion to Dismiss the Fund (R. Ex. 1) and finds that the Fund is liable for payment of this award under the Act. The circumstances behind Petitioner filing against the Fund are laid out in the Findings of Fact as well as in Petitioner's Response to Respondent Illinois State Treasurer, as Ex Officio of the Injured Workers' Benefit Fund's Motion to Dismiss. (PX 16)

The party Respondent Injured Workers' Benefit Fund (IWBF) argues that because A-Tech had an insurance policy at the time of the accident, the IWBF is not liable to make any payments related to case 08 WC 15587. The Arbitrator disagrees and finds that the legislative intent of the IWBF is to protect injured workers that find themselves in situations similar to Petitioner. For the purposes of this case, A-Tech's insurance policy is essentially null and void due to the order of Judge Mary K. Rochford that the insurance carrier had no duty to defend or indemnity A-Tech in case 08 WC 15587 and Petitioner was bound by that order. To make matters worse for Petitioner, both A-Tech and Bajas filed for bankruptcy and listed Petitioner as a creditor. As such, Petitioner's only recourse to secure any type of benefits whatsoever would be through the IWBF. The Arbitrator finds that the IWBF's legislative intent was to help injured workers that found themselves in situations similar to Petitioner.

The Arbitrator acknowledges that there is no case law on point on this specific issue, and that it is a matter of first impression before this Commission. Respondent argues that since there are no cases saying that Petitioner should be entitled to benefits in this instance, that benefits should be denied. The Arbitrator disagrees. The IWBF was formed in July 2005, less than two years before Petitioner's accident and certainly was still very new in the eyes of the Commission at the time of trial 10 years later. It is not unusual that a case with this specific fact pattern has not yet come before the IWBF.

Section 4(d) of the Act clearly states:

> "Moneys in the Injured Workers' Benefit Fund shall be used only for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage as determined under this paragraph (d) and has failed to pay the benefits due to the injured employee." 820 Ill. Comp. Stat. Ann. 305/4(d).

Under the circumstances of this case, A-Tech failed to provide coverage to Petitioner as well as failed to pay him the benefits that were due. There is no case law in Illinois that distinguishes the different ways an employer can "fail to provide coverage" under 4(d) and the Illinois Workers' Compensation Commission Rules do not present any information on this issue. However, it is clear from Section 4(d), under, "Penalties For Employer Lacking Insurance", that the legislature believed that there were different ways an employer could "fail to provide coverage". This section specifically distinguishes penalties for employers that "knowingly" fail to provide coverage as well as those that "negligently" fail to provide coverage.

Section 4(d) states:

> "Whenever a panel of 3 Commissioners comprised of one member of the employing class, one member of the employee class, and one member not identified with either the employing or employee class, with due process and after a hearing, determines an employer has knowingly failed to provide coverage as required by paragraph (a) of this Section, the failure shall be deemed an immediate serious danger to public health, safety, and welfare sufficient to justify

service by the Commission of a work-stop order on such employer, requiring the cessation of all business operations of such employer at the place of employment or job site..."

Section 4(d) also states:

"Any individual employer...who knowingly fails to provide coverage as required by paragraph (a) of this Section is guilty of a Class 4 felony... "

Furthermore, Section 4(d) states

"Any individual employer...who negligently fails to provide coverage as required by paragraph (a) of this Section is guilty of a Class 4 misdemeanor... "

The Arbitrator finds that A-Tech negligently failed to provide coverage. There are several ways that a Respondent can fail to provide coverage. Certainly breaching its agreement with its workers' compensation carrier in a way that the carrier is able to secure a judgment that it does not need to defend its insured falls within the meaning of "failing to provide coverage" to this Arbitrator. Although A-Tech may not have "knowingly" failed to provide coverage, it was certainly "negligent" in not following the terms and conditions of the policy and notifying the carrier within the time frame determined by the policy. In fact, A-Tech, did not notify the carrier for over one year after the accident, when it clearly had notice of the accident and was being sent all of Petitioner's medical records from Dr. Zoellick. The IWBF clearly states that it is funded by the penalties and fines collected from employers that both "negligently" and "knowingly" fail to provide coverage.

In light of the above, the Arbitrator finds that since A-Tech failed to provide adequate coverage pursuant to 4(d) of the Act and failed to pay benefits due to Petitioner, the IWBF is an appropriate party to this case, and as such, denies the IWBF's Motion to Dismiss itself from the case.

With respect to (O.) (3.) Was notice proper, the Arbitrator finds as follows:

The Arbitrator finds that notice of the January 25, 2016 hearing in Waukegan, Illinois, was properly served on both Respondent A-Tech and party Respondent the Injured Workers' Benefit Fund. Specifically, with respect to A-Tech, the Arbitrator notes that notice was sent certified mail to both addresses listed on Petitioner's pay stubs, 29 W. 160 Calumet Avenue, Warrenville, Illinois 60555 and 1001 Aurora Avenue, Unit C, Aurora, Illinois 60505, respectively, on December 16, 2015. (PX 2C and 2D) The letter sent to the Calumet Avenue address was tracked and the status of the letter on January 4, 2016 was "Moved, left no address" and it was eventually sent back to the United States Post Office on January 16, 2016. (PX 2C) The letter sent to the Aurora Avenue address was tracked and the status of the letter on December 18, 2015 was, "Notice left (no authorized recipient available). On January 7, 2016, the maximum hold time expired and the United States Post Office found the letter to be "unclaimed". (PX 2D)

The Injured Workers' Benefit Fund was copied on all notices sent to A-Tech.

With respect to issue (O.) (4.) Can an award be entered against respondent employer when it has been discharged in bankruptcy, the Arbitrator finds as follows:

For the purposes of proceeding against the Injured Workers' Benefit Fund, the Arbitrator notes that Section 4(d) of the Act does not prevent Petitioner's from proceeding against the Fund if the Respondent-Employer has been discharged in Bankruptcy.

The Arbitrator will not determine whether federal bankruptcy law prevents the Illinois Attorney General's office from prosecuting Respondent A-Tech for failing to provide coverage to Petitioner at the time of the injury.

With respect to (O.) (5.) Was amended Application against Fund timely filed, the Arbitrator finds as follows:

Petitioner's Application for Adjustment of Claim was timely filed. Due to the complicated nature of this case and the fact that Petitioner tried many avenues to collect workers' compensation benefits, all of which were unsuccessful, on April 16, 2010, Petitioner amended his Application to include the Illinois State Treasurer as ex-officio custodian of the Injured Workers' Benefit Fund as a party Respondent to case 08 WC 15587. (PX 20) The Fund was added exactly three years and four weeks after the date of accident. The Arbitrator again notes that the legislative intent of the Fund is to protect workers' whose employers fail to provide adequate workers' compensation coverage and that the Fund is Petitioner's only recourse for benefits under the Illinois Workers' Compensation Act ("Act"). Section 4(d) of the Act does not indicate any time limit under which the Fund may be added to an Application.

Furthermore, the Act specifically itemizes who is considered an Employer under Section 1(a). The Fund is not considered an employer under 1(a) and thus there is no statute of limitations under which the Fund may be added to a timely filed Application for Adjustment of Claim against an employer-respondent. Based upon the above reasons, the Arbitrator finds that the Application against the Fund was timely filed.

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

Alexandria Dawson,

Petitioner,

vs.

No. 08 WC 37731

Net 56, Inc.,

Respondent.

17IWCC0346

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

A petition for review under section 8(a) and a contemporaneous petition for penalties, attorney fees and costs having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues raised in the petitions, and being advised of the facts and law, denies both petitions for the reasons set forth below.

On March 12, 2012, the arbitrator approved a settlement contract in this matter for a lump sum of $175,000.00 "plus an additional amount to be determined for an 'MSA Fund.' " The contract provides, in pertinent part:

> "Respondent further agrees its obligations, and Petitioner's rights under Section 8(a) of the Illinois Workers' Compensation Act *** remain open, viable and enforceable until such time Respondent, at its sole option, establishes and funds a Medicare Set Aside acceptable to and approved by CMS ***. Upon approval of the MSA by CMS, all of Petitioner's rights under Section 8(a) are waived.
>
> * * *
>
> If an MSA approved by CMS requires more than the current MSA

proposal the Respondent at its sole discretion has the right to do one of the following:

> A. Pay the higher MSA amount approved by CMS
> B. Not fund the MSA, and medical rights under Section 8(a) remain open."

On April 7, 2016, Petitioner filed a motion under section 8(a), as well as a motion for penalties, attorney fees and costs. Petitioner requested "a hearing to determine the enforcement of the Petitioner's rights under [the contract]." Petitioner also seeks penalties, attorney fees and costs.

On August 24, 2016, Commissioner Stephen Mathis held a hearing in the matter. At the outset of the hearing, Petitioner's counsel stated an MSA had been approved by CMS in February of 2015.[1] However, in 2013 Petitioner underwent surgery on her right arm after being involved in an automobile accident. The main issue before us is whether the surgery was related to the automobile accident or Petitioner's work accident. After the hearing, the parties waived briefs and oral argument.

Petitioner testified on direct examination that on January 4, 2007, she worked as a computer repair technician. That day, Petitioner felt a pop and severe pain in the right shoulder while setting down a heavy computer monitor. Ultimately, Petitioner underwent four surgeries on the right shoulder and arm. The last surgery took place in 2009. After the last surgery, Petitioner still had "[a] lot of tenderness, pain in the right shoulder, limited mobility, extremely limited" and sensitivity to touch. A functional capacity evaluation performed in 2011 placed Petitioner at the sedentary physical demand level. In 2012, Petitioner underwent conservative treatment for a left shoulder condition. Petitioner noted the settlement contract was for injuries to the "[l]eft and right arms." In 2013, Petitioner's right arm continued to be extremely painful and tender.

Petitioner further testified that on June 29, 2013,[2] she was involved in a "minor" car accident while riding in the front passenger seat. The impact, which was to the front bumper on the passenger side, caused Petitioner to "bump" her right shoulder into the door panel. Paramedics responded to the accident; however, Petitioner refused to go to the hospital because she wanted to "make sure the police report got done properly." Subsequently, Petitioner's mother drove her to Advocate South Suburban Hospital. Petitioner characterized her pain at the time as "some increased moderation of pain but wasn't extreme, nothing bad." Petitioner stated after the emergency room treatment the right arm "was back to the way it was before. It was back to baseline probably." Nevertheless, Petitioner returned to her treating surgeon, Dr. John Sonnenberg, who again told her there was nothing more he could do for her right shoulder and suggested pain management. Petitioner consulted a pain management specialist, who

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[1] In a letter dated February 23, 2015, CMS required an MSA in the sum of $51,169.00, rather than the $16,096.00 proposed by Respondent. The record is silent as to whether Respondent ever funded an MSA in the amount required by CMS.

[2] According to the police report, the accident occurred on June 19, 2013.

17IWCC0346

recommended getting a second orthopedic opinion from Dr. Edward Joy. Dr. Joy obtained an MRI and recommended surgery. Petitioner stated that after the surgery, the right shoulder "felt a lot better. [She] had increased range of motion and the tenderness and the pain [she] was experiencing prior to the surgery had gone away." Petitioner described the right shoulder condition at the time of the hearing as follows: "It's not 100 percent and I know it would never be. I still have decreased range of motion but the tenderness and inflammation that I had suffered from before was gone and I am sleeping a lot better."

On cross-examination, Petitioner maintained the car accident did not cause injuries to the right shoulder or arm. Petitioner denied telling her doctors the car accident caused her to slam the right shoulder into the door. Rather, she stated she told the doctors she bumped the right shoulder. Further, Petitioner denied having swelling with pain in the right shoulder when she presented at the emergency room. Upon further questioning, Petitioner admitted telling the emergency room staff she had increased pain in the right shoulder as a result of the car accident. Petitioner denied that in July or August of 2013, Dr. Sonnenberg performed an injection into the right arm. Petitioner acknowledged that no MRI of the right shoulder had been recommended between 2009 and the car accident, whereas an MRI was recommended after the car accident. Also, no surgery had been recommended between 2009 and the car accident. On redirect examination, Petitioner maintained her right shoulder pain returned to baseline shortly after the car accident.

The police report in evidence states Petitioner's car was struck by another car on the front right side. The other car was traveling in the right lane of a divided highway and Petitioner's car was traveling in the left lane, when the other car attempted to make a left turn. A photograph of the damage to Petitioner's car shows a dented bumper on the front right side.

The medical records in evidence show that on June 12, 2007, Dr. Sonnenberg performed a right shoulder arthroscopy and subacromial decompression. On October 30, 2007, Dr. Sonnenberg performed a right shoulder arthroscopy, lysis of adhesions and repair of a partial thickness rotator cuff tear. On February 24, 2009, Dr. Sonnenberg performed manipulation and injection of the right shoulder with lysis of adhesions. On October 13, 2009, Dr. Sonnenberg performed a right shoulder arthroscopy, release of biceps tendon, removal of adhesions from the subacromial space, biceps tenodesis, and repair of the rotator cuff.

On March 19, 2012, Petitioner consulted Dr. Gregory Portland at the Illinois Bone & Joint Institute. Dr. Portland noted a history of multiple surgeries on the right shoulder. Petitioner complained of "constant pain and disability with the right shoulder," although her main concern was worsening symptoms in the left shoulder. Physical examination focused on the left shoulder. On April 5, 2012, Petitioner followed up for her left shoulder condition.

On July 27, 2012, Petitioner consulted Dr. Giridhar Burra at Hinsdale Orthopaedics about her left shoulder condition. With respect to the right shoulder, Dr. Burra noted "significant history of 4 right shoulder surgeries which have ultimately left her with a permanent disability." Petitioner did not return to Dr. Burra.

On June 19, 2013, Petitioner presented at the emergency room of Advocate South

17IWCC0346

Suburban Hospital with complaints of right shoulder pain after the car accident. X-rays showed no acute findings. The attending physician diagnosed a shoulder sprain.

On July 3, 2013, Petitioner returned to Dr. Sonnenberg at Midland Orthopedic Associates. Dr. Sonnenberg noted the following history: "[The patient] has a long storied history of right shoulder pain with chronic adhesive capsulitis of the right shoulder. On 06/19/13 she was in a car accident. She was on the passenger side when her car was struck. She slammed her right shoulder into the door. She is complaining of pain in the right shoulder. An x-rays at South Suburban Hospital did not reveal any fracture." On physical examination, Dr. Sonnenberg noted tenderness and significantly decreased range of motion. Dr. Sonnenberg diagnosed "pain syndrome of the right shoulder which has created chronic frozen shoulder syndrome. She has superimposed trauma on top of this." Dr. Sonnenberg performed a steroid injection into the right shoulder. On August 19, 2013, Petitioner followed up. Dr. Sonnenberg noted: "[The patient] had minor improvement after the injection into the subacromial space of her right shoulder but then she states that the pain came back with a vengeance. The pain is now more in the myofascial area from her neck to the periscapular area. This has always been her problem with shifting pain and the incomplete responses to treatment course." Dr. Sonnenberg continued: "From an orthopedic standpoint there is not really much that I can do for [the patient]. We have been through an entire treatment course 3 years ago and she did not do well with treatment nor were we able to relieve her pain. ¶ At that time I recommended that she [be] seen by a pain management service. That recommendation still holds at this time." Dr. Sonnenberg referred Petitioner to a pain management program at Advocate South Suburban Hospital.

On September 25, 2013, Petitioner consulted Dr. Lindsey Job at the pain clinic. Dr. Job noted the following history and complaints: "The patient *** presents with right-sided shoulder pain. She reports this has been ongoing since 2007 when she was working as a computer tech. She reports that she has since been seeing an orthopedic surgeon. She has had 4 total surgeries in the past 6 years on her right shoulder. She reports no relief with any of these surgeries." Petitioner also reported no improvement with injections or physical therapy. She did not mention the car accident. Dr. Job diagnosed "[r]ight shoulder pain status post multiple surgeries secondary to scar tissue formation and underlying pathology," and recommended obtaining a second surgical opinion.

On October 1, 2013, Petitioner consulted Dr. Joy at Integrity Orthopedics for a second opinion. She gave a history of four previous surgeries and also reported a recent car accident in June. On physical examination, she complained of moderate to severe pain with diagnostic maneuvers. The range of motion was noted to be severely limited. Dr. Joy suspected adhesive capsulitis, a tear, or a nerve root or plexus disorder, and ordered diagnostic studies.

On October 7, 2013, Petitioner underwent electrodiagnostic studies, which showed no evidence of right cervical radiculopathy or brachial plexopathy. On October 11, 2013, Petitioner underwent an MRI arthrogram of the right shoulder, which showed "[p]ostsurgical changes from rotator cuff repair and biceps tenodesis with mild articular surface fraying of the distal supraspinatus tendon. No full-thickness re-tear is seen. ¶ Mild muscular atrophy of the supraspinatus muscle."

17IWCC0346

On October 18, 2013, Petitioner followed up with Dr. Joy. Dr. Joy performed an injection into the right shoulder. On November 1, 2013, Petitioner reported the injection only took the edge off the pain. Dr. Joy recommended surgery. On November 20, 2013, Dr. Joy performed a diagnostic arthroscopy, debridement of significant postsurgical scar tissue and some fraying, and an open "gentle subcoracoid decompression." No tears were found. Dr. Joy's postoperative diagnosis was subcoracoid impingement syndrome. After the surgery, Petitioner continued to complain of significant pain with diagnostic maneuvers. Petitioner last saw Dr. Joy on May 13, 2014, reporting some improvement. On physical examination, she complained of moderate pain. The range of motion was only mildly limited. Dr. Joy performed an injection into the right shoulder.

On July 8, 2016, Dr. Aaron Bare at Northwestern Medicine Orthopaedics performed a records review at Respondent's request. Dr. Bare noted that Petitioner did not treat for her right shoulder condition between early 2011 and the car accident approximately two and a half years later. Dr. Bare stated: "The medical records document that she reached maximum medical improvement by 2010 and was released to permanent stationary early in 2011. Due to the fact that she did not seek medical care for 2-1/2 years suggested that her pain, while most likely present, was stable and did not worsen or accelerate and thus she did not seek medical care until a motor vehicle accident caused an additional problem to her shoulder that required medical care. Any treatment for *** the right shoulder[] after the motor vehicle accident is based on her motor vehicle accident. Had she not had the motor vehicle accident, she would have stayed at her stable stationary state that she had for 2-1/2 years. Therefore, *the motor vehicle accident was the sole cause of her need for medical care for her shoulder *** after 06/19/2013.*" (Emphasis added.)

We begin our analysis by noting that at the time of the car accident, Petitioner's 8(a) rights were open because there was no MSA in place. Thus, Respondent would be liable to pay for medical treatment for the right shoulder condition, unless the car accident constituted an independent, intervening cause that broke the chain of causation. See National Freight Industries v. Workers' Compensation Comm'n, 2013 IL App (5th) 120043WC. Petitioner did not submit into evidence any expert opinion stating the treatment she received for her right shoulder condition after the car accident was related to her work accident. On the other hand, Respondent tendered into evidence a detailed and persuasive opinion from Dr. Bare that the treatment Petitioner received following the car accident was related solely to the injuries she sustained in the car accident. Having carefully considered the entire record, the Commission finds the car accident constituted an independent, intervening cause that broke the chain of causation from the work accident. Accordingly, the Commission denies the petitions under section 8(a) and for penalties, attorney fees and costs.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under section 8(a) is denied.

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

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

17IWCC0346

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.

JUN 6 - 2017

DATED:
d-05/18/2017
SM/sk
44

Stephen Mathis

David L. Gore

Kevin W. Lamborn

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

MARK GOLISH,

Petitioner,

vs. NO: 10 WC 23602

HARRISBURG UNIT SCHOOL DISTRICT No. 3,

Respondent.

ORDER

This matter comes before the Commission pursuant to Respondent, Harrisburg Unit School District No. 3's Petition for Review filed July 29, 2016. The Respondent was represented by Rouse & Cary. The Respondent filed its Petition for Review listing cases 10 WC 23565, 10 WC 23602, and 10 WC 23603 on the Petition.

The Petitioner has alleged three separate work-related accidents. The cases were consolidated at trial and a separate Decision was issued for each of the three cases.

The first claim, 10 WC 23602, alleged an accident date of December 1, 2008, and the second claim, 10 WC 23603, alleged an accident date of August 11, 2008. AIG was the insurance carrier for those two accidents, and the Respondent was represented by Rusin & Maciorowski.

The third accident, 10 WC 23565, occurred on February 1, 2010. Indiana Insurance was the insurance carrier for that accident, and the Respondent was represented by Rouse & Cary.

Neither the Petitioner nor Respondent's counsel, Rusin & Maciorowski, filed a Petition for Review for case 10 WC 23602 or case 10 WC 23603.

Accordingly, the Commission finds that Rouse & Cary lacked standing to challenge the Decision of the Arbitrator in case 10 WC 23602 or 10 WC 23603. Therefore, the Commission amends Rouse & Cary's Petition for Review, *sua sponte*, and strikes case 10 WC 23602 and 10 WC 23603 from the Petition for Review.

As a timely Petition for Review has not been filed in either 10 WC 23602 and 10 WC 23603, the Decision of the Arbitrator for each of those two cases is now final. The Commission lacks jurisdiction to decide those two cases.

A separate Decision has been issued for each case, 10 WC 23565 and case 10 WC 23603.

DATED: JUN 7 - 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 4-11-17
052

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

MARK GOLISH,

Petitioner,

vs. NO: 10 WC 23603

HARRISBURG UNIT SCHOOL DISTRICT No. 3,

Respondent.

ORDER

This matter comes before the Commission pursuant to Respondent, Harrisburg Unit School District No. 3's Petition for Review filed July 29, 2016. The Respondent was represented by Rouse & Cary. The Respondent filed its Petition for Review listing cases 10 WC 23565, 10 WC 23602, and 10 WC 23603 on the Petition.

The Petitioner has alleged three separate work-related accidents. The cases were consolidated at trial and a separate Decision was issued for each of the three cases.

The first claim, 10 WC 23602, alleged an accident date of December 1, 2008, and the second claim, 10 WC 23603, alleged an accident date of August 11, 2008. AIG was the insurance carrier for those two accidents, and the Respondent was represented by Rusin & Maciorowski.

The third accident, 10 WC 23565, occurred on February 1, 2010. Indiana Insurance was the insurance carrier for that accident, and the Respondent was represented by Rouse & Cary.

Neither the Petitioner nor Respondent's counsel, Rusin & Maciorowski, filed a Petition for Review for case 10 WC 23602 or case 10 WC 23603.

Accordingly, the Commission finds that Rouse & Cary lacked standing to challenge the Decision of the Arbitrator in case 10 WC 23602 or 10 WC 23603. Therefore, the Commission amends Rouse & Cary's Petition for Review, *sua sponte*, and strikes case 10 WC 23602 and 10 WC 23603 from the Petition for Review.

As a timely Petition for Review has not been filed in either 10 WC 23602 and 10 WC 23603, the Decision of the Arbitrator for each of those two cases is now final. The Commission lacks jurisdiction to decide those two cases.

A separate Decision has been issued for each case, 10 WC 23565 and case 10 WC 23602.

DATED: JUN 7 - 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 4-11-17
052

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARK GOLISH,

Petitioner,

vs. NO: 10 WC 23565

17IWCC0347

HARRISBURG UNIT SCHOOL DISTRICT No. 3,

Respondent.

DECISION AND OPINION ON REVIEW

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

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.

17IWCC0347

This matter was consolidated at trial with cases 10 WC 23602 and 10 WC 23603. A separate decision has been issued for each case.

The Commission modifies, in part, and affirms in part, the Decision of the Arbitrator. The Commission modifies the Decision relative to the cervical and lumbar spine. The Commission finds that Mark Golish failed to prove that the cervical and lumbar surgeries as rendered by Dr. Sonjay Fonn were medically reasonable or necessary as a result of his February 1, 2010 accident. Consequently, the Respondent is not liable for the surgeries and the associated expenses incurred thereafter as a result of the surgeries. The Commission finds that Petitioner is entitled to TTD benefits relative to his lumbar and cervical spine through June 24, 2013, the date of Dr. deGrange's second Section 12 examination, which found Golish was at maximum medical improvement (MMI). Petitioner's claim for prospective medical treatment consisting of a spinal cord stimulator and associated treatment as recommended by Dr. Fonn is denied.

The Commission affirms the Decision of the Arbitrator relative to the right hand. Petitioner is entitled to TTD benefits to the right hand from February 9, 2010 through the date of hearing, March 4, 2015, as Dr. Young had Petitioner off work. Petitioner is also entitled to MP joint arthroplasty as recommended by Dr. Young.

Golish sustained three work-related accidents while employed by Harrisburg School District.

Per the Application for Adjustment of Claim filed June 21, 2010 (case # 10 WC 23603), Golish alleged injury on August 11, 2008 while opening a stuck door lock, which caused him to experience a pop in his right hand. The nature of the injury was listed as "second and third MP joints injured and MP joint arthroplasty discussed."

Per the Application filed June 21, 2010 (case # 10 WC 23602), Golish alleged injury to his low back on December 1, 2008 while pulling a plow to put it on a tractor. The nature of the injury was listed as "disc injuries needs surgery at multiple levels of low back."

Per the Amended Application filed September 3, 2014 (case # 10 WC 23565), Golish alleged injury to his neck, low back, and right hand when he "slipped on ice while carrying back (sic) of ice melt" on February 1, 2010. The extent of the injury was unknown.

Petitioner had been employed by the Respondent since 1992 and was most recently working as the head maintenance supervisor with three assistants.

On August 11, 2008, Golish was trying to open a jammed lock when the handle broke open and struck him in the right hand. T.33. His right hand began to swell and he had pain and bruising. T.34. He continued to work after the accident and first sought medical treatment on August 25, 2008. *Id.* He took high doses of Ibuprofen to help him work.

17IWCC0347

Per the First Report of Injury completed August 25, 2008, Golish alleged injury to his right middle and right index joints while lifting a heavy trash bag. RX.14.

Golish was seen by Dr. Elliot Partridge on August 25, 2008 for right hand pain. Examination revealed some mild edema, especially at the second MTP with some in the third and fourth. He had full range of motion and some tenderness to deep palpation. X-ray of the right hand revealed mild degenerative changes with no acute bone abnormality. Dr. Partridge noted that the x-ray looked fine. Golish was diagnosed with post traumatic tendonitis right MCP. PX.7.

On December 1, 2008, Golish was pulling a tractor plow over the carpet when the plow he was pulling got caught on the carpet causing him to fall forward and over the plow. He experienced a "real bad" pull in his back, and fell to the ground. T.37.

Per the accident report dated December 1, 2008, Golish alleged injury to his lower back as the result of the incident. He had pain into his left leg. Then on December 3, 2008, Golish authored an e-mail to Respondent's employee, Cindy Mitchell indicating that he hurt his back while moving the plow. He reported that his back has been hurting and Dr. Partridge put him on muscle relaxers. PX.3.

Golish was seen by Dr. Partridge on December 23, 2008 and was diagnosed with an acute low back strain and right hand tendonitis. He had right hand tenderness and brawny edema of the MCP #2 of the right hand. He had a questionable straight leg raise and no tenderness or spasms in his back. An MRI of the right hand was recommended. PX.7.

Petitioner underwent an MRI of the right hand without contrast on December 31, 2008 at Ferrell Hospital. The MRI revealed changes of his osteoarthritis at the level of the 2nd and 3rd metacarpal phalangeal articulation with small focal areas of bone marrow edema involving the subcortical regions of the 2nd and 3rd metacarpal heads, which may be related to small post traumatic bone contusions or degenerative subchondral reactive marrow changes. The study was otherwise normal. PX.7.

Golish presented for follow-up with Dr. Partridge on June 3, 2009. As to the low back, he had a positive straight leg raise on the right with L5-S1 dermatomal radiculopathy. The assessment was edema, pain in the right hand, and low back pain with radiculopathy. PX.6.

Golish underwent an open MRI of the lumbar spine without contrast on June 9, 2009 at The CT and Open MRI Center. The impression was broad based mild disc herniation at L2-L3 and L3-L4 resulting in mild thecal sac effacement and bilateral foraminal encroachment. There were no abnormalities at L4-L5 and L5-SI. There was no fracture or subluxation. PX.7.

Petitioner underwent lumbar epidural steroid injections on August 12, 2009 and September 10, 2009. The injections were administered by Dr. Paul Juergens. PX.6.

Per the addendum issued on June 30, 2009, Dr. Steven Young opined Golish had a substantial metacarpal phalangeal arthrosis of the index and long finger, with the index finger actually worse than the long finger. Dr. Young noted that Golish may have ruptured his radial sagittal band at the long finger as there was a little bit of a lag. Dr. Young noted that surgery was not warranted as it had been a year since his August 2008 accident. He provided Golish with an injection. PX.7

Golish was seen by Dr. Juergens on July 23, 2009 for back pain. He had left-sided back pain and left leg pain that stopped at his knee. He had some tingling in the left foot and toes, worse in the low back. He reported that his pain began in December 2008 following his work accident. He had decreased flexion of the lumbar spine without pain and decreased extension with pain. The lumbar spine showed palpatory paraspinal tenderness on the left and palpatory spinous tenderness. The straight leg raise was abnormal with radiating pain at 90 degrees on the left. The impression was chronic pain due to trauma and low back pain, chronic, lumbar degenerative disc disease, lumbar herniation, and lumbar radiculopathy. PX.14.

Petitioner underwent a CT scan of the lumbar spine with contrast on December 10, 2009. The impression was mild posterior bilateral paracentral bulging of the L2-L3 disc with mild encroachment upon the ventral thecal sac. There was moderate posterior bilateral paracentral bulging of the L3-L4 disc with mild facet hypertrophy and ligamentum flavum thickening resulting in moderate spinal and mild bilateral neural foraminal stenosis. There was a mild posterior bilateral paracentral bulging of the L4-L5 disc resulting in mild spinal and mild bilateral neural foramina stenosis. There was mild posterior bulging of the L5-S1 disc without significant spinal or neural foramina stenosis. There was spondylolysis of L5 bilaterally. The scan was noted as unremarkable. PX.6.

On December 22, 2009, Dr. Young saw Petitioner for continued pain. He had MP joint motion that was limited in the right 2nd and 3rd finger. The x-ray revealed substantial arthrosis of the 2nd MP joint, and the 3rd MP joint was arthritic to a lesser extent. While they discussed the risks of an MP joint arthroplasty, Dr. Young did not recommend surgery. Dr. Young noted that while surgery may alleviate his pain, his activity level may produce some problems as far as early prosthetic loosening was concerned. Petitioner did not want to proceed with surgical intervention. PX.11.

Petitioner underwent an EMG of the lower limbs on January 12, 2010. The EMG was normal with no evidence of lumbosacral radiculopathy, peripheral neuropathy, or focal mononeuropathy in the muscles of either limb. RX.5.

Golish sustained a third injury on February 1, 2010 to his right hand, low back and neck. T.60. On that date, he was carrying a 50 pound bag of ice melt with his left hand when he slipped on some ice. His feet went up in the air and he used his right hand to protect his head. He landed on his right hip and buttock. He had pain in his hand and back. Golish testified that he had a whiplash type of injury to the neck, and his head struck the ramp. T.66.

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Golish completed a First Report of Injury on February 1, 2010 indicating that he slipped on an icy ramp while exiting the storage building. He reported that his right hand ached all the way to his elbow with sharp pains. He did not have any swelling, bruising, discoloration, or deformity.

Golish was seen by Dr. Partridge on February 1, 2010 and reported his injury. He fell with most of his weight on his right hip and right hand, which was previously injured. This also caused his back to hurt. There was no evidence of fracture or dislocation in the right hand, wrist or hip. The assessment was a fall with a contusion, right wrist and hand, right hip with low back strain. PX.7.

X-ray of the right wrist and right hand revealed mild osteoarthritis with no acute bone abnormality. X-ray of the right hip was negative. PX.7.

Golish was seen by Dr. Young on February 9, 2010. Dr. Young noted Golish responded well to the second steroid injection. He recently sustained another injury and now had pain in the 2nd and 3rd MP joints. Examination revealed some swelling at the 2nd and 3rd MP joints. He was reluctant to move the fingers. He had pain with palpation over both the 2nd and 3rd MP joint. There was no evidence of subluxation. A splint was provided. PX.11. Dr. Young noted Golish was unable to perform any work duties until re-evaluation. The date of injury, however, was listed as August 22, 2008. PX.11.

Golish was seen by Dr. Sonjay Fonn D.O. of Midwest Neurosurgeons on February 17, 2010. Petitioner had a significant amount of back pain radiating down to his left and right legs, with paresthesia and some weakness secondary to pain. He also reported some neck pain and right arm pain with paresthesia in the first and second digits. Examination revealed 5/5 motor strength throughout, he had a normal gait and station. He had 2.4 deep tendon reflexes throughout. He had a negative Hoffman's. The Babinski was downgoing. Dr. Fonn reviewed the MRI from June 2009 and noted Golish had traumatic changes to the L2-L3 and L3-L4 level with a broad based disc herniation causing moderate to severe foraminal stenosis. By his comment, this was confirmed by the CT myelogram from December 2009. He recommended a repeat MRI and noted Petitioner may be a candidate for surgical intervention, pending a discogram. PX.15.

Golish was seen by Dr. Fonn on February 26, 2010 with continued pain. He had 5/5 motor strength and a normal gait. He had 2.4 deep tendon reflexes and a negative Hoffmann's. The Babinski's was downgoing. Dr. Fonn noted that based upon his review of the MRI and the history, it appeared that the L2-L3 and L3-L4 level became symptomatic after the December 1, 2008 accident and the L4-L5 level became symptomatic after the February 1, 2010 incident. He recommended a discogram. PX.15.

Golish underwent an MRI of the right hand without contrast on March 11, 2010. There was joint effusion contained within the 2nd and 3rd metacarpal phalangeal articulation with

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surrounding soft tissue edema being nonspecific, and may be inflammatory or post traumatic in nature. There were also osteoarthritic changes in the hand and wrist. PX.15.

Golish followed-up with Dr. Young on March 23, 2010. Dr. Young reviewed the MRI findings and noted that the options included arthroplasty of the right 2nd and 3rd MP joint. Petitioner indicated he needed to talk to his attorney. PX.11.

Petitioner was seen by Dr. Fonn on March 26, 2010 with continued pain. Dr. Fonn compared the June 9, 2009 MRI to the March 11, 2010 MRI and noted that at L2-L3 and L3-L4, there appeared to be a progression of the symptomatology and further collapse of the disc height and foraminal stenosis. At L4-L5, he noted a larger foraminal disc herniation worse on the right than the left but certainly bilaterally. This would explain the new symptoms in the right leg radiating down to his mid-thigh and knee after February 1, 2010. He recommended epidural steroid injections followed by a discogram. PX.15.

Dr. Fonn performed a discogram on April 27, 2010. Per the report, Golish had minimal extravasation at L2-L3, L4-SI, at best. It was questionable whether he, Petitioner, had concordant pain at L2-L3, L4-L5, L5-SI. PX.15.

Petitioner followed-up with Dr. Fonn on June 3, 2010. Dr. Fonn noted that the discogram showed pathology at L2-L3, L3-L4 and L4-L5. While it was somewhat inconclusive, Dr. Fonn noted he obtained most of his information from the MRI, CT scan, and physical examination. His examination findings remained unchanged from his previous examinations. Dr. Fonn recommended a three level fusion at the levels of L2-L3, L3-L4, and L4-L5. PX.15.

Golish underwent an MRI of the cervical spine without contrast at CT and Open MRI Center on June 28, 2010. The MRI revealed a tiny central disc herniation producing slight effacement of the thecal sac from C3-C4 through C6-C7. The MRI was negative for spinal cord compression or nerve root impingement. PX.15.

Golish was seen by Dr. Fonn on July 8, 2010. Dr. Fonn reviewed the June 28, 2010 MRI with Petitioner and noted it showed pathology at the levels from C3 through C7. Dr. Fonn indicated Golish had significant straightening of the cervical spine suggestive of a whiplash injury and severe muscle spasms. Dr. Fonn also indicated Golish had moderate sized disc herniations, worse at C4-C5, C5-C6, and C6-C7 level. The C3-C4 level was very minor. Per Dr. Fonn, the herniation came up to and abutted the spinal cord at C4-C5, C5-C6, and C6-C7, and would need to be addressed in the future. PX.15.

On July 9, 2010, Dr. Fonn performed a posterior L2-L3, L3-L4, L4-L5 interbody fusion and stabilization with laminotomy. PX.15.

Petitioner was seen by Dr. Young on January 31, 2011 for continued right 2nd and 3rd MP joint issue. The assessment was metacarpal phalangeal arthrosis of the index and long finger.

They decided to go forward with the arthroplasty of the left index and long metacarpal phalangeal joint arthroplasties as this would provide the best option for pain relief. PX.11.

Petitioner underwent an MRI of the lumbar spine on February 8, 2011 that revealed post-operative changes from the prior fusion at L2 through L5. There was a mild annular disc bulge at L5-S1 and multilevel right-sided neural foraminal stenosis at L3-L4 and mild to moderate at L4-L5 along with left sided neural foraminal stenosis being mild at L2-L3 through L5-S1. PX.15.

It was noted that the MRI of the cervical spine from February 8, 2011 revealed no overall significant interval change from the June 28, 2010 study. PX.15.

Golish underwent a Section 12 examination with Dr. David Brown on March 29, 2011 at the Orthopedic Center of St. Louis. Dr. Brown noted Petitioner had advanced, chronic, MP joint osteoarthritis of the right index finger and middle finger that failed conservative treatment. His options were to live with the condition or consider a joint replacement as suggested by Dr. Young. He did not believe the accident caused the osteoarthritis. The injury was consistent with a contusion that might have caused some temporary symptoms, but his current symptoms were clearly related to the osteoarthritis at the MP joint of the index and middle finger, which would not have been caused by the August 11, 2008 accident. RX.2.

Petitioner underwent a Section 12 examination with Dr. Donald deGrange on April 6, 2011. Dr. deGrange diagnosed Golish with degenerative disc disease of the lumbar spine, status post fusion L2 through L5. Dr. deGrange noted that the slip and fall appeared to have aggravated a longstanding and chronic condition of the low back and degenerative disc disease. He could find no new symptomatology that would conclude that there was a structural change in Golish's pre-existing degenerative disc condition in his lumbar spine. No cervical studies were presented, so Dr. deGrange could not comment on any cervical pathology. RX.2.

Dr. deGrange stated that the February 1, 2010 incident aggravated Golish's pre-existing condition that had been severely symptomatic as noted by Dr. Gocio's notes from November 2009. He could not find any significant or noticeable difference between Petitioner's symptoms, nor were his MRIs pre and post-accident noticeably different. This was an aggravation of his previous and ongoing chronic condition. By Dr. deGrange's comment, this caused an aggravation for approximately 6 weeks at which time Golish returned to his pre-morbid state. It did not aggravate his condition beyond the normal progression. The surgery was not causally related to the accident. He was at MMI by 12 weeks post-accident. Golish did not need any work restrictions relative to the accident, but needed restrictions only as a result of the surgery, which was not work-related and not necessitated by the work accident. RX.2.

Dr. Brown authored an addendum on May 2, 2011 after his review of additional records. He did not believe the August 11, 2008 accident was a cause of Golish's osteoarthritis or need for joint replacement. RX.2.

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Dr. Brown authored another addendum on May 31, 2011. Dr. Young did not believe Golish sustained a significant traumatic injury to his right hand on February 1, 2010. The diagnosis of advanced chronic MP joint osteoarthritis in the right middle and right index finger clearly pre-dated the February 1, 2010 injury. RX.2.

On June 24, 2011, Dr. Fonn performed a posterior L5-S1 interbody fusion and stabilization, and bilateral lumbar laminotomy at L5-S1. PX.15.

On July 7, 2011, Dr. Fonn performed a repair of new cerebrospinal fluid (CSF) leak post-op. There was a small tear evident at the L5-SI level. PX.15.

Golish underwent an MRI of the cervical spine on October 27, 2011 that revealed no overall significant interval change from February 8, 2011. PX.15.

During the follow-up visit on November 15, 2011, Dr. Fonn noted the myelogram revealed disc osteophyte complex causing stenosis at C4-C7. The MRI from October 27, 2011 revealed a tiny broad based central disc herniation. Dr. Fonn was of the opinion this was not tiny and looked fairly significant with indentation of the spinal cord at all three levels. When Dr. Fonn compared the October 27, 2011 MRI to the February 8, 2011 MRI, he noted the disc herniation clearly got substantially larger. He recommended an anterior cervical discectomy and fusion (ACDF) at C4-C7. PX.15.

Dr. Fonn performed C4-C5, C5-C6, and C6-C7 anterior microdiskectomies and decompression, arthrodesis and placement of 8mm interbody spacers at C4-C5, C5-C6, and C6-C7 on December 28, 2011. The post-operative diagnosis was C4-C5, C5-C6, and C6-C7 central disc herniation with spinal cord compression. PX.15.

Golish underwent removal of the posterior instrument from L4-L5 and L5-SI on December 14, 2012. The post-operative diagnosis was failed back syndrome with osteomyelitis and discitis at L5-SI. PX.15.

Dr. deGrange performed a second Section 12 examination on June 24, 2013. He found that Golish had a C4-C7 ACDF and L2-SI spinal fusion. Golish had persistent back and neck pain. Despite his multiple surgeries, there had been no improvement in the overall clinical condition or functional level. He noted the June 28, 2010 MRI did not show any significant or acute injury; rather, the presence of mild pre-existing degenerative changes. He noted Dr. Fonn was of the opinion that the MRI in October 2011 showed that the tiny herniation got substantially larger at the three levels fused. He noted that the fusion performed by Dr. Fonn was not a direct consequence of the February 2010 accident. Any change between the June 2010 and October 2011 MRI could not have been the result of the February 2010 accident. The surgery was, therefore, not medically causally related to the February 2010 accident. He was at MMI. RX.2.

Different insurance carriers were involved in the 2008 and 2010 work accidents. For this reason, the Respondent had two different Section 12 examiners: one for the December 1, 2008 accident and another for the February 1, 2010 accident.

Golish underwent a Section 12 examination on July 10, 2013 with Dr. Frank Petkovich. Dr. Petkovich diagnosed Petitioner with a lumbar strain, degenerative disc disease, cervical spine fusion at C4-C5, C5-C6, and C6-C7, and lumbar fusion at L2-L3, L3-L4, L4-L5, and L5-SI. He sustained a lumbar strain as a result of the work accident on December 1, 2008. The accident did not aggravate the degenerative disc disease. It may have been exacerbated by the accident, which had resolved by the time of the February 1, 2010 accident. The lumbar surgeries were not related to the December 1, 2008 accident. His current condition was in no way related to the accident. His cervical condition was not related to the accident. He had reached MMI as of the February 1, 2010 accident. PX.52. Dr. Petkovich authored an addendum on October 4, 2013 following his review of additional medical records. His opinion remained unchanged. RX.1.

Dr. Young was deposed on September 10, 2013. Dr. Young is a board certified orthopedic surgeon focusing primarily on the upper extremities. He did not feel Golish could continue to work as a maintenance supervisor following his second accident. PX.12. pg.17. Dr. Young stated there was some advancement in the arthritic process in the 2nd and 3rd metacarpophalangeal joints during the course of treatment from the first and second accident. He opined that the arthritic condition pre-existed the August 11, 2008 injury. PX.12. pg.23. He opined that the August 11, 2008 accident aggravated, exacerbated, or accelerated his arthritic condition and made it symptomatic. PX.12. pg.24. He further opined that the second accident of February 1, 2010 aggravated, exacerbated, or accelerated his arthritic condition. Both accidents caused permanent damage to the right hand. The proposed surgery was causally related to the injuries.

Dr. Fonn was deposed September 11, 2013. He stated that the three level lumbar fusion and the L5-SI fusion was medically necessary as Golish was having symptoms of back pain, leg pain, leg paresthesia, and weakness in the legs. PX.16. pg.13. He also performed a decompression at the C4-C5, C5-C6 and C6-C7 levels. He visualized the hernias during the operation. PX.16. pg.16. He then removed the hardware and performed exploration at L4-L5, L5-SI on December 14, 2012. The surgeries were necessary based upon Petitioner's signs, symptoms, and physical examination. PX.16. pg.17.

Dr. Fonn noted that Golish was currently seeing Dr. Jiang and will likely need lifelong treatment or suppressive antibiotic treatment, and possibly additional surgery to remove the spacers in his lumbar spine. PX.16. pg.19. Dr. Fonn noted this may be too traumatic, and the best option was to keep him on lifelong chronic suppressive antibiotic medication. PX.16. pg.20.

Dr. Fonn testified that the final diagnoses were lumbar and cervical radiculopathy, cervical and lumbar stenosis, and discitis/osteomyelitis. PX.16. pg.21. The accidents contributed significantly to Petitioner's condition. *Id.* He testified that the December 1, 2008 accident caused

the disc herniations. He noted that the L2-L3 and L3-L4 levels were symptomatic after the 2008 accident, and the L4-L5 level became symptomatic after the 2010 accident. PX.16. pg.23. Dr. Fonn stated that the 2008 and 2010 accidents aggravated Golish's degenerative disc disease. PX.16. pg.26. He stated there is no way to separate the need for surgery between the two accidents. PX.16. pg.28. He also stated that the February 2010 accident aggravated and exacerbated his pre-existing condition. *Id.* Petitioner's time off work was related to the accident.

Dr. Fonn testified that Golish will be in pain forever. He was of the opinion Golish could not return to any meaningful work. PX.16. pg.30. He could not work an uninterrupted 8 hour day. PX.16. pg.31. He stated that the neck symptoms could have been related to the February 2010 accident. PX.16. pg.34.

On cross-examination by the attorney defending the February 1, 2010 injury, Dr. Fonn stated that his personal attorney was present at the deposition. PX.16. pg.38. He noted that the June 28, 2010 cervical MRI revealed that the intervertebral discs throughout the cervical spine maintained normal signal and no disc space narrowing. There was no fracture or subluxation. PX.16. pg.41. There was some mild degenerative anterior marginal spurring at C5-C6 and C6-C7. Dr. Fonn noted that the report revealed there were tiny central disc herniations slightly effacing the thecal sac at C3-C4 through C6-C7 without spinal cord compression. PX.16. pg.42. He noted the report also indicated there was no spinal stenosis. *Id.*

Dr. Fonn reviewed the February 8, 2011 cervical MRI noted there was no overall significant interval change from the June 28, 2010 MRI. Dr. Youssef, the radiologist who reviewed all three MRIs, noted the same thing on the October 27, 2011 MRI.

On cross-examination by the attorney defending the 2008 injuries, Dr. Fonn noted that Dr. Gocio indicated Petitioner may need surgery. Dr. Fonn stated that he is board eligible. He has taken the written examination "several times" and the orals one time. He did not pass. Dr. Fonn stated that "several" is more than three. PX.16. pg.74. Dr. Fonn is not board certified.

Dr. deGrange was deposed September 20, 2013. He is a board certified orthopedic surgeon. He reviewed the June 2009 MRI and noted that it revealed normal alignment of the spine, some slight drying of the disks, and slight decrease in the thickness of the disks at L2-L3 and L3-L4. There was very mild degeneration at L4-L5 without any significant stenosis. RX.11. pg.12. He then reviewed the March 2010 lumbar MRI and noted there was no significant change when compared to the June 2009 MRI. RX.11. pg.13. Petitioner sustained a lumbar strain as a result of the February 1, 2010 injury. RX.11. pg.14. He stated that the three level fusion was not medically causally related to the February 1, 2010 accident. Golish was at MMI. He found no compelling orthopedic surgical evidence supporting any claim that the fusion was reasonable. RX.11. pg.15. There were no generally accepted lesions or pathology necessitating a three level fusion. There was nothing serious such as a fracture, infection, tumor, progressive deformity, or significant lumbar instability.

Dr. deGrange performed a second Section 12 examination on June 24, 2013. He reviewed the cervical MRI and noted the radiologist found mild degenerative anterior marginal spurring at C5-C6 and C6-C7, and a tiny disc herniation at C3-C4 through C6-C7 without spinal cord compression. RX.11. pg.16. Given there was no spinal cord compression, there was no surgical lesion and nothing of any concern in regard to damage to either the spinal cord or the spinal nerve roots. This was a normal MRI for a 52 year old male. He stated that Golish sustained a cervical strain (whiplash) as a result of the February 2010 injury. RX.11. pg.19. He was at MMI. The surgery was not medically necessary as there was no serious or significant neural compression and no signs of progressive deformity, and no sign of any segmental cervical instability requiring a fusion. RX.11. pg.21. None of his surgeries were causally related to the February 1, 2010 accident. RX.11. pg.23.

On cross-examination by Respondent's attorney, Dr. deGrange noted that the June 9, 2009 MRI revealed degenerative changes only, nothing acute. RX.11. pg.28.

On cross-examination by petitioner's attorney, Dr. deGrange noted that Dr. Gocio indicated on November 18, 2009 that Golish may need a laminicetomy and fusion. RX.11. pg.41. He was not aware that the radiologist interpreted the June 9, 2009 MRI and noted Golish had a broad based mild disk herniation at L2-L3 and L3-L4. He did not know there was mild thecal sac defacement which could cause symptoms. He did not review the April 27, 2010 discogram. He was not giving any opinions whether the December 1, 2008 accident aggravated or exacerbated the degenerative disc disease that pre-dated December 1, 2008. RX.11. pg.50. His opinions were relative to the February 1, 2010 accident only. He was not aware that Dr. Fonn visualized a broad based disc herniation at both levels during the surgery. RX.11. pg.58. He stated that the fall could be one reason for the neck surgery. RX.11. pg.72. He stated that he could not exclude the February 1, 2010 accident as a contributing cause for the need for the surgeries, if found medically necessary. RX.11. pg.76.

Dr. Petkovich was deposed October 10, 2013. He is a board certified orthopedic surgeon. He noted that the June 9, 2009 lumbar MRI showed degenerative disc changes at L2-L3 and L3-L4. There were some disc protrusions centrally, which were part of the degenerative process. There were no specific disc herniations and no evidence of nerve root compression. RX.1. pg.14. He disagreed with the radiologist report which stated there were broad based herniations at L2-L3 and L3-L4 resulting in thecal sac effacement and bilateral foraminal encroachment. He stated that no spine surgeon would call the findings disc herniations. There was no nerve root compression. He noted the study looked very good for a person of Petitioner's age. He noted that Golish had a nerve study performed on January 12, 2010 that was normal without any evidence of peripheral nerve involvement of the lower extremities. RX.1. pg.20.

Dr. Petkovich noted that Dr. Gocio had mentioned surgery, but Golish reported he was getting better and he did not want surgery. RX.1. pg.21. He did not see anything in the medical records from December 1, 2008 through January 2010 warranting a three-level lumbar fusion. *Id.*

Dr. Petkovich noted that Petitioner sustained another accident in February 2010. He reviewed the March 11, 2010 lumbar MRI that revealed degenerative changes at L2-SI, mild stenosis at L2-L4, but no specific nerve root compression and no specific herniation. He compared the MRI to the June 9, 2009 MRI and noted no appreciable difference in the two, the only change was a mild progression of the degenerative process which was a chronic condition unrelated to the accidents. RX.1. pg.24. There was no nerve root compression on either MRI. RX.1. pg.25.

Dr. Petkovich reviewed the cervical MRI from June 28, 2010, which showed mild degenerative changes at C3-C7. He testified there was no evidence of a disc herniation or nerve root compression, and no evidence of spinal cord compression. Following his review of the evidence, he stated that Golish had a lumbar strain that was causally related to the December 1, 2008 accident. RX.1. pg.38. The lumbar degenerative disc disease was not causally related to the work accident. *Id.* He believed Golish sustained a muscular and ligamentous lumbar strain. The incident did not cause any aggravation or acceleration of his pre-existing degenerative lumbar condition. It may have caused some exacerbation of his pre-existing condition, but temporary in nature. RX.1. pg.39. He stated that his treatment until the CT myelogram was reasonable. Petitioner reached MMI by the time he had the myelogram in December 2009.

Dr. Petkovich stated that none of the treatment after February 1, 2010 was reasonable or related to the December 2008 injury. RX.1.pg.42. None of the surgical treatment received relative to his cervical or lumbar spine was related to the December 1, 2008 accident. RX.1. pg.43. His cervical spine surgery was not related to the December 1, 2008 accident. He was in no need of further treatment after January 2010 relative to December 1, 2008 accident. Any work restrictions were not related to the December 1, 2008 accident. RX.1. pg.46.

On cross-examination by Respondent's attorney, he agreed with Dr. deGrange that there was no compelling reason to perform surgery from L2 through L5. There was no generally accepted lesion or pathology necessitating a three-level fusion. He did not believe any of the surgeries Petitioner had on his cervical or lumbar spine were reasonable or necessary. RX.1. pg.50. He did not see anything on the second MRI that could be related to some type of traumatic change from the first MRI of June 2009. RX.1. pg.53. There was nothing in the diagnostic studies of the cervical spine that indicated some type of traumatic change to the cervical spine.

On cross-examination by Petitioner's attorney, Dr. Petkovich testified that he was not offering any opinion relative to a causal connection between Petitioner's current condition and the February 1, 2010 accident. He stated that the broad based disc herniation identified by the radiologist on the June 9, 2008 MRI was a degenerative condition. There was no focal disc herniation identified. He would disagree with Dr. Fonn if he thought there were herniations. RX.1. pg.80. He stated that the lumbar strain certainly resolved by December 2009. RX.1. pg.81. He noted that Dr. Gocio noted on October 12, 2009 that Petitioner may need a lumbar fusion. RX.1. pg.89. He was aware that on November 18, 2009, Golish was diagnosed with lumbar radiculopathy and complained of pain in his low back that was worse and moved to his right leg,

and was still going up and aching in his left leg. RX.1. pg.91. Despite all of this, he still thought Petitioner's condition had resolved. RX.1. pg.91.

Dr. Brown was deposed January 27, 2014. He is a board certified hand surgeon. He examined the Petitioner and noted Golish had two choices: live with his condition or undergo joint replacement surgery as suggested by Dr. Young. RX.12. pg.11. Petitioner's diagnosis was not related to the August 2008 injury. His opinion was based upon the diagnostic studies, which did not show any evidence of acute injury to the joint that would cause, accelerate, or aggravate his arthritis.

On cross-examination, Dr. Brown stated the August 11, 2008 accident may have caused a contusion, but it was not a factor in the cause or aggravation of the arthritic joints. RX.12. pg.22. Golish did not sustain an acute injury. He disagreed with Dr. Partridge's August 25, 2008 diagnosis of post-traumatic tendonitis of the right MCP. RX.12. pg.30. Based upon his review of the diagnostic studies, there was no evidence of any significant trauma from either incident. RX.12. pg.41.

Golish was seen by Dr. Steven Young on March 11, 2014. Dr. Young noted that he last saw Petitioner on November 5, 2012. He was last provided with a steroid injection into the MP joint, which helped tremendously. However, recently Golish has been having increased pain at the MP joint. He rated his pain as 5 out of 10. Dr. Young provided Petitioner with another injection. They discussed the x-rays, which revealed bone spurring at the volar aspect of the MP joint of the index and long finger. There were also severe arthritic changes at the MP joint. Golish was still considering the MP joint replacement. PX.32.

Golish was seen by Dr. Fonn on May 28, 2014. He recommended Petitioner see Dr. Jiang for repeat C-Reactive Protein (CRP) since his pain was returning in the mid-back region. He also recommended a lumbar MRI. Petitioner expressed interest in a spinal cord stimulator. PX.15.

Petitioner was seen by Dr. Young on October 30, 2014 for continued pain in the right hand of the second and third metacarpals. Dr. Young reiterated his opinion that it would be reasonable to perform arthroplasties in the hand. PX.32.

Golish testified that he is still treating with Dr. Fonn. Dr. Fonn is recommending a bone nerve block and a spinal cord stimulator. T.88.

Petitioner stated that the right hand surgery has been denied by workers' compensation. He currently has burning, aching, and extreme pain in his right hand. He drops things. He cannot make a fist and does not have strength. T.96. This is all an increase from the February 1, 2010 injury. T.97.

Petitioner was ultimately dismissed by the Respondent. Petitioner testified that he has not received any TTD benefits from February 1, 2010 through the present. T.102. He has been paying out-of-pocket medical expenses since 2008. T.113. He has paid $11,242.62 and has incurred $16,066.34 in medical expenses. T.115. He was awarded social security disability. *Id.*

Golish testified that Dr. Fonn never mentioned that he was not board certified, that he failed his board examinations, that he was reprimanded by the State of Ohio, or the allegations raised by the State medical board of Ohio. T.148. Dr. Fonn also never mentioned why his own malpractice attorney was present during the deposition in his case. T.148.

Per Respondent's exhibit 15, Dr. Fonn was reprimanded by the State Medical Board for Ohio on October 10, 2007. RX.15. He was reprimanded for failing to inform the Board in his training certificate application that he had been warned by his residency program director that conflicts with personnel could lead to a nonrenewal of his residency contract. Dr. Fonn also made factual misstatements regarding the conflicts in his residency program and the residency director's response when deposed by the State Medical Board of Ohio in April 2007. RX.15.

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. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

The Petitioner has undergone extensive surgeries involving his lumbar and cervical spine. As a result of those surgeries, Mr. Golish experiences severe limitations that impact his activities of daily living. Mr. Golish continues to experience pain despite Dr. Fonn's multiple surgeries. Dr. Fonn's testimony regarding Mr. Golish's road ahead is, to say the least, troubling at best.

Mr. Golish has been treated by a physician who is neither board certified nor proven as an expert in his chosen field. To say the least, Dr. Fonn does not have stellar credentials. By his own admission, he has failed his orthopedic surgical boards at least three (3) times. By his testimony, it may have been more than three times. Additionally, Fonn was reprimanded by the State of Ohio for making factual misstatements regarding his residency program, and "making a false, fraudulent deceptive or misleading statement in the solicitation of patients..." RX.15. Golish apparently was never aware of Fonn's status or reputation in the medical community.

Though the Commission has encountered physicians that are not board certified, by the Commission's observations, surgeons operating without such certifications are becoming a very rare breed. Board certification is not the hallmark by which all physicians are to judged, but it is

an indicator of competence in today's world. When physicians lack such certifications, one questions the level of their competency.

For good cause, the Commission is deeply troubled by Dr. Fonn's credentials and past questionable conduct. Fonn's testimony and clinical findings, when taken in light of the voluminous record, is not to be believed. Neither his resume nor his testimony has evoked confidence on the part of the Commission. As a result, the Commission cannot rely upon the testimony of Dr. Fonn and finds that he is not a credible witness.

Despite its serious reservations regarding Dr. Fonn's qualifications and competency, the Commission is bound by the record. In that regard, the Commission affirms the Decision of the Arbitrator relative to accident. The Commission, however, finds that Petitioner failed to prove that the lumbar and cervical surgeries performed by Dr. Fonn were either causally related to the accident of February 1, 2010, or were reasonable and necessary.

Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2010)), 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 his employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164, 596 N.E.2d 823, 173 Ill. Dec. 199 (1992). Whether a medical expense is either reasonable or necessary is a question of fact to be resolved by the Commission, and its determination will not be overturned on review unless it is against the manifest weight of the evidence. *F&B Manufacturing Co. v. Industrial Comm'n*, 325 Ill. App. 3d 527, 534, 758 N.E.2d 18, 259 Ill. Dec. 173 (2001).

The Commission is faced with determining whether the treatment provided by Dr. Fonn was reasonable and necessary under Section 8(a) of the Act. The Commission is presented with conflicting medical opinions in this regard. Dr. Fonn was of the opinion that the L2-3, L3-4, L4-5, and L5-SI fusion and the C4-5, C5-6, and C6-C7 fusions were a consequence of the February 1, 2010 accident, and were reasonable and necessary. Dr. deGrange and Dr. Petkovich were of the opinion that the surgeries was not medically necessary and, to say the least, were neither reasonable nor necessary.

The Commission finds the opinions of Dr. deGrange and Dr. Petkovich far more compelling and far more persuasive than the opinion of Dr. Fonn. It is patently obvious that these physicians were aware of the gravamen of their opinions and the questionable practices of Dr. Fonn.

The Commission finds that the evidence does not support Dr. Fonn's opinion. Dr. Fonn compared the June 9, 2009 lumbar MRI to the March 11, 2010 lumbar MRI and noted that there appeared to be a progression of Petitioner's symptomatology, a further collapse of the disc height, and a larger foraminal disc herniation at L4-L5. Dr. Fonn then recommended that Petitioner undergo a discogram.

Fonn performed that test on April 27, 2010. The discogram was, as Dr. Fonn stated, "somewhat inconclusive." It was also questionable as to whether or not Golish had **any** concordant pain at the levels of L2-3, L3-4, L4-5, and L5-SI. Concordant pain is an indicator that there is a defect in the disc space. Concordant pain is often cited as a justification for surgery.

Despite his own equivocal finding, Dr. Fonn proceeded to recommend the three-level lumbar fusion, relying on the findings from the MRI, prior CT scan, and his examination findings to provide justification for the surgery. He patently ignored his own equivocal findings on the discogram.

However, when the same two MRIs were examined by Dr. deGrange and Dr. Frank Petkovich, both of whom are board certified orthopedic surgeons, they noted there was no significant change demonstrated on the March 2010 MRI when compared to the June 2009 MRI. Dr. deGrange noted there were no generally accepted lesions or pathology necessitating the three level fusion, and found that the MRI did not show anything serious such as a fracture, infection, tumor, progressive deformity, or significant lumbar instability.

Dr. Petkovich also found no appreciable difference between the two MRIs. Rather, he noted there was only a mild progression of the degenerative process, which was chronic and unrelated to the accident. Dr. Petkovich found no nerve root compression or herniation on either MRI and did not see anything that could be related to some traumatic change. In that regard, both Dr. Petkovich and Dr. deGrange stated that the three level lumbar fusion was not reasonable or necessary.

When asked to comment on the cervical spine, Dr. deGrange noted there was no spinal cord compression, no surgical lesion, and nothing of any concern to the spinal cord or spinal nerve roots. Dr. deGrange found that the surgery was not medically necessary as there was no serious or significant neural compression, no signs of progressive deformity, and no sign of any segmental cervical instability. Dr. Petkovich also reviewed the same MRI and found no evidence of a disc herniation, no nerve root compression, and no evidence of spinal cord compression. Again, both doctors found that the cervical fusions were not reasonable or necessary.

The Commission finds that the overwhelming majority of the evidence supports the opinions of Dr. Petkovich and Dr. deGrange. The Commission affords no weight to Dr. Fonn's opinions. Accordingly, the Commission finds that Golish failed to prove that the surgeries and resulting treatment provided by Dr. Fonn were causally related to the work accident and were reasonable and/or necessary. Accordingly, Respondent is not liable for either the lumbar or cervical fusion surgeries or the subsequent medical treatment rendered by Dr. Fonn thereafter.

To be entitled to TTD, a claimant must prove that he or she is unable to work. *Freeman United Coal Mining Co. v. Industrial Comm'n*, 318 Ill. App. 3d 170, 177, 741 N.E.2d 1144, 251 Ill. Dec. 966 (2000). A claimant may recover TTD up until the point that his or her condition stabilizes. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 759, 800 N.E.2d 819,

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279 Ill. Dec. 531 (2003). A condition has stabilized where the claimant has recovered to the extent that the nature of the injury will permit, that is, when the claimant reaches maximum medical improvement. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 471, 949 N.E.2d 1158, 351 Ill. Dec. 63 (2011); *Briggs Manufacturing Co. v. Industrial Comm'n*, 212 Ill. App. 3d 318, 320, 570 N.E.2d 1152, 156 Ill. Dec. 430 (1989).

The Commission finds that Golish is entitled to TTD for his cervical and lumbar spine through June 24, 2013, the date of Dr. deGrange's second Section 12 opinion which found Petitioner was at MMI, long before.

Relative to the right hand, the Commission affirms the Decision of the Arbitrator. In support, the Commission finds the opinion of Dr. Young persuasive. Dr. Young was of the opinion that the February 1, 2010 accident caused or contributed so as to cause Petitioner's right hand to become symptomatic. Dr. Young took Golish off work primarily because of the second injury. Further, during his deposition, Dr. Young testified that he had Petitioner off work.

Dr. Young testified that Golish could not continue working as a maintenance supervisor after the February 1, 2010 accident as a result of the injury to Golish's hand. The medical records thereafter do not indicate that Dr. Young ever released Golish to return to work. Accordingly, the Commission finds that Golish is entitled to TTD for his right hand injury through the date of hearing, March 4, 2015.

Furthermore, the Commission finds that Golish is entitled to MP joint arthroplasty as recommended by Dr. Young.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 14, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $497.98 per week for a period of 262-3/7 weeks, (February 2, 2010 through February 3, 2010, and February 17, 2010 through March 4, 2015) that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services, as provided in Section 8(a) and 8.2 of the Act, and shall reimburse Petitioner for his out-of-pocket expenses related to his right hand and all out-of-pocket expenses related to his cervical and lumbar spine up to the date of each surgery. Respondent shall have no responsibility for any medical care and treatment to either the cervical or lumbar spine after the respective dates of surgery, performed by Dr. Fonn. 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.

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 Petitioner's request for penalties is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for prospective medical treatment pursuant to Sections 8(a) and 8.2 of the Act including but not limited to, the surgery and associated treatment recommended by Dr. Steven Young for Petitioner's right hand. Petitioner's claim for prospective medical treatment as recommended by Dr. Fonn is denied.

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

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

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: JUN 7 - 2017

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 4-11-17
052

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

GOLISH, MARK
Employee/Petitioner

Case# **10WC023565**

10WC023602
10WC023603

HARRISBURG UNIT SCHOOL DISTRICT NO 3
Employer/Respondent

17IWCC0347

On 3/14/2016, 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 0.47% 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:

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

0439 ROUSE & CARY
STEPHEN CHRISTIANSEN
10733 SUNSET OFFICE DR
ST LOUIS, MO 63127

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)

Mark Golish
Employee/Petitioner

v.

Harrisburg Unit School District No. 3
Employer/Respondent

Case # 10 WC 23565

Consolidated cases: 10WC23602 & 10 23603

17IWCC0347

An *Application for Adjustment 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 **March 4, 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 _____

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FINDINGS

On the date of accident, **2/1/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,842.96**; the average weekly wage was **$746.98**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **2** dependent children.

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

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

Respondent is entitled to a credit for **any medical benefits paid, as well as any bills paid by the group insurance carrier up to 12/1/11** 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 shall reimburse Petitioner for his out of pocket expenses, from 2/1/10 through the date of hearing. 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 $497.98/week for 262 3/7 weeks, commencing 2/2/10 through 2/3/10 (2/7 weeks), and 2/17/10 through 3/4/15 (262 1/7 weeks), as provided in Section 8(b) of the Act.

Because Respondent reasonably relied on the opinions of Dr. DeGrange, Dr. Brown, and Dr. Petkovich to defend the claim for medical expenses and TTD benefits the claims for penalties and attorneys' fees are denied

Respondent shall authorize and pay for prospective medical treatment pursuant to Sections 8(a) and 8.2 of the Act including, but not limited to, the surgery and associated treatment recommend by Dr. Steven Young for Petitioner's right hand and the spinal cord stimulator and associated treatment as recommended by Dr. Fonn.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

10/24/15
Date

ICArbDec19(b)

MAR 14 2016

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BACKGROUND

Petitioner filed three applications for adjustment of claim for accidents which occurred while working for Respondent. In case number 10 WC 23603, Petitioner alleges an injury to his right hand that occurred on August 11, 2008, while opening a stuck door lock. In case number 10 WC 23602, he alleges an injury to his low back that occurred on December 1, 2008, while pulling a plow to hook onto a tractor. Finally, in case number 10 WC 23565, Petitioner alleges an injury to his neck, low back, and right hand that occurred on February 1, 2010, as a result of a slip and fall on ice while carrying a bag of ice melt. All claims were filed against the same employer and have been consolidated for trial. Respondent employer changed insurance carriers prior to the February 1, 2010, date of accident. Respondent's carriers for claims 10 WC 23603 and 10 WC 23602 shall be referred to as "Carrier A." Respondent's carrier in 10 WC 23565 Shall be referred to as "Carrier B."

Petitioner testified that he began working for Respondent in 1992. In 1995 Petitioner had complaints of low back pain and sought treatment very briefly with his primary care physician, Dr. Partridge. He had no long term symptoms and he missed no work due to his low back. In 1997 Petitioner returned to Dr. Partridge complaining of neck pain following a motor vehicle accident. By April of 1998 Petitioner was at MMI regarding the cervical spine. He lost no time from work as a result of the neck condition, other than to attend medical appointments. On 4/3/08 Petitioner telephoned Dr. Partridge and requested medication due to a pulled muscle in his back. He continued to work and sought no other treatment at that time.

At the time of each alleged injury, Petitioner was employed as the head maintenance supervisor with three Assistant Custodians. He testified that his job duties were consistent with the information provided in the work history Questionnaire that he completed for Dr. Steven Young. He described his job duties as general maintenance work, including plumbing, carpentry, electrical, some mechanical, some grounds care, book work, moving items and the use of a lot of hand tools. (PX 11)

FINDINGS OF FACT

Petitioner testified that he injured his right hand on August 11, 2008 when he tried to open a jammed door lock and forcible struck his hand on the door. He hit the top of the right hand. He experienced swelling, pain, and burning. He continued to work with the use of medications and by assigning out work.

Petitioner first sought treatment with Dr. Elliot Partridge on August 25, 2008. Petitioner complained of pain and swelling in his right hand. He reported an injury that occurred two weeks earlier when he tried to unlock a frozen lock. He reported feeling a pop in his hand. Dr. Partridge's diagnosis was post traumatic tendonitis of the right metacarpal. He was given a Medrol Dosepak and instructed to follow-up in one month. An x-ray was ordered which showed mild degenerative changes with no acute bony abnormality. (RX 10, p.48; PX 28).

Petitioner testified that he injured his low back on December 1, 2008, while pulling a plow across the floor to hook to a tractor. The plow hung on a piece of carpet. He felt a pull in his back and fell to the ground.

Petitioner presented to Dr. Partridge on December 23, 2008, complaining of low back pain radiating into his left leg, mostly to the knee, and into the crack of his buttocks. Dr. Partridge's diagnosis was acute low back strain. Dr. Partridge recommended physical therapy. Petitioner also complained of right hand pain. He reported some relief of the swelling with the Medrol Dosepak. Dr. Partridge ordered an MRI, physical therapy, and instructed Petitioner to follow-up in one month. (RX 10, p.41) The MRI was obtained at Ferrell Hospital on December 31, 2008. (PX 28)

Petitioner next saw Dr. Partridge on April 13, 2009[1]. He presented with both low back and right hand symptoms at that time. He complained of pain in his back and his left leg to the knee. Dr. Partridge continued to recommend physical therapy. He also complained of right hand pain with tenderness between the second and third digits. His diagnosis was a contusion of the right hand. (RX 10, p.37) Petitioner was referred to Dr. Steven Young. (RX 10, p. 32-33)

Petitioner presented to Harrisburg Medical Center on April 23, 2009, for a Physical Therapy Evaluation. Petitioner attended physical therapy 10 times from April 25, 2009, to June 26, 2009.

Petitioner returned to Dr. Partridge on June 3, 2009, with continued complaints of back pain into his left leg. Dr. Partridge recommended an MRI. (RX 10, p.32) Petitioner underwent an MRI of his lumbar spine at the CT and Open MRI Center on June 9, 2009. (PX 28) Following the MRI, Dr. Partridge referred Petitioner to Dr. Allan Gocio. (PX 7)

Petitioner's first presented to Dr. Gocio on June 25, 2009. His primary complaint was pain in his mid-back radiating down to his left hip and left knee to his foot. He reported some numbness and tingling in his left leg and hip. Dr. Gocio's impression was lumbar degenerative disc disease with radiculopathy. (PX 10) Dr. Gocio referred Petitioner to pain management.

Petitioner presented to Dr. Young at Southern Orthopedic Associates June 30, 2009 complaining of pain, numbness, tingling and stiffness in his right hand, fingers and knuckles. He reported difficulty making a fist. Dr. Young reviewed the MRI and noted significant osteoarthritis. His impression was osteoarthritis of the second and third metacarpal phalangeal joints. Petitioner was given an injection. (PX 11)

Petitioner saw Dr. Partridge on July 13, 2009. He reported that Dr. Goccio told him he had arthritis and a couple of bulging discs. He reported that Dr. Goccio recommended epidural injections. He stated "surgery is last resort". (RX 10, p.30)

Petitioner presented to Dr. Paul Juergens with Southern Illinois Pain Management on July 23, 2009 for evaluation. Petitioner's primary complaint was low back pain down into his left buttock and leg stopping around his knee. He complained of some tingling in his left foot and toes. He reported a worsening of pain during the last three months. He described the pain as intermittent that worsened with activity. (PX 14)

[1] It was noted that Petitioner was scheduled to appear in January but was unable to do so because of weather and an escalation of his un related ear problem. (PX 7) According to the Attendance records from Respondent, Petitioner missed work on January 5, 6, 21, 22, 23, and February 4, 2009 for problems with his Meniers disease. He was off work for said condition from February 23, 2009 through March 20, 2009, during which time he underwent surgery. (RX 3, p.21, 23-24)

Petitioner returned to Dr. Young on July 28, 2009 complaining of pain in the hand. He had improved flexion of the fingers with mild to moderate edema. Injections were given. (PX 11).

Petitioner attended Physical therapy at Primary Care Group Physical Therapy Center. He presented for evaluation on July 30, 2009. His primary complaint was back pain. He attended the initial evaluation and 3 sessions. (PX 13)

Petitioner presented to Dr. Juergens for lumbar epidural steroid injections on August 12, 2009, at the L2-3 level and on September 10, 2009, at the L5-S1 level. (PX 14)

Petitioner saw Dr. Gocio on October 12, 2009. He reported some relief from the injections. Dr. Gocio noted that Petitioner said he was doing "okay," and that he was not ready to consider surgery. It was recommended that Petitioner obtain a third epidural injection with a recheck in four weeks. Dr. Gocio noted that Petitioner may need a lumbar facet fusion. (PX 10)

Petitioner returned to Dr. Gocio on November 18, 2009. He reported that the pain was a little worse in the lumbar area and had moved to the right. Petitioner continued to complain of aching in his left leg. Dr. Gocio recommended a lumbar myelogram/CT and EMG testing. (PX 10)

Petitioner presented to Cedar Court Imaging on December 10, 2009, where he underwent a lumbar myelogram and post myelogram CT. (PX 28).

Petitioner saw Dr. Young again on December 22, 2009, with continued complaints of right hand pain. Examination revealed limited range of motion of the second and third fingers. Petitioner was given another injection. Dr. Young discussed the possibility of an MP joint arthroplasty. Dr. Young noted that Petitioner was "nowhere near wanting to have surgical intervention" but he felt that it needed to be discussed as a potential option. (PX 11) Petitioner testified that he did not want surgery at that time and was "scared to death".

Petitioner presented to the Rehabilitation Institute of Chicago on January 12, 2010 where he underwent electrodiagnostic studies. The impression was a normal study with no evidence of lumbo-sacral radiculopathy. Petitioner reported zero pain down his right side. (RX 5)

When Petitioner presented for follow-up with Dr. Gocio, he learned that Dr. Gocio's office had closed. He returned to Dr. Partridge for a referral to another neurosurgeon. A referral to Dr. Fonn was made by Dr. Partridge's office on January 29, 2010. (RX 10, p. 13)

Petitioner testified that he was carrying a 50 pound bag of ice melt on February 1, 2010, when he slipped and fell on the ice. He put his hand down and his hip hit the ground. He testified that he struck his head on the ramp He injured his right hand, low back, and neck if the fall. He experienced immediate pain and swelling in his right hand, an increase in low back pain with an onset of pain in his right buttocks and right leg, and neck pain traveling down his right shoulder and up his right arm. He testified that he suffered headaches after the fall. He testified that prior to the slip and fall he had experienced some symptoms in his right leg on occasion, but after the slip and fall, the pain was constant. When asked to describe how the hand pain was different from before the slip and fall, he testified that the swelling was like he had never seen before and that the pain was "massive." Petitioner presented to Dr. Partridge that same day complaining of right hand pain, neck pain, low

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back pain, and right hip pain. Petitioner reported that he slipped on the ice and fell, landing with most of his weight on his right hand and right hip. (RX 10, p.11) Petitioner presented to Ferrell Hospital where he underwent x-rays. X-rays of his right wrist and right hand were interpreted as showing mild osteoarthritis. An x-ray of his right hip was interpreted as being normal. Petitioner testified that his hand hurt so bad after the February 1, 2010 fall that he did not want to use it at all. Petitioner testified that he was unable to work after the February 1, 2010 accident.

Petitioner presented to Dr. Young on February 9, 2010. His examination revealed swelling at the second and third MP joints. Petitioner was reluctant to move his fingers. He was given an injection, placed in a splint, and taken off work. (PX 11) He returned with continued complaints of pain on February 15, 2010. An MRI was ordered. (PX 11) When Petitioner returned on February 22, 2010, he presented with moderate swelling, tenderness and decreased range of motion. A right 2nd and 3rd MP joint arthroplasty was recommended. (PX 11)

Petitioner presented to Dr. Sonjay Fonn, on February 17, 2010. Petitioner advised Dr. Fonn that he had been seeing Dr. Gocio, but he suddenly left town. He reported the February 1, 2010 accident. He presented with a primary complaint of back and left leg pain that was aggravated with new complaints of radiation down to the right leg. He also complained of neck pain and right arm pain with numbness in the first and second digits. Dr. Fonn reviewed the diagnostic studies and opined that Petitioner had pathology at the L2-3 and L3-4 levels. (PX 15)

Petitioner presented to the CT and Open MRI Center for MRIs of his right hand, and lumbar spine on March 11, 2010. (PX 28)

He returned to Dr. Young on March 23, 2010, to discuss treatment options. Dr. Young's continued recommendation was arthroplasty. (PX 11)

Petitioner returned to Dr. Fonn on March 26, 2010. He reviewed the MRIs of Petitioner's lumbar spine obtained on June 9, 2009, and March 11, 2010. It was his assessment that there appeared to be a progression of the symptomatology and further collapse of the disc height and foraminal stenosis at L2-3 and L3-4. He also noted a larger foraminal disc herniation, worse on the right than the left, which would explain Petitioner's new symptomatology in the right leg. He opined that the multilevel foraminal stenosis from L2 through S1 shown on the most recent study was not present on the June 9, 2009 MRI. Petitioner also complained of a significant amount of headaches during this visit and an MRI of the cervical spine was ordered. (PX 15)

Dr. Fonn gave Petitioner a series of three lumbar epidural steroid injections at the L4-5 level between March 30, 2010, and April 13, 2010. Petitioner returned on April 21, 2010 with continued complaints of pain in his back and legs. He reported some relief with the injections. He indicated a desire to proceed with surgical intervention. Dr. Fonn recommended that Petitioner undergo a discogram to identify and confirm pain generators. (PX 15) A discogram was performed on April 27, 2010. (PX 15) On June 3, 2010, Dr. Fonn recommended a three level fusion. (PX 15) Petitioner testified that he agreed to the surgery because of constant pain.

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An MRI of Petitioner's cervical spine was performed at the CT and Open MRI Center on June 28, 2010. (PX 28) On July 8, 2010, Dr. Fonn reviewed the findings from the cervical spine MRI. He noted findings of a whiplash injury with severe muscle spasm. He felt that there was a moderate size disc herniation abutting the spinal cord that would require surgery. (PX 15) Dr. Fonn elected to focus treatment on the low back first.

Petitioner presented to St. Francis Medical Center on July 9, 2010, where he underwent a three level lumbar fusion from L2-5. (PX 17) On August 11, 2010, Petitioner informed Dr. Fonn that his pre-operative symptoms had resolved. (PX 15) Petitioner was referred for physical therapy during his appointment on November 3, 2010. (PX 15)

Petitioner presented to Dr. Young on January 31, 2011 with continued complaints of right hand pain. He was given injections and instructed to report back as needed after addressing his issues with his neck and back. (PX 11)

Petitioner presented to the CT & Open MRI Center for an MRI of his lumbar spine and cervical spine on February 8, 2011. (PX 28)

Dr. Fonn reviewed the lumbar MRI on February 8, 2011, and opined that it showed degenerative spondylolisthesis at the L5-S1 level. Dr. Fonn recommended lumbar injections with a CT myelogram in approximately 2 months. (PX 15)) Dr. Fonn reviewed Petitioner's cervical MRI on February 10, 2011, and recommended injections at the C4-5 and C6-7 levels. (PX 15)

Petitioner underwent lumbar epidural steroid injections at the L5-S1 level bilaterally on February 10, March 10, and March 17, 2011. (PX 15)

Petitioner underwent a lumbar myelogram on April 7, 2011. (PX 15) Dr. Fonn opined that there was a grade 1 spondylolisthesis at the L5/1 level. He recommended surgery. (PX 15)

Petitioner presented to St. Francis Medical Center on June 24, 2011, where he underwent a single level fusion at the L5-S1 and exploration of the fusion at the L4-5. (PX 18) Petitioner developed a post-operative spinal headache and was admitted to St. Francis Medical Center on July 7, 2011 where he underwent surgery to repair a CSF leak at the L5-S1 level. (PX 19)

Petitioner presented to Dr. Fonn for cervical epidural injections at the C4-5 and C6-7 levels on September 29 and October 6, 2011. (PX 15) Petitioner presented to Dr. Fonn on October 13, 2011, and reported no relief from the injections. He indicated a desire to proceed with surgery. Petitioner was scheduled for an MRI of his cervical spine and a CT myelogram of the cervical spine. (PX 15) Petitioner presented to the CT and Open MRI Center for an MRI of his cervical spine on October 27, 2011, with no overall significant interval changes noted from the February 8, 2011, MRI. (PX 15) A myelogram was performed by Dr. Fonn on November 8, 2011. (PX 15).

Dr. Fonn's diagnosed Petitioner with C4-5, C5-6, and C6-7 central disc herniations with spinal cord compression on November 15, 2011. He recommended surgery. (PX 15)

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Petitioner presented to St. Francis Medical Center on December 28, 2011, where he underwent a three level cervical fusion at the C4-5, C5-6, and C6-7. (PX 20) At trial, Petitioner testified that his symptoms in his right upper extremity and neck pain resolved after surgery.

Petitioner presented to St. Francis Hospital on February 28, 2012 with a history of fever, chills and lower back pain. He underwent a bone biopsy. His diagnosis was systemic inflammatory response syndrome. He was referred to Dr. Matthew Shoemaker for further treatment. (PX 22E) On March 26, 2012, he was diagnosed with discitis/osteomylitis by Dr. Shoemaker. (PX 22H). He has also received treatment for this condition from Dr. Jiange (PX 25) and Dr. Chaudhari (PX 23).

Petitioner presented to Dr. Young on November 5, 2012 with continued complaints of right hand pain. He was given injections and instructed to report back as needed after addressing his issues with his neck and back. (PX 11)

Petitioner presented to Saint Francis Medical Center on December 14, 2012 where he underwent removal of the posterior instrumentation at the L5-S1 level and exploration of the fusions at the L4-5 and L5-S1. The preoperative and post-operative diagnosis was failed back syndrome with osteomyelitis and discitis at the L5-S1 level. (PX 21) Petitioner testified that he continues to receive treatment for this condition.

Dr. Young testified his diagnosis was metacarpophalangeal arthrosis of the second and third joints. (PX 12, p. 10) He testified that he discussed the possibility of a MP joint replacement arthroplasty with Petitioner during his appointment on December 22, 2009. (*Id.*, at 13) He did not, however recommend surgery at that time. (*Id.*, at 45) He examined Petitioner on three occasions between August 11, 2008 and December 22, 2009. (*Id.*, at 14) He did not take Petitioner off work or recommend any work restrictions during this time frame. (*Id.*, at 46) He took Petitioner off work on February 9, 2010, following the February 1, 2010, fall and recommended that Petitioner undergo an MP joint arthroplasty of the second and third metacarpophalangeal joints. (*Id.*, at 16-20)

Dr. Young testified that it was his opinion that the accidents of August 11, 2008, and February 1, 2010, aggravated, exacerbated or accelerated Petitioner's arthritic condition to the extent that it became permanently symptomatic. (PX 12, p. 24-27) He testified that the first accident caused him to be symptomatic and the second made the symptoms worse. (*Id.*, at 29) He testified that Petitioner was taken off work primarily because of the second injury. (*Id.*, at 29) He testified that the treatment received to date was causally related to both accidents. (*Id.*, at 33)

A §12 exam was performed by Dr. David Brown on March 29, 2011. Dr. Brown diagnosed Petitioner with advanced degenerative arthritis at the MP joints (or knuckles) of his index finger and middle fingers. (RX 12 p. 11) Dr. Brown opined that the condition was not related to the alleged injuries of August of 2008 or February of 2010. He testified that the diagnostic studies taken around the time of each accident did not evidence any acute injuries to the joints that would cause, accelerate, or aggravate arthritis. *Id.*, at 11- 12) He testified that there was a natural progression of the degenerative disease from August of 2008 to March of 2011. (*Id.*, at 13) He reviewed the MRI of December 31, 2008, and found that the bone marrow edema at 4 ½ months post-accident was consistent with arthritis and not an acute process. (*Id.*, at 23) He examined Petitioner's left

hand for comparison. He found arthritic changes in both hands consistent with a diagnosis of osteoarthritis. (*Id.*, at 16-17)

Dr. Brown testified that the surgery recommended by Dr. Young would be appropriate, but that the need for the surgery was not causally related to either the accident of 8/11/08 or that of 2/1/10. (RX 12, p. 17) He testified that Petitioner could work without restrictions. (*Id.*, at 18-19) He testified that at most Petitioner sustained a contusion as a result of the August 11, 2008, accident that may have caused temporary symptoms. (*Id.*, at 22, 27) At the time of his examination of Petitioner, he opined that Petitioner's current symptoms were caused by arthritis and not the alleged accidents. (*Id.*, at 28)

Petitioner has continued to treat and receive injections from Dr. Young regarding right hand complaints. Dr. Young continues to recommend MP joint arthroplasties. (PX 32)

An evidence deposition was obtained with Dr. Fonn on September 11, 2013. Dr. Fonn testified that he reviewed the June 9, 2009 MRI of Petitioner's lumbar spine during his initial examination of Petitioner and opined that it showed traumatic changes to the L2-3 and L3-4 with broad-based disc herniations, and moderate to severe foraminal stenosis. (PX 16, p. 7) He ordered a second MRI and compared the two MRIs. He opined that the L2-3 levels became symptomatic after the December 1, 2008, injury and that the L4-5 became symptomatic after the February 1, 2010 injury. (*Id.*, at 8-9) He testified that the 3 level lumbar fusion performed on July 9, 2010, was medically necessary to address petitioner's complaints of back pain, leg pain, and leg paresthesia and weakness, and a progressive neurological deficit. (*Id.*, at 12-13) He performed a single level fusion at the L5-S1 level to address the same complaints. (P. 13) He repaired a CSF leak that occurred after the single level fusion. (*Id.*, at 14-15)

Dr. Fonn testified that Petitioner developed an infection in his low back after the surgery at the L5-S1 level which led to further treatment and relapses in pain. (PX 16, p. 17-18) He performed surgery on December 14, 2012, to remove the instrumentation and explore the fusion at the L4-5 and 5-S1. (*Id.*, at 16-17) He testified that Petitioner will probably need lifelong treatment to address said condition. (*Id.*, at 19) At the time of the deposition, his current diagnosis was lumbar and cervical radiculopathy, cervical and lumbar stenosis, and discitis/osteomyelitis. (*Id.*, at 21) He testified that in his opinion both accidents contributed to Petitioner's symptoms, his diagnosis and subsequent treatment. (*Id.*) He testified that both accidents aggravated Petitioner's pre-existing condition of degenerative lumbar disc disease resulting in treatment. (*Id.*, at 26)

Dr. Fonn testified that he performed the 3 level fusion in the cervical spine to address a finding of spinal cord compression of the exiting nerves at the C4-5, 5-6, and 6-7. (*Id.*, at 16) He testified that the cervical spine condition and subsequent surgery were related to the February 1, 2010, injury. (*Id.*, at 33-34) Dr. Fonn testified that he took Petitioner off work during his initial evaluation and that he had never released Petitioner to return to work. (*Id.*, at 29)

Dr. Donald deGrange performed §12 examinations on April 6, 2011, and June 24, 2013 at the request of Carrier B in reference to the lumbar and cervical spine. The Arbitrator notes that both examinations occurred after Petitioner's July 9, 2010 surgery. During his initial examination, Dr. deGrange diagnosed Petitioner with a lumbar strain as a result of the slip and fall that occurred on February 1, 2010. He opined that the three level lumbar surgery received by Petitioner on July 9, 2010 was not causally related to the February 1, 2010, accident.

(RX 11, p. 14) He found that Petitioner was at maximum medical improvement regarding the February 1, 2010 accident, and was in need of no further treatment. (*Id.*, at 15) He testified that there was no compelling orthopedic surgical evidence that the fusion at the L2-3, 3-4, and 4-5 was reasonable. He testified that there were "no generally accepted lesions or pathology necessitating a three-level fusion". (*Id.*) He testified that the pathology observed did not fall within the generally acceptable criteria for a fusion. (*Id.*) He testified that he reviewed the MRI of Petitioner's lumbar spine obtained on June 9, 2009, before the February 1, 2010, slip and fall, and observed no acute findings or specific nerve root compression. His only finding was "very mild degeneration". (*Id.*, at 28) Dr. deGrange testified that none of the surgeries performed since his initial evaluation on April 6, 2011 were causally related to the February 1, 2010, accident. (*Id.*, at 22-23) He testified that the he found no pathology that would warrant a four level fusion in Petitioner's lumbar spine. (*Id.*, at 23)

Dr. deGrange testified that he reviewed the MRI of Petitioner's cervical spine obtained on June 28, 2010 and found that the MRI was essentially normal. (RX 11, pp. 16-18) He diagnosed Petitioner with a cervical strain or whiplash type of injury as a result of the February 1, 2010 accident. He testified that the surgery to Petitioner's neck was not causally related to the February 1, 2010, slip and fall. (*Id.*, at 20) He opined that Petitioner had reached maximum medical improvement and was in no need of further treatment. (*Id.*) He testified that the surgery to Petitioner's spine was not reasonable because he had no serious or significant neural compression, no sign of any progressive deformity, and no sign of segmental cervical instability that would require a fusion. (*Id.*, at 21)

Dr. Frank Petkovich conducted a §12 examination on July 9, 2013 at the request of Carrier A in reference to the December 1, 2008, accident. Dr. Petkovich reviewed the MRI of Petitioner's lumbar spine from June 9, 2009, and found that it showed degenerative disc changes at the L2-3 and L3-4 with central disc protrusions without any specific disc herniations, nerve root compression, or acute findings. (RX1, p. 14) He reviewed diagnostic films and medical records through the end of January of 2010, and found nothing to indicate the necessity of a three level lumbar fusion. (*Id.*, at 21) Dr. Petkovich reviewed the MRI of Petitioner's lumbar spine obtained on March 11, 2010 and found no appreciable differences from the MRI obtained on June 9, 2009, other than mild progression of the degenerative process, which he opined was chronic and unrelated to either accident. (*Id.*, at 24)

Dr. Petkovich opined that Petitioner sustained a lumbar strain as a result of the December 1, 2008 accident that may have caused a temporary exacerbation of his preexisting condition of degenerative lumbar disc disease. He opined that the accident did not result in any permanent aggravation or acceleration of Petitioner's condition. (RX1, p. 39) He testified that the treatment received by Petitioner from December of 2008 through January of 2010 was reasonable and necessary, although he probably would not have ordered a lumbar myelogram and post myelogram CT. (*Id.*, at 40) He testified that Petitioner reached maximum medical improvement before the February 1, 2010 slip and fall. (*Id.*, at 41-42) He testified that during his examination of Petitioner, Petitioner advised that Dr. Gocio had mentioned the possibility of surgery but that he really did not want to have surgery. (*Id.*, at 21) He testified that any treatment and/or surgical procedures performed on Petitioner's lumbar spine after February 1, 2010 were not causally related to the December 1, 2008 accident. (*Id.*, at 43, 46) He testified that any work restrictions would not be causally related to the December 1, 2008 accident. (*Id.*, at 46) Dr. Petkovich testified that although he was asked to examine Petitioner in reference to the

December 1, 2008 injury, he did not believe that any of the surgeries to Petitioner's lumbar spine were reasonable or necessary for any reason, regardless of etiology. (*Id.*, at 50)

Dr. Petkovich testified that he reviewed the MRI of Petitioner's cervical spine obtained on June 28, 2010, and found that it showed some mild degenerative changes at the C3-4, 4-5, 5-6 and, 6-7 with no evidence of nerve root or spinal cord compression. He opined that the study was typical of a man of Petitioner's age. (RX 1, p. 35) He did not believe that the surgery to Petitioner's cervical spine was "reasonable and necessary for any reason, regardless of etiology". (*Id.*, at 50)

At trial, Petitioner testified that he is continuing to treat with Dr. Fonn for spine complaints. He underwent another series of lumbar epidural steroid injections, trigger point injections and there is a current recommendation of insertion of a spinal cord stimulator. (PX 31) He has also continued to treat with Dr. Jiang for his complaints of osteomyelitis. (PX 33) Dr. Young continues to recommend MP joint arthroplasty.

CONCLUSIONS OF LAW

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

Petitioner's testimony and the medical evidence established, without rebuttal, that on 8/11/08 Petitioner was attempting to unlock a jammed lock to a freezer when the top of his right hand, specifically, the base of the middle and index fingers, struck the door. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained an accidental injury to his right hand which arose out of and in the course of his employment with respondent on 8/11/08.

The parties stipulated and agreed that Petitioner sustained an accident which arose out of and in the course of his employment with respondent on 12/1/08 while pulling a plow across the floor to hook to a tractor. Therefore the Arbitrator finds Petitioner has met his burden of establishing that he sustained an accidental injury to his low back which arose out of and in the course of his employment with respondent on 12/1/08.

The unrefuted testimony of Petitioner, as well as the medical records, establish that Petitioner injured his right hand, neck, and low back on 2/1/10 when he slipped and fell on a slick sidewalk while carrying a 50 pound bag of ice melt. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained accidental injuries to his right hand, neck, and low back which arose out of and in the course of his employment with respondent on 2/1/10.

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

RIGHT HAND

Petitioner had no complaints or symptoms in his right hand or fingers prior to his accident of 8/11/08. Shortly following this accident Petitioner sought treatment with his primary care physician due to pain and swelling in his right hand. The doctor diagnosed post traumatic tendonitis of the right metacarpal. An x-ray was ordered which showed mild degenerative changes with no acute bony abnormality. When Petitioner's symptoms persisted he was referred to hand specialist Dr. Steven Young in April of 2009. Dr. Young treated

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Petitioner conservatively, including injections, without resolution of his symptoms. When he saw Petitioner on 12/22/09 they discussed the possibility of an MP joint arthroplasty. The doctor stated it needed to be discussed as a potential option. He did not recommend the surgery at that time and Petitioner credibly testified he did not want to have the surgery at that time.

Shortly thereafter, on 2/1/10, Petitioner was carrying ice melt out of a storage building, slipped on ice and fell, landing with most of his weight on his right hand. When asked to describe how the hand was different from before the slip and fall, Petitioner testified that the swelling was like he had never seen before and the pain was "massive." Petitioner testified that his hand hurt so bad after the February 1, 2010 fall that he did not want to use it at all.

Dr. Young testified that he discussed the possibility of a MP joint replacement arthroplasty with Petitioner during his appointment on December 22, 2009.) He did not, however recommend surgery at that time. He examined Petitioner on three occasions between August 11, 2008 and December 22, 2009. He did not take Petitioner off work or recommend any work restrictions during this time frame. He took Petitioner off work on February 9, 2010, following the February 1, 2010, fall and recommended that Petitioner undergo an MP joint arthroplasty of the second and third metacarpophalangeal joints. It was his opinion that the accidents of August 11, 2008, and February 1, 2010, aggravated, exacerbated or accelerated Petitioner's arthritic condition to the extent that it became permanently symptomatic. He testified that the first accident caused him to be symptomatic and the second made the symptoms worse.

Dr. David Brown, Respondent's §12 examiner diagnosed Petitioner with advanced degenerative arthritis at the MP joints (or knuckles) of his index finger and middle fingers. Dr. Brown opined that the condition was not related to the alleged injuries of August of 2008 or February of 2010. He testified that the diagnostic studies taken around the time of each accident did not evidence any acute injuries to the joints that would cause, accelerate, or aggravate arthritis. He felt that there was a natural progression of the degenerative disease from August of 2008 to March of 2011. Dr. Brown agreed that the surgery recommended by Dr. Young would be appropriate, but that the need for the surgery was not causally related to either the accident of 8/11/08 or that of 2/1/10. He opined that Petitioner's current symptoms were caused by arthritis and not the alleged accidents.

The Arbitrator finds the testimony and opinions of Dr. Young more persuasive. The Arbitrator notes the Petitioner was asymptomatic prior to the 8/11/08 accident. Thereafter he had unremitting symptoms which were dramatically worsened by the 2/1/10 accident. The Arbitrator further notes that although surgery was generally discussed following the 8/11/08 accident Petitioner did was not interested in surgery and Dr. Young had not actually recommended it. Following the 2/1/10 accident Petitioner's condition had progressed to the point that Dr. Young was recommending surgery and Petitioner wished to have it done.

Petitioner has continued to receive treatment, including injections from Dr. Young regarding right hand complaints. Dr. Young continues to recommend MP joint arthroplasties. Petitioner testified that he wishes to have the surgery now due to the increase in his symptoms following the 2/1/10 fall.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that the condition of ill-being of his right hand up to 2/1/11, which did not require

surgery, is causally related to the accident of 5/11/08 and that his current condition of ill-being, which does require surgery is causally related to the accident of 2/1/10.

LUMBAR SPINE

Petitioner had no significant complaints or symptoms in low back prior to his accident of 12/1/08. Petitioner saw Dr. Partridge on December 23, 2008, complaining of low back pain radiating into his left leg, mostly to the knee, and into the crack of his buttocks. Dr. Partridge's diagnosis was acute low back strain. Dr. Partridge recommended physical therapy. Petitioner attended physical therapy at Harrisburg Medical. When Petitioner's symptoms failed to resolve Dr. Partridge recommended an MRI which was done at the CT and Open MRI Center on June 9, 2009. Following the MRI, Dr. Partridge referred Petitioner to Dr. Allan Gocio.

Petitioner saw Dr. Gocio on June 25, 2009. Dr. Gocio's impression was lumbar degenerative disc disease with radiculopathy. He referred Petitioner to pain management. Petitioner presented to Dr. Paul Juergens with Southern Illinois Pain Management on July 23, 2009 for evaluation. Petitioner attended additional Physical therapy at Primary Care Group Physical Therapy Center beginning July 30, 2009. Petitioner returned to Dr. Juergens for lumbar epidural steroid injections on August 12, 2009, at the L2-3 level and on September 10, 2009, at the L5-S1 level. Petitioner returned to Dr. Gocio on October 12, 2009 reporting some relief from the injections. Dr. Gocio noted that Petitioner said was doing "okay," and that he was not ready to consider surgery. It was recommended that Petitioner obtain a third epidural injection with a recheck in four weeks. Petitioner returned to Dr. Gocio on November 18, 2009. He reported that the pain was a little worse in the lumbar area and had moved to the right. Petitioner continued to complain of aching in his left leg. Dr. Gocio recommended a lumbar myelogram/CT and EMG testing. Petitioner presented to Cedar Court Imaging on December 10, 2009, where he underwent a lumbar myelogram and post myelogram CT. Petitioner's electrodiagnostic studies were interpreted as normal. When Petitioner learned that Dr. Gocio's office had closed he was referred to another neurosurgeon. A referral to Dr. Fonn was made by Dr. Partridge's office on January 29, 2010.

On 2/1/10 Petitioner was carrying ice melt out of a storage building, slipped on ice and fell further injuring his low back, among other body parts. He experienced an immediate increase in low back pain with an onset of pain in his right buttocks and right leg. Prior to the slip and fall he had experienced some symptoms in his right leg on occasion, but after the slip and fall, the pain was constant.

Petitioner saw Sonjay Fonn, on February 17, 2010 He presented with a primary complaint of back and left leg pain that was aggravated with new complaints of radiation down to the right leg. Dr. Fonn reviewed the diagnostic studies and opined that Petitioner had pathology at the L2-3 and L3-4 levels. A new MRI was obtained on March 11, 2010. Dr. Fonn compared the MRIs of Petitioner's lumbar spine obtained on June 9, 2009, and March 11, 2010. He noted a further collapse of the disc height and foraminal stenosis at L2-3 and L3-4 consistent with progression of the symptomatology. He also noted a larger foraminal disc herniation, worse on the right than the left, which would explain Petitioner's new symptomatology in the right leg. He opined that the multilevel foraminal stenosis from L2 through S1 shown on the most recent study was not present on the June 9, 2009 MRI. Dr. Fonn gave Petitioner a series of three lumbar epidural steroid injections at the L4-5 level between March 30, 2010, and April 13, 2010. Petitioner reported some relief with the injections. Dr. Fonn

recommended that Petitioner undergo a discogram to identify and confirm pain generators. Following the discogram Dr. Fonn recommended a three level fusion. Petitioner testified that he agreed to the surgery because of constant pain. Petitioner underwent a three level lumbar fusion from L2-5 on July 9, 2010. When Petitioner returned to Dr. Fonn for follow up he indicated his pre-operative symptoms had resolved. Petitioner was referred for physical therapy in November 2010. When his symptoms returned Dr. Fonn sent him for a repeat MRI on February 8, 2011. Dr. Fonn reviewed the MRI and opined that it showed degenerative spondylolisthesis at the L5-S1 level. Dr. Fonn recommended lumbar injections with a CT myelogram in approximately 2 months. Petitioner underwent lumbar epidural steroid injections at the L5-S1 level bilaterally on February 10, March 10, and March 17, 2011. Petitioner underwent a lumbar myelogram on April 7, 2011. Dr. Fonn opined that there was a grade 1 spondylolisthesis at the L5/1 level. He recommended surgery. On June 24, 2011 he underwent a single level fusion at the L5-S1 and exploration of the fusion at the L4-5. Petitioner developed a post-operative spinal headache which required an additional surgery to repair a CSF leak at the L5-S1 level.

Petitioner developed an infection at the site of the L5-S1 fusion. He was referred to Dr. Matthew Shoemaker for further treatment and he was diagnosed with discitis/osteomyelitis. In December 2012 Petitioner had an additional surgery in which he underwent removal of the posterior instrumentation at the L5-S1 level and exploration of the fusions at the L4-5 and L5-S1. The preoperative and post-operative diagnosis was failed back syndrome with osteomyelitis and discitis at the L5-S1 level. Petitioner continues to receive treatment for this condition.

Dr. Fonn testified that he reviewed the June 9, 2009 MRI of Petitioner's lumbar spine during his initial examination of Petitioner and opined that it showed traumatic changes to the L2-3 and L3-4 with broad-based disc herniations, and moderate to severe foraminal stenosis. He ordered a second MRI and compared the two. He indicated that the L2-3 level became symptomatic after the December 1, 2008, injury and that the L4-5 level became symptomatic after the February 1, 2010 injury. He testified that the 3 level lumbar fusion performed on July 9, 2010, was medically necessary to address petitioner's complaints of back pain, leg pain, and leg paresthesia and weakness, and a progressive neurological deficit. He performed a single level fusion at the L5-S1 level to address the same complaints. He repaired a CSF leak that occurred after the single level fusion. Dr. Fonn testified that Petitioner developed an infection in his low back after the surgery at the L5-S1 which led to further treatment and relapses in pain. He performed surgery on December 14, 2012, to remove the instrumentation and explore the fusion at the L4-5 and 5-S1. He testified that Petitioner will probably need lifelong treatment to address this condition. At the time of the deposition, his diagnosis was lumbar and cervical radiculopathy, cervical and lumbar stenosis, and discitis/osteomyelitis. He testified that in his opinion both accidents contributed to Petitioner's symptoms, his diagnosis and subsequent treatment. He testified that both accidents aggravated Petitioner's pre-existing condition of degenerative lumbar disc disease resulting in the development of symptoms which ultimately required treatment. Dr. Fonn testified that he took Petitioner off work during his initial evaluation and that he had never released Petitioner to return to work.

Dr. deGrange performed two §12 examinations after Petitioner's July 9, 2010 surgery. Dr. deGrange opined that the three level lumbar surgery received by Petitioner on July 9, 2010 was not causally related to the February 1, 2010, accident. He felt that Petitioner was at maximum medical improvement as of April 6, 2011,

and was in need of no further treatment. Dr. deGrange further testified that none of the surgeries performed since his initial evaluation on April 6, 2011 were causally related to the February 1, 2010, accident.

Dr. Petkovich opined that Petitioner sustained a lumbar strain as a result of the December 1, 2008 accident that may have caused a temporary exacerbation of his preexisting condition of degenerative lumbar disc disease. He opined that the accident did not result in any permanent aggravation or acceleration of Petitioner's condition. He testified that the treatment received by Petitioner from December of 2008 through January of 2010 was reasonable and necessary, although he probably would not have ordered a lumbar myelogram and post myelogram CT. He testified that Petitioner reached maximum medical improvement before the February 1, 2010 slip and fall. He testified that during his examination of Petitioner, Petitioner advised that prior to the February 1, 2010 accident he really did not want to have surgery. He testified that any treatment and/or surgical procedures performed on Petitioner's lumbar spine after February 1, 2010 were not causally related to the December 1, 2008 accident. Dr. Petkovich testified that although he was asked to examine Petitioner in reference to the December 1, 2008 injury, he did not believe that any of the surgeries to Petitioner's lumbar spine were reasonable or necessary. (*Id.*, at 50)

The Arbitrator finds the testimony and opinions of Dr. Fonn more persuasive than those of Dr. deGrange and Dr. Petkovich. The Arbitrator finds it significant that Petitioner had no ongoing low back symptoms prior to the 12/1/08 accident. There after he remained symptomatic until the accident of 2/1/10 at which point the symptoms dramatically increased. There was an increase in back pain following the second accident as well as bilateral radicular symptoms instead of symptoms only down the left leg. Petitioner initially showed marked improvement following surgery. Unfortunately, post-operative complications arose which resulted in deterioration of Petitioner's condition and additional treatment. Further, there had been no surgical recommendation prior to the 2/1/10 accident and Petitioner credibly testified he did not feel he needed surgery at that time. Following the slip and fall Dr. Fonn recommended surgery and Petitioner wished to proceed.

At trial, Petitioner testified that he is continuing to treat with Dr. Fonn for spine complaints. He underwent another series of lumbar epidural steroid injections, trigger point injections and there is a current recommendation of insertion of a spinal cord stimulator. (PX 31) He has also continued to treat with Dr. Jiang for his complaints of osteomyelitis. (PX 33)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that the condition of ill-being of his low back up to 2/1/10, which did not require surgery, is causally related to the accident of 12/1/08 and that his current condition of ill-being, which did require surgery is causally related to the accident of 2/1/10.

CERVICAL SPINE

Prior to the accident of 2/1/10 Petitioner had not experienced neck symptoms or gotten any treatment for his neck since 1998. Following the accident Petitioner began experiencing neck pain as well as headaches. On February 17, 2010 Petitioner advised Dr. Fonn he was experiencing neck pain and right arm pain with numbness in the first and second digits. An MRI of 6/28/10 was notable for findings of a whiplash injury with severe muscle spasm. Dr. Fonn also felt that there was a moderate size disc herniation abutting the spinal cord that would require surgery. Dr. Fonn elected to focus treatment on the low back first. Following a second MRI of

2/10/11 Dr. Fonn recommended injections at the C4-5 and C6-7 levels. (PX 15) When the injections provided no relief he was scheduled for a cervical myelogram. Dr. Fonn diagnosed Petitioner with C4-5, C5-6, and C6-7 central disc herniations with spinal cord compression and recommended surgery. Petitioner presented to St. Francis Medical Center on December 28, 2011, where he underwent a three level cervical fusion at the C4-5, C5-6, and C6-7. At trial, Petitioner testified that his symptoms in his right upper extremity and neck pain resolved after surgery.

Dr. Fonn testified that he performed the 3 level fusion in the cervical spine to address a finding of spinal cord compression of the exiting nerves at the C4-5, 5-6, and 6-7. He testified that the cervical spine condition and subsequent surgery were causally related to the February 1, 2010, injury.

Dr. deGrange diagnosed Petitioner with a cervical strain or whiplash type of injury as a result of the February 1, 2010 accident. He testified that the surgery to Petitioner's neck was not causally related to the February 1, 2010, slip and fall. He opined that Petitioner had reached maximum medical improvement and was in no need of further treatment. He testified that the surgery to Petitioner's spine was not reasonable because he had no serious or significant neural compression, no sign of any progressive deformity, and no sign of segmental cervical instability that would require a fusion.

Dr. Petkovich testified that he did not believe that the surgery to Petitioner's cervical spine was "reasonable and necessary for any reason, regardless of etiology."

The Arbitrator finds the testimony and opinions of Dr. Fonn more persuasive than those of Dr. deGrange and Dr. Petkovich. The Arbitrator finds it significant that Petitioner had no ongoing cervical symptoms prior to the 2/1/10 accident. He developed symptoms there after which appear consistent with the diagnosis of Dr. Fonn. The Arbitrator also finds it significant that Petitioner's symptoms resolved following surgery.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that the condition of ill-being of his cervical spine is causally related to the accident of 2/1/10.

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?

For the reasons set forth above the Arbitrator finds Petitioner proved the testing and treatment to the right hand from 8/11/08 through 1/31/10 was reasonable, necessary and causally related to the 8/11/08 work accident. The Arbitrator further finds Petitioner proved the testing and treatment to the right hand from 2/1/10 up to the date of hearing was reasonable, necessary and causally related to the 2/1/10 work accident. In addition, Both Dr. Young and Dr. Brown opined the arthroplasty is reasonable and necessary. Therefore Arbitrator finds Petitioner is entitled to prospective medical care for his right hand as a result of the 2/1/10 accident.

For the reasons set forth above the Arbitrator finds Petitioner proved the testing and treatment to the lumbar spine between 12/1/08 and 1/31/10 is reasonable, necessary and causally related to the 12/1/08 accident and that the testing and treatment to the lumbar spine from 2/1/10 up to the date of hearing is reasonable,

necessary and causally related to the 2/1/10. The Arbitrator further finds Petitioner proved by a preponderance of the evidence that he is entitled to prospective medical care for his lumbar spine as a result of the 2/1/10 accident

For the reasons set forth above the Arbitrator finds Petitioner proved the testing and treatment to the cervical spine is reasonable, necessary and causally related to the 2/1/10 accident. There is currently no recommendation for ongoing treatment for the cervical spine.

The Arbitrator further finds Petitioner is entitled to reimbursement of out of pocket medical expenses as set forth in Petitioner's Exhibits 43-49.

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

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to temporary total disability benefits of $497.98 per week for a period of 262 3/7 weeks from 2/2/10 through 2/3/10 (2/7 weeks) and 2/17/10 through 3/4/15 (262 1/7 weeks) as a result of the 2/1/10 accident.

Issue (M) Should penalties or fees be imposed upon Respondent?

Because Respondent reasonably relied on the opinions of Dr. DeGrange, Dr. Brown, and Dr. Petkovich to defend the claim for medical expenses and TTD benefits the claims for penalties and attorneys' fees are denied.

Issue (N): Is Respondent due any credit?

Respondent is granted a credit for the medical bills previously paid as well as any bills paid by the group carrier up to the date Petitioner began paying the premiums for his health insurance on 12/1/11.

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julio C. Gaytan,

Petitioner,

vs. NO: 11 WC 09980

TJ Fabricators, Inc.,

Respondent.

ORDER

A "Motion to Reinstate" having been filed by Petitioner herein, due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on March 15, 2017 in Geneva, Illinois. The Commission, having jurisdiction over the persons herein, and after being advised in the premises, dismisses the motion, for the reasons set forth below.

The record shows that this claim was originally dismissed for want of prosecution on April 12, 2013 by Arbitrator Doherty.

On July 2, 2013, or 81 days later, Petitioner filed a Motion to Reinstate alleging "[t]hat when this case was last before the arbitrator the Petitioner and his attorney was [sic] not given notice of the hearing date by their clerking service. Had notice been given counsel for the Petitioner would have appeared. Petitioner is in contact with his attorney. This case has not been previously dismissed. This Petition has been filed within 60 days of receipt of the dismissal." The Commission notes that there is no indication in the record as to when counsel for Petitioner received said dismissal notice.

In an order dated October 10, 2013, Arbitrator Doherty granted Petitioner's motion to reinstate. A record was not made at that time.

In an unfiled Notice of Motion and Order form showing a call date of October 18, 2016, counsel for Respondent requested a trial date certain or dismissal of the above claim.

The Commission's Mainframe computer tracking system shows that the case was subsequently dismissed by Arb. Granada on October 26, 2016. The Commission notes that the case would have been well above the red-line as of the date of this dismissal.

On November 9, 2016, Petitioner filed a Petition to Reinstate before Arb. Granada and showing a call date of January 19, 2017 in Wheaton, Illinois. There is no indication that the parties ever appeared before the arbitrator on this motion, let alone that the Petition was ever ruled upon.

On January 27, 2017, Petitioner filed with the Commission on Review the present Motion to Reinstate.

A hearing on review was held before Commissioner Tyrrell on March 15, 2017. On that date, counsel for Petitioner represented that his predecessor had appeared before the arbitrator on October 26, 2016 at which time he was under the impression the case was going to be returned to the call. (T.4). Counsel for Petitioner represented that his office then received notice on November 4, 2016 that the case had been "inadvertently" dismissed. (T.4).

Counsel for Respondent objected to reinstatement based on its argument that the claim "... was properly dismissed for the second time, in October of 2016, the second DWP ..." and that "... it should not have been reinstated in the first place" on October 10, 2013, given that the initial Petition to Reinstate was not timely filed and in light of the fact that Respondent had not been given proper notice. (T.8-10).

The Commission agrees that the initial Petition to Reinstate appears to have been filed more than 60 days after Petitioner's receipt of the dismissal order of April 12, 2013, in contravention of Section 7020.90 of the Rules Governing Practice Before the Commission. However, the fact remains that the case was reinstated on October 10, 2013, and that the operative dismissal currently in dispute is the one that was entered on October 26, 2016.

Along these lines, the record shows that Petitioner filed a Petition to Reinstate before the arbitrator well within the 60 days mandated by the statute, having allegedly received a copy of the order of dismissal on November 4, 2016. However, there is no indication that the Petition was ever ruled upon, or whether it was even presented to the arbitrator for consideration thereafter. Instead, for whatever reason, Petitioner chose to file the instant Motion to Reinstate before the Commission on Review, said motion having been filed 84 days after the alleged receipt of the dismissal order in question.

Based on the above, and given the pendency of the Petition to Reinstate filed on November 9, 2016, the Commission finds that the proper venue for consideration of

reinstatement would be at arbitration and not with the Commission on Review, at least until such time as the arbitrator rules on said Petition.

Therefore, the Commission dismisses the Motion to Reinstate filed by Petitioner before the Commission on Review on January 27, 2017 and hereby orders the parties to present the Petition previously filed by Petitioner on November 9, 2016 to the assigned arbitrator for further consideration, pursuant to Section 7020.90 of the Rules Governing Practice Before the Commission.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Motion to Reinstate is hereby dismissed.

IT IS FURTHER ORDERED BY THE COMMISSION that the parties present the previously filed Petition to Reinstate to the arbitrator for further consideration.

The Commission further notes that since this order is not final and appealable the need for the filing of a Notice of Intent to File for Review in Circuit Court would not be applicable.

DATED: JUN 7 - 2017

Thomas J. Tyrrell

r-3/15/17
TJT/pmo
51

STATE OF ILLINOIS)
) SS:
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Roehm,

Petitioner,

vs.

NO: 11 WC 40014
13 WC 06064
15 WC 07287

Costco Wholesale,

Respondent.

ORDER

A "Motion to Enforce Contract and Penalties" having been filed by Petitioner herein, due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on January 11, 2017 in Geneva, Illinois and January 25, 2017 in Chicago, Illinois. The Commission, having jurisdiction over the persons and subject matter, at least with respect to the issue of penalties, and after being advised in the premises, grants in part and denies Petitioner's motion in part, for the reasons set forth below.

The record shows that settlement contracts were approved in this matter by Arb. Hegarty on September 29, 2015. The total amount of settlement was $99,000.00, plus an advance of $5,000.00, for a total settlement amount of $104,000.00, representing 36% person-as-a-whole pursuant to §8(d)2 of the Act. On the front of this contract, the parties represented that the employer "has not" paid all medical bills, although no unpaid bills were listed in the space provided. This section also contains the statement "SEE TERMS OF SETTLEMENT."

In the "Terms of Settlement" attached to the contract, and as part of the agreement, it was noted that "Respondent paid reasonable, necessary and causally related medical expenses incurred by Petitioner before April 22, 2015 and submitted to Respondent for payment before July 21, 2015." In addition, the terms provide that "[r]eview under Sections 19(h) and all rights under 8(a) are specifically waived" and that "[i]n the event Petitioner seeks future medical care for the work-related injury, Petitioner

understands that in consideration for the settlement he is hereby waiving all rights pursuant to Section 8(a) for future medical expenses, and he shall have sole responsibility for any future Medicare-covered medical expenses."

The Commission notes, as an aside, that the terms of the contract also state that "[t]his settlement shall be null and void unless accepted and approved by the Illinois Workers' Compensation Commission on or before **August 31, 2015.**" (Emphasis in original). As already mentioned, the contracts were approved by the Arbitrator on September 29, 2015, or almost a full month after the aforementioned deadline. However, by their actions since the approval of these contracts, including payments made with respect thereto, the Commission finds that the parties have shown their willingness to proceed under the terms of said agreement and to forego any possible action to have it declared null and void.

Petitioner filed the present "Motion to Enforce Contract and Penalties" on December 7, 2016, or fourteen (14) months after approval of the settlement contracts and well after the time for filing a review pursuant to §19(b).

In support of his claim for enforcement of the contract and penalties/attorneys' fees, Petitioner alleged in his motion that "[t]he contracts specifically state Respondent will pay any and all reasonable medical bills connected to this accident..." and that "Petitioner has unpaid medical bills from Prescription Partners and Windy City Anesthesia that are related to the work accident of 8/11/11..."

The Commission notes that approval of a settlement agreement constitutes a decision of the Commission and is, in legal effect, the equivalent of an award within the meaning of §19(g). *Ahlers v. Sears Roebuck, Co.*, 73 Ill.2d 259, 265, 383 N.E.2d 207, 210 (1978). Absent fraud or a clerical error, review of an approved lump sum settlement is specifically prohibited under §19(f) of the Act. See *Gillmore v. Ideal Industries, Inc.*, 74 Ill.App.3d 143, 392 N.E.2d 933 (4th Dist. 1979).

Faced with an employer's failure or refusal to pay a final award from which no further appeal is taken, §19(g) of the Act provides a statutory remedy for a claimant to reduce the award to an enforceable judgment in the circuit court. *Aurora East School District v. Dover*, 363 Ill.App.3d 1048, 846 N.E.2d 623, 301 Ill.Dec. 298 (2nd Dist. 2006); citing *Blacke v. Industrial Commission*, 268 Ill.App.3d 26, 28, 644 N.E.2d 23, 205 Ill.Dec. 807 (1994).

As a result, the Commission lacks the statutory authority to enforce the settlement contract in question; instead, the proper remedy for such a request lies with the circuit court pursuant to §19(g) of the Act. Therefore, the Commission denies that portion of Petitioner's motion requesting enforcement of the settlement contract.

However, the Commission notes that it does retain jurisdiction subsequent to settlement contract approval with respect to the imposition of penalties and/or attorneys' fees, and that in effectuating this imperative the Commission is allowed to interpret the

settlement contract. See *Loyola University of Chicago v. Illinois Workers' Compensation Commission*, 31 N.E.3d 905; 391 Ill. Dec. 930 (1st Dist. 2015).

The Commission's lack of authority to enforce a settlement contract, and its retention of jurisdiction to affix penalties and/or attorneys' fees, was recently reiterated in the case of *Millennium Knickerbocker Hotel v. Illinois Workers' Compensation Commission (Rudy Guzman, Jr.)*, 2017 IL App (1st) 161027WC (filed April 14, 2017).

In the present case, the terms of the contract do not specifically state that Respondent will pay any and all reasonable medical bills connected to the accident, as Petitioner now claims, although the front of the contracts do show that Respondent has not paid all medical bills and the terms indicate that Respondent had paid bills incurred before April 22, 2015 and submitted for payment before July 21, 2015. However, the bills offered as part of the current motion all predate April 22, 2015. (PX3,PX4). In addition, counsel for Petitioner submitted into evidence at the hearing on review an email sent to defense counsel dated March 13, 2014, or prior to settlement, setting forth his settlement demand, including "... the satisfaction of the outstanding medical bills from Windy City, University Pathologists, Prescription Partners, Advocate Good Samaritan Hospital and Accelerated Rehab." (PX2).

Respondent has offered no reason as to why the bills in question were singled out and not paid by its adjustors at Sedgewick; instead, defense counsel simply argues that it is Petitioner's burden to prove that the bills in question are causally related and to determine the fee schedule amounts that would be due and owing. The Commission notes that these requirements were not specified in the terms of the contract. In fact, the terms simply set forth that "Respondent paid reasonable, necessary and causally related medical expenses incurred by Petitioner before April 22, 2015 and submitted to Respondent for payment before July 21, 2015", the reasonable inference being that it would also pay, if it had not already done so, bills incurred and submitted prior thereto.

Furthermore, since the parties elected to bind themselves by contract, and not avail themselves to a trial on the issues raised by Respondent on review, the Commission finds that the terms of the contract control, and Respondent's demand for strict proof of causation and the proper fee schedule amount prior to payment is no longer applicable.

As a result, the Commission finds that Respondent was liable for the payment of the reasonable and necessary medical expenses associated with the services provided by Windy City Anesthesia, PC (PX3) and Prescription Partners, LLC (PX4), pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act, and that its failure to do so in a timely matter was unreasonable under the circumstances.

Therefore, the Commission finds that Petitioner is entitled to additional compensation pursuant to §19(l) in the amount of $5,730.00 ($30 per day for 191 days). The record shows that counsel for Petitioner sent an email to defense counsel demanding payment of the bills in question on July 19, 2016, and that as of the date of the second hearing on review on January 25, 2017 these bills remain unpaid. (PX2). The

Commission notes §19(l) of the Act provides that a delay in payment of 14 days or more creates a rebuttable presumption of unreasonable delay, which the Respondent in this case was unable to overcome.

However, the Commission finds that Respondent's failure to pay the remaining medical bills in question was not vexatious so as to warrant the imposition of penalties pursuant to §19(k) and/or attorneys' fees pursuant to §16 of the Act. Respondent raised reasonable questions as to the amounts due, issues that would have otherwise been relevant had the matter proceeded to trial or if the language of the contracts had actually permitted such a qualification. As a result, the Commission is unwilling to find that Respondent's conduct was such as to justify the imposition of penalties and/or attorneys' fees under §19(k) and §16, respectively, and Petitioner's request for same is hereby denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition to Enforce the Settlement Agreement is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to additional compensation in the amount of $5,730.00 pursuant to §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties and/or Attorneys' Fees pursuant to §19(k) and §16, respectively, is hereby denied.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,800.00. 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: JUN 7 - 2017

Thomas J. Tyrrell

r-1/11/17
TJT/pmo
51

STATE OF ILLINOIS)
)SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Arnold Barragan,
Petitioner,

vs.

NO. 11 WC 45220

Vista Motors, DBA Fletcher Jones,
Respondent.

ORDER

This matter comes before the Commission on a Petition to Set Fee filed by Attorney Marsha A. Chepov of the law firm of Chepov & Scott LLC. After due consideration, the Commission finds the following:

1. Petitioner, through Attorney Marsha A. Chepov (Ms. Chepov), filed an Application for Adjustment of Claim on November 30, 2011, alleging a date of accident of June 8, 2010 and that he had sustained severe and permanent back injuries in the course and scope of his employment. The Application and Attorney Representation Agreement were signed by Petitioner on November 3, 2011. The claim was given case number 11 WC 45220 and was assigned to Arbitrator Thompson-Smith.

2. On January 22, 2013, Ms. Chepov filed a Notice of Motion and Petition to Set Fee to be before Arbitrator Thompson-Smith. In her Petition to Set Fee, Ms. Chepov indicated her law firm had expended considerable time and effort in representing Petitioner in his case. Ms. Chepov indicated that by letter dated January 11, 2013, her law firm was advised that Petitioner had retained new counsel and the parties had been unable to reach a fee splitting agreement.

3. Ms. Chepov indicated that her law firm is entitled to have the Commission set its entitlement to a fee in this matter out of the proceeds of any settlement or award. Ms. Chepov requested her law firm be given notice of any settlement or award in Petitioner's case and be afforded the opportunity to have a hearing on its petition to fix fees and that no distribution of money be made in this matter until after said hearing on her law firm's petition to fix fees.

4. On January 29, 2013, a Stipulation to Substitute Attorneys was filed. Petitioner wanted Attorney Harriette Lakernick (Ms. Lakernick) to appear on his behalf in this case. Ms. Chepov withdrew her representation of Petitioner and Ms. Lakernick entered her appearance as the attorney for Petitioner.

5. Ms. Chepov appeared before Arbitrator Thompson-Smith on May 2, 2013, who by Order that date continued the Petition to Set Fee to disposition.

6. The parties entered into a lump sum settlement contract. The amount of the settlement was for $350,000.00 plus a Medicare Set-Aside of $364,899.00 and future medical funds for non-Medicare covered treatment. Attorney's fees were $57,079.57 (cap of 20% of the TTD rate of $784.06 x 364 weeks). The lump sum settlement contract was approved by Arbitrator Thompson-Smith on July 29, 2015.

7. On August 7, 2015, Ms. Lakernick filed a Notice of Motion and Petition to Set Attorney's Fees to be before Commissioner Basurto on September 30, 2015. In her Petition to Set Attorney's Fees, Ms. Lakernick indicated that when before Arbitrator Thompson-Smith on July 29, 2015 regarding the lump sum settlement contract, both she and Respondent's attorney advised her that Petition for Fees had been filed by Ms. Chepov on January 22, 2013. Ms. Lakernick indicated that Arbitrator Thompson-Smith directed the attorneys to have the Petition for Fees that had been filed by Ms. Chepov heard by the Commission. Ms. Lakernick indicated that as per that direction, this Notice of Motion and Petition to Set Attorney's Fees was filed. Ms. Lakernick requested the Commission set a hearing date for the Petition for Fees that had been filed by Ms. Chepov.

8. On September 30, 2015, the matter was continued to November 30, 2015. On that date, the matter was continued to January 28, 2016.

9. On December 21, 2015, Ms. Chepov filed a Notice of Motion and Petition to Set Fee to be before Commissioner Basurto on January 28, 2016. In her Petition to Set Fee, Ms. Chepov reiterated her previously filed Petition to Set Fee, noted above. Ms. Chepov also indicated that in support of her Petition, the law firm attached an itemization of hours spent on Petitioner's case as well as her affidavit. Ms. Chepov noted that neither she nor her law firm had been apprised of the amount of the settlement. Ms. Chepov requested the Commission order settling fees equivalent to the quantum meruit and that no distribution of money be made in this matter until after said hearing on her law firm's petition to fix fees.

10. The itemization of hours, Exhibit 1 attached to the Petition to Set Fee, indicates that Ms. Chepov began her representation of Petitioner on November 3, 2011 and ended on January 11, 2013. The itemization evidences the work done by Ms. Chepov, her paralegal Morgan Ariel and another attorney in the law firm, Mr. George Chepov. Staff is indicated by the initials of these individuals, the work done is noted as well as the amount of time dedicated to each matter. The Commission has reviewed Exhibit 1 in detail and notes the extraordinary efforts of Ms. Chepov and the staff of her law firm in assisting Petitioner in securing authorization for his ongoing medical care with various providers as well as securing TTD benefits. The many contacts between Petitioner, the adjuster and Ms. Chepov and her staff were meticulously noted in Exhibit 1.

11. Ms. Chepov also attached Exhibit 2 to the Petition to Set Fee, her Affidavit. In her Affidavit, Ms. Chepov noted how her representation of Petitioner began and as a family friend, Petitioner and his wife had open access to her personal cell phone and home phone number. Ms. Chepov indicated that she had attempted to request call log records from her cell phone and home phone providers. No such records can be produced for her home phone and the request to the cell phone provider would take at least 60 days as the records are in archives. Ms. Chepov indicated that the Petition to Set Fee did not include all time dedicated to Petitioner's claim, but only that which was recorded. Ms. Chepov explained that her law office maintains a database system called Time Matters in which staff maintains records of all work done on each file. At times, not everything is properly documented, especially when calls are handled on her personal cell phone and after hours. Ms. Chepov attested that countless additional hours were spent discussing matters with Petitioner and his wife that are not documented in the Petition to Set Fee.

12. A hearing on the Petition to Set Fee was held before Commissioner Basurto on January 28, 2016. At this hearing, Ms. Chepov presented her Petition to Set Fee filed on December 21, 2015, which was admitted into evidence as CommEx1. Ms. Chepov explained her claim as noted in her Petition to Set Fee and indicated there was a total of 154.5 hours logged on the itemization of hours, Exhibit 1. In addition, there was $140.00 in costs that she had forgotten to add in her Petition to Set Fee. Ms. Chepov indicated that on the day of this hearing, Ms. Lakernick provided her with a copy of the lump sum settlement contract, which she had previously requested. Ms. Chepov indicated that Ms. Lakernick had previously offered her $1,500.00 attorney fee and that if she did not agree with the offer to file an itemized fee petition, which she did. Ms. Chepov rejected the offer. Ms. Chepov stated she was seeking a quantum meruit because there was no communication or negotiation with Ms. Lakernick. Ms. Chepov also offered an Affidavit of Amanda Biesiada and this was admitted into evidence as Px3. In her Affidavit, Ms. Biesiada indicated that she was the medical assistant for Dr. Mark Lorenz and that Petitioner was a patient at Hinsdale Orthopedics. Ms. Biesiada noted that during the time of Petitioner's treatment, she spent a considerable amount of time speaking with Ms. Chepov and her staff regarding numerous issues with the Barragans. Ms. Biesiada also noted that Ms. Chepov and her staff returned all her emails and calls and worked diligently to try and mediate between her office and the Barragans in an effort to effectively treat Petitioner.

13. Ms. Chepov stated that there was value added to Petitioner's case other than time. Ms. Chepov indicated that she obtained authorization for a second surgery, perpetual pain management and psychiatric care. She also worked on getting a spinal stimulator approved, but that Petitioner got kicked out of three different pain management clinics due to non-compliance and problems with the doctors' offices. Ms. Chepov requested an Order setting fees equivalent to quantum meruit, but later during the hearing requested 50% of the attorney fee noted in the lump sum settlement contract of $57,079.57.

14. Ms. Lakernick explained that in her only telephone conversation she had with Ms. Chepov, she withheld the settlement amount because she did not feel it was germane to the quantum meruit petition. Ms. Chepov did not present a request for her costs and she

could not pay them if not presented. Ms. Lakernick indicated the itemization presented by Ms. Chepov contained legal entries and paralegal entries. Ms. Lakernick argued that under §16, paralegal fees are not really covered as attorney's fees. In her review of the itemization, Ms. Lakernick noted there was no court work done, no motions filed and the telephone calls and medical summaries are overblown and exaggerated. Ms. Lakernick indicated that 13 hours of the itemization are related to research and work-up of a third party case, filed by Ms. Chepov's law firm. Ms. Lakernick stated that she took depositions of three treating doctors and had to obtain a narrative pharmacologist. The Medicare Set-Aside was probably 70% of the problem is settling Petitioner's case. At no time was a spinal cord stimulator ever approved and that was one of the reasons why pain medications had to continue. Ms. Lakernick stated she had been to court 3 or 4 times with various petitions. Hours of work were spent on the Medicare Set-Aside.

15. Ms. Chepov indicated there was no §19(b) filed on Petitioner's case by Ms. Lakernick. Ms. Chepov agreed that she did not file a §19(b) as she was able to work with the adjuster and doctors' offices. Ms. Chepov stated that part of being an attorney is being able to handle the client and making sure he gets the treatment he needs. Ms. Chepov felt she was very successful in that.

16. On March 7, 2016, a motion to set a briefing schedule was granted. On April 29, 2016, Ms. Lakernick filed Petitioner's Brief on Determination of Attorney's Fees. In her brief, Ms. Lakernick made the same arguments she did at the January 28, 2016 hearing before Commissioner Basurto. On May 23, 2016, Ms. Chepov filed Brief of Petitioner's Former Counsel's Brief to Determine Apportionment of Attorneys' Fees. In her brief, Ms. Chepov made the same arguments she did at the January 28, 2016 hearing before Commissioner Basurto. On June 2, 2016, Ms. Lakernick filed a Reply Brief on Petition for Fees.

The Commission notes that Ms. Chepov and Ms. Lakernick both are seeking an allocation of attorneys' fees. The evidence shows that Ms. Chepov and her staff performed substantial work on behalf of Petitioner. The attorneys' fees in this case were $57,079.57 (cap of 20% of the TTD rate of $784.06 x 364 weeks) as evidenced by the lump sum settlement contract approved by Arbitrator Thompson-Smith on July 29, 2015. Ms. Chepov sought quantum meruit, but presented no evidence of an hourly fee.

Based on the above, the Commission grants Ms. Chepov's Petition to Set Fee to the extent of 40% of $57,079.57, an amount of $22,831.83, plus costs of $140.00. The total amount due to Ms. Chepov's law firm from Ms. Lakernick is $22,971.83 ($22,831.83 + $140.00). The Commission assumes that
Ms. Lakernick received the attorneys' fees of $57,079.57 as noted in the lump sum settlement contract.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Petition to Set Fee filed by Attorney Marsha A. Chepov of the law firm of Chepov & Scott LLC is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Attorney Harriette Lakernick pay to the law firm of Chepov & Scott LLC $22,831.83, which is 40% of the attorneys' fees, and $140.00 for costs, the total sum of $22,971.83.

DATED: JUN 7 - 2017
DLS/dw
R-01/28/16
46

Deborah L. Simpson

Joshua D. Luskin

Charles J. DeVriendt

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

Tellis Williams,

Petitioner,

vs. NO: 11 WC 20580

State of Illinois, Department of Corrections/ Stateville,

Respondent,

17IWCC0337

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, permanent partial disability, notice, jurisdiction 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 22, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

DATED: JUN 1 - 2017
o051817
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

WILLIAMS, TELLIS
Employee/Petitioner

Case# **11WC020580**

ST OF IL DEPT OF CORRECTIONS STATEVILLE
Employer/Respondent

17IWCC0337

On 9/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.50% 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:

0924 BLOCK KLUKAS & MANZELLA PC
MICHAEL D BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
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1350 CENTRAL MANAGEMENT SYSTEMS
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PO BOX 19208
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
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SPRINGFIELD, IL 62794-9255

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

SEP 22 2016

GERALD A. NAGOLA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0337

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

TELLIS WILLIAMS
Employee/Petitioner

v.

STATE OF ILLINOIS DEPT. OF CORRECTIONS STATEVILLE
Employer/Respondent

Case # **11** WC **20580**

Consolidated cases: _____

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

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **08/07/2010**, 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 **$56,333.68**; the average weekly wage was **$1,083.34**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$70,192.39** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$70,192.39**.

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

ORDER

Credits
Respondent shall be given a credit of **$70,192.39** for TTD, **$0** for TPD, and **$0** for maintenance benefits, for a total credit of **$70,192.39**.
Medical benefits
Respondent shall pay reasonable and necessary medical services of $301,220.21, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit of ALL 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.
Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $722.23/week for 141 weeks, commencing 10/17/2013 through 07/7/2016, as provided in Section 8(b) of the Act. Respondent shall receive credit as set forth above for all payments previously made hereunder.
In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.
RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Robert E. Abrams

Signature of Arbitrator

August 17, 2016
Date

SEP 22 2016

ICArbDec19(b)

17IWCC0337

BEFORE THE WORKERS' COMPENSATION COMMISSION

TELLIS WILLIAMS, Petitioner, v. STATE OF IL DOC STATEVILLE, Respondent.	)	No.: 11 WC 20580

RIDER TO ARBITRATOR'S DECISION

Findings of Fact, Common to all issues in the case:

This case was previously tried before Arbitrator Andros on October 16, 2013, and a decision was rendered December 17, 2013 (Pet's 26). Under the law of the case doctrine the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. *Irizarry v. Industrial Commission*, 337 Ill. App. 3rd 598, 606, 786 N.E. 2nd 218 (2003). The Arbitrator takes judicial notice of the decision, and that it was not reviewed and became the final decision of the Commission. Findings therein significant to the current hearing are Petitioner was a 35 year old correctional officer with no prior injuries or treatment to his left knee, who on August 7, 2010, was involved in an inmate assault at Stateville. Petitioner underwent two significant left knee surgeries prior to the hearing, the first being February 11, 2011, by Dr. William Farrell, and the second February 24, 2012 by Dr. Sherwin Ho, a Sports Medicine Orthopedist at the University of Chicago. Findings at that time included osteonecrosis, significant condyle damage and avascular necrosis. Thereafter, on October 4, 2013, when Petitioner was 20 months post an extensive debridement with a full thickness lesion of the medial femoral condyle and micro-fracture, a third surgery was recommended which was contested by the State on the basis of a Section 12 Examination by Dr. Nikhil Verma. In awarding a third surgery, the Arbitrator found Dr. Verma's opinions were not only unpersuasive, but lacked credibility and were litigation driven. Respondent now contests this 19(b) proceeding based on its IME Dr. Cohen's findings that the knee was at MMI in his May 15, 2015 report, and it

not accepting Dr. Ho's opinions that his hip condition was due to overuse without medical to the contrary. The case being above the red line, it proceeded to Trial in compliance with 50 Ill Adm. Code ch11, § 9020.60(b)(2)(c). The case was set off the call without objection.

In his opinion, Arbitrator Andros awarded the third surgery, which Petitioner had June 17, 2014 by Dr. Ho, being 16 months since the previous surgery and 8 months since the trial which necessitated the additional delay. November 21, 2014, Petitioner returned to Dr. Ho, five months status post third left knee arthroscopy consisting of patellar chondroplasty, plica excision, and lateral retinacular release, "who is progressing very slowly." He received an injection into the knee (Pet's. Ex. 16, p. 72). At that time Dr. Ho prescribed additional physical therapy (Id @ 76) which in total was from July 7, 2014 thru January 28, 2015. Petitioner received physical therapy at Liberty Physical Therapy (Pet's. Ex. 10). Petitioner testified that at approximately the time he was ending his physical therapy he began to have right (opposite) hip pain. He had never had hip pain before, and testified how his right extremity functioned well in physical therapy. For well over three years, he required the use of a cane most of the time, with crutches occasionally following surgeries, where the greater weight is on his right extremity. At that time, completing physical therapy, Petitioner noticed the hip started to not be able to bear weight as before, it was sore, with swelling, and it was hard to sit.

Petitioner's testimony is corroborated by the medical records. On July 8, 2014, Petitioner saw Dr. Masood, his primary care doctor, which would have been shortly after his June 17, 2014 surgery when he was using crutches. He complained of pain in the right ankle, which he stated was "because he had to favor his left lower extremity so he was using right ankle more than usual." (Pet's. Ex. 3, p. 57). Similarly, on November 11, 2014, he reported to Dr. Masood, in addition to left knee pain, which was still hurting him, where he was using a brace and a cane, that "his back is hurting because he is compensating for his left knee." (Id @ 59) January 19, 2015, Petitioner saw Dr. Masood for paperwork for a placard card and work forms, and for a compound or cream for pain, relating he still awakes with pain in his left knee, got a cortisone shot in the left knee by

the surgeon, and: "he still uses cane and complains of pain in left knee especially (sic) in walking and standing." (Id @ 60)

Two months later, on March 19, 2015, he saw Dr. Masood for a one month follow up, referrals and medicine refills, and on exam Dr. Masood noted, "flexion of the right hip is uncomfortable and painful and patient feels pain on anterior surface of his right hip. Dr. Masood noticed pain in the joint involving the pelvic region and thigh, and hip pain (Id @ 61). Petitioner testified, and the medical records reflect, that prior to this period his hip was in good health. May 14, 2015, Petitioner saw Dr. Masood noting that his right hip is hurting now as he has compensated for his left knee, had been prescribed an MRI by his orthopedist, which he could not get, grading right hip pain at 8 out of 10. Additionally, he noted grinding and discomfort in the left knee, using a brace which helps him (Id. @ 67).

As indicated in the last office note, Petitioner had returned to Dr. Ho, April 27, 2015 (Pet's. Ex. 18a p. 35). He was ten months post surgery of the left knee, and also complaining of right hip pain and a left thumb cyst. Dr. Ho noted that the left knee continued to bother him, better than the previous visit, although still noticing popping and clicking and pain both interior, medial and lateral in the left knee, which was certainly getting better. The doctor noted that he was actually there for a different problem, being the right hip with pain in the right buttocks, groin and hip region for the last six weeks with no specific injury. He had pain at rest which was worse with ambulation, and with certain movements a shooting pain that goes down his hip to the knee, for which he had no treatment. Additionally, Dr. Ho in the record noted that with regards to the left thumb, he had been using the cane continuously in his left hand and developed a cyst to the point where the cane keeps rubbing against the thumb, (Pet's. Ex. 18a p. 35) which also evidenced overuse. Dr. Ho noted that considering that Petitioner had avascular necrosis in the knee before, given that history he wanted an MRI of the right hip. Regarding the left thumb, Dr. Ho noted that he had gotten some irritation because he was overusing his cane in the left thumb and asked him to pad the cane, with Petitioner to return once the MRI of the right hip was done (Id. @ 36): (Pet's Ex. 16 @ 141-142).

Petitioner was thereafter examined on May 15, 2015, by Dr. James Cohen at his office in downtown Chicago. This was the day after he had seen Dr. Masood. Petitioner testified he had to travel 4 or 5 blocks each way, and was on crutches. Later the same day he presented at the Emergency Room. There they noted a 40 year old with past medical history significant for chronic left knee pain, many years with orthopedic procedures, presenting with right hip pain, which has been progressive over the course of months, "which he feels is secondary to putting more weight on the right leg." The pain is significantly worse over the past two weeks and he now has been unable to ambulate for 2 to 3 days using crutches, with no trauma to the leg, and pain worse with movement. He had X-rays March 25, 2015, which were unremarkable, but an MRI ordered as an out-patient was cancelled due to insurance reasons (Pet's. Ex. 16 p. 180).

He was treated at the ER for pain control and physical therapy was recommended. After he finally obtained the MRI, Petitioner returned to Dr. Ho on June 19, 2015 (Pet's. Ex. 8a, pp.37-38, Pet's. Ex. 16 pp. 220-221). Dr. Ho noted that he came in for his follow up on his right hip and left knee, with pain still in the left knee, but less severe than when compared with the right hip, using a crutch to help with ambulation, and anti-inflammatories not having helped, and not having done any recent physical therapy. Dr. Ho noted pain with leg roll and significant pain with internal rotation and full hip flexion. He noted the outside MRI of the right hip demonstrated significant increased signal changes over the femoral head with possible femoral head collapse and an area of avascular bone, for which he diagnosed right hip pain due to avascular necrosis and one year status post left knee arthroscopy. Dr. Ho explained to the patient that there was quite a bit of bony edema as well as a possible area of dead bone which could explain the symptoms. He put him on crutches with toe touch weight bearing and gave him a referral to see Dr. Luu or Dr. Adelani (Id. @ 37, 220).

July 2, 2015, Petitioner saw Dr. Muyibat Adelani, an Assistant Professor of Orthopedic Surgery, who prescribed a core depression of the right hip in the hope of avoiding a total hip, "given that he is young with a fairly active lifestyle, he wishes to make an attempt at joint salvage with core decompression." (Id. @ 257). July 29, 2015, Dr. Adelani performed the core decompression (Id. @ 260 – 261).

December 9, 2015, Petitioner returned to the other doctor to whom he was referred, Dr. Hue Luu, who noted that he was a very pleasant 40 year old gentlemen four months status post right hip core decompression by Dr. Adelani, with continued pain with ambulation which was not much better than before. Repeat radiographs revealed a collapse of the superior lateral aspect of the right femoral head, which had not progressed from the previous X-rays when it was initially diagnosed a month earlier. At that point, Dr. Luu felt the right hip decompression failed and prescribed right total hip arthroplasty (Pet's. Ex. 17, pp. 40 – 41). December 2, 2012, Petitioner underwent a right total hip arthroplasty for avascular necrosis and collapsed right hip (Pet's. Ex. 15, pp. 258 – 260). He underwent physical therapy through April 21, 2016, where at the last physical therapy his hip strength and function was getting better but hip flexibility was lacking to the extent he had difficulty putting on shoes. The therapist noted right hip flexion strength at 4/5 and right hip abduction strength at 4-/5 (Pet's. Ex. 15 p. 521).

In his report of December 5, 2015, Dr. Ho noted: "whether the avascular necrosis of the right hip was present or developed during this time of overuse, the hip pain and now subsequent collapse, (fracturing) of the femoral head was certainly caused by these periods of overuse of the right hip and leg (Pet's. Ex. 17 p. 52; Pet's. Ex. 18)

Dr. Sherwin Ho was deposed on May 4, 2016 (Pet's. Ex. 24). He is the Director of the Sports Medicine Residency Fellowship Program at the University of Chicago, who specializes in knees, shoulders, hips, elbows and ankles (Id. @ 5). While qualified to do hip replacement surgeries, he will do them if he is on call and a fracture comes in that requires it, but for most of the elective hip surgeries he refers them to his partners who specialize in hip and knee replacements (Id. @ 6). He noted that 18 months lapsed from the time he recommended surgery until he was able to do it, with the trial intervening (Id. @8). In relation to potential problems with the delays, the left knee continued to hurt, he would be favoring the right side, putting most of his weight and doing most of weight bearing activities utilizing the right side, so he overloaded the right side, which was evidenced in multiple right sided complaints which could be seen in a number of different ways. Even his use of the cane was becoming overdone and he was starting to get calluses or blisters (Id @ 8-9). He noted that the thumb, back pain,

ankle pain which he had at some point, are all just overuse symptoms from favoring the one side (Id @ 9-10).

He was also shown notes from Dr. Masood of Internal Medicine and Family Physicians, and he said they reflected the same biomechanics of overuse which are fairly simple. Just the fact he is avoiding prolonged use or weight bearing on the left knee is overloading the right side (Id. @ 10-11). Dr. Ho noted that six months was a long and difficult course for left knee physical therapy (Id. @ 13). Even at the end of physical therapy he only had 120 degrees flexion, with normal being 135 and 150. 120 would be called functional range of motion, where you can do most of your activities of daily living but it's not normal. He would expect Mr. Williams to be in the 135 to 140 degree range. He was able to ambulate a treadmill with limited heel strength due to the limitations and the last degrees of knee flexion, and he was able to do some jogging at 3.5 miles per hour (Id. @ 14 -15). There were additional goals to be reached in physical therapy, but since it was never approved it was likely the goals were probably not fully achieved (Id @ 16). When Petitioner first saw him for hip complaints April 27, 2015, the knee was slowly getting better so there was still improvement but it was not typical with this being a third surgery. The exam of that day recreated popping and clicking with pain on physical examination, and another competent orthopedist should be able to reproduce the same findings done at approximately the same time (the Exam of Dr. James Cohen was less than 3 weeks later) (Id @ 16 – 17).

He testified that the significance of the findings was he still had some symptomatic pathology in the knee that would be the condromalacia or what you might call early arthritis. It is significant in that it has continued to bother Petitioner for this length of time, and it is hard to know whether it's just a condromalacia or some of the underlying avascular necrosis from the previous injury. He thought they both contributed to his knee pain (Id @ 17-18). The physical therapy findings that he was able to jog at basically a walking speed at 25% meant he could do it, but he was still using the cane because the knee hurt. He was told to use the cane if the knee hurts, and the cyst in the thumb evidences that (Id @ 19-20).

Dr Ho further testified that Petitioner presented to the Emergency Room May 15, 2015, having seen Dr. Masood the day before with hip pain 8/10 and Dr. Cohen the

same day (Pet. Ex. 3, p. 67). It was a situation of avascular necrosis, where dead bone was being overstressed and starting to fracture, or collapse, and the sooner you can get him off the hip, the more likely you are to salvage the hip and get the collapse or stress fracture to heal, before it collapses. Delays are critical because of putting weight on it, the fracture can collapse at which point it is more difficult to treat without a hip replacement. The core depression done was appropriate, but the odds were stacked against it working due to the delay (Id @ 21-22). In terms of the delay, the doctor was referring to the 18 month delay for the knee surgery (Id @ 22 -23). The delay had some effect on the knee but not quite as severe as it had on the hip where it was known to be stable and asymptomatic with normal activities of daily living, for at least at long as he's had it. The increased stress on the hip is then caused by the knee injury and the knee pain, and the greater the stress on dead bone, the greater the chances you ultimately cause a stress fracture or overstress a weakened bone end due to dead bone. The fact is the dead bone was still functioning fairly well prior to this, then with the increased weight and lack of use of the left knee, over time it becomes a bigger problem, causing the collapse of the dead bone in the right hip. (Id @ 23-24) Delaying the treatment of the left knee did affect the left knee over time, it may have become a little worse, but that was much less significant than the effect that the delay would have had on the right hip. Nobody knows if he had that issue with the right hip, as it's all in retrospect that it was found that this delay for the left knee (SIC) really caused the damage to the right hip.

He further testified that each step or increased step or abnormal step shifting most of the weight to the right side would have the effect of a microinjury. If Petitioner had no avascular necrosis in the right hip, those effects probably would have been temporary, as onecan get tendinitis, those types of overuse, bursitis, which are expected to resolve but in a case like this there was underlying pathology, and that delay could cause permanent injury (Id @ 24 - 25). He did not know exactly when the avascular necrosis in the right hip began (Id @ 35 - 36). Up until June 25, 2015, Petitioner had been restricted from work due to the knee.

From that point forward he was off due to both the knee and the hip (Id. @ 26 – 27).

Dr Ho also testified that the normal healing period for a total hip such as Tellis had in February 2016 is six months (Id @ 28). Petitioner testified that while he was to

see Dr. Ho on July 22, 2016, he is not to see Dr. Luu, the hip arthroplasty doctor until September 28, 2015. Dr. Ho further testified that for return to work he would wait until Petitioner was at maximum medical improvement, and then assess the knee as well as the hip, as it would be hard to assess the knee without a fully recovered right hip (Id @ 29).

Dr. Ho at the time of his deposition last saw Petitioner April 22, 2015 and he was still having left knee pain and taking occasional pain pills, with other symptoms such as tingling from the knee down to the toes (Id @ 30). The knee on exam itself was unremarkable, and he injected it with both some cortisone and a little bit of joint lubricant, and they discussed how to manage the knee in the future because he would likely have permanent or chronic symptoms. It's a reasonably good knee but it is not normal. Also there is an area of dead bone in the knee, the osteonecrosis which was treated four years earlier, but even on the most recent MRI which never fully returned to normal, so the concern is that it is always a potential site of re-injury or further damage to the knee, so it bears keeping some watch over (Id @ 30 – 32). It is reasonable to assess both the knee and the hip on the same date, as the hope is to get him back to 100% in terms of his function and use of the hip, and he is hoping it helps the left knee because throughout the two right hip surgeries more was asked of the left knee during that time. He is again favoring the left knee to protect the healing or recovering right hip. The hope is that once it fully recovers it will then begin to bear it fair share of the load on the day to day basis and the left knee will benefit from this long term in the future (Id @ 32 – 33). Dr. Ho expected that ultimately his left knee would not be a restricting factor, but he did not know for sure as he would have to pass his FCE. The history to date indicates he has never fully recovered with the left knee, but he was still optimistic that hopefully with the recovery of the right hip that the left knee will be at a functional level that allows him to return to his previous job duties, but the proof of the pudding would be in the FCE (Id @ 33 – 34). In the doctor's opinion the right hip treatment was all reasonable, necessary and causally related to the accident of August 7, 2010 (Id @ 34).

The only other medical evidence is a Section 12 Exam of Dr. Cohen referred to earlier. Dr. Cohen in his initial report, (Resp. Ex. 2), reviewed some of the records from

the initial Emergency Room in 2010, an August 30, 2010 MRI and some records in 2011 and 2012. He then extensively reviewed the report of Dr. Verma. His opinions were that Petitioner did suffer contusion and condromalacia at the time of the exam, and the medical treatment to date was reasonable and necessary. He opined Petitioner was at MMI and needed no further treatment regarding the left knee, with a good prognosis, and that the complaints of pain seemed out of proportion. He was later provided additional treating records which were lacking from his initial exam, evidencing he did not have complete records for his initial opinions, and he opined that the complete records did not change his opinions (Resp. Ex. 4). Even though Dr. Cohen clearly stated in his initial report that Petitioner was on crutches for his right hip and had positive findings on physical exam for the right hip, he was not asked to review any records in that regard when he performed his IME addendum, nor did he render any opinions regarding the right hip at that time.

In Support of the Arbitrator's Decision regarding "F" (Causal Connection) the Arbitrator makes the following findings and conclusions:

The law on causal connection, generally has most recently been expressed by the Illinois Supreme Court in *Sisbro v. Industrial Commission*, 207 Ill. 2d 193 (2003). In *Contreras v. Industrial Commission*, 306 Ill.App. 3d 1071, 1076, 715 N.E. 2d 701, 705 (1999), the Appellate Court stated:

> "The Act is a humane law of remedial nature, whose fundamental purpose is to protect employees by providing efficient remedies, and prompt and equitable compensation for their injuries.(Citation) By its very nature, the Act mandates a duty of due diligence."

In *National Lock-Hardware the Jetern v. Industrial Commission*, 166 Ill. App. 3d 601, 520 N.E. 2d 43 (1987), a case which preceded *Sisbro*, the Appellate Court held that where an accident, as here, either caused a new injury or aggravated a pre-existing condition, being uncertain which, the accident is compensable. It is also well established that a chain of events showing a prior condition of good health followed by a sudden change after a work injury, can establish causation. *Illinois Power Co., v. Industrial Commission*, 176 Ill. App. 3d 317, 324 (1988). It is further understood that if the work injury itself causes a subsequent injury, for purposes of recovering workers'

compensation benefits, the chain of causation has not been broken; *International Harvester v. Industrial Commission*, 46 Ill. 2d 238, 245 (1970).

There have been previous cases before the Commission where an individual injures one extremity and during the course of treatment sees overuse in favoring that injured member, and suffers a deteriorating condition on the contralateral side. (eg., *Michael Healey v. University of Illinois*, 09 IWCC 1267. See *also Boyd Elec. Co. v. Dee* 356 Ill. App. 3d 851 (2005) See also *Benyon v. Parillo BMW*, 08 IWCC 1212 and *Hubner v. Useco – Uselton Oil Co.*, 09 IWCC 0510. Most recently, the Illinois Appellate Court has confirmed that in aggravation of pre-existing condition cases, that the chain of events is sufficient to establish causation even without medical evidence, *Corn Belt Energy Corp., v. IWCC*, 2016 Ill App. (3d) 150311WC, although in the case at bar Dr. Ho's testimony is more than sufficient. See also *Maxwell v. C Glass Industries, Inc.*, 13 IWCC 0199; *Engleking v. Ashland Chemical* 12 I.W.C.C. 1082, (where even Respondent's initial Section 12 Examiner, Dr. Verma, agreed there can be overcompensation injuries due to knee surgery); *Fiedler v. Washington Group International*, 11 I.W.C.C. 0638; and *Bauman v. Maya Reomanoff Corp.*, 12 I.W.C.C. 0741.

The Petitioner testified that he did walking both inside and outside of his house as recommended to help his left knee. There is in the medical records supporting evidence, such as the calluses and blister on the thumb which used the cane, the right ankle problems, and the back problems, all evidencing Petitioner was overcompensating for a lengthy period of time. The medical records are devoid of any symptoms from or treatment to the left hip. The Arbitrator notes that the Respondent offered no evidence to either rebut Petitioner's testimony of how his right hip symptoms developed or to contest Dr. Ho's opinion on causal connection. Based on the chain of events, the direct and circumstantial evidence, and the opinions of Dr. Ho, which the Arbitrator finds credible, and the lack of any rebuttal evidence, the Arbitrator finds causal connection between the accident in question and the conditions of ill being in Petitioner's right hip for which he has undergone two surgeries and for which he remains in the recovery period and not at MMI.

In Support of the Arbitrator Decision regarding "L" (Temporary Total Disability), the Arbitrator notes Dr. Ho's testimony that Petitioner would not reach maximum medical improvement regarding his hip until the earliest six (6) months following his total knee arthroplasty, which had not occurred as of the time of the trial. Petitioner testified that both his knee and hip were slowly improving. He is to see Dr. Ho for the knee, July 22, 2016, and Dr. Luu, the hip replacement specialist has only scheduled him for September 28, 2016,. Dr. Ho testified that the knee couldn't even be tested for a return to work until the hip heals, as a Functional Capacity Evaluation could not be performed. Neither Dr. Ho for the knee or Dr. Luu for the hip have released claimant to return to work. The only contrary evidence is Dr. Cohen's opinion, limited to the left knee only, that Petitioner had reached MMI. Dr. Cohen rendered no findings or opinions with regard to the right hip. Accordingly, Temporary Total Disability is Awarded from the time of the last hearing, October 17, 2013 through the date of hearing herein, July 8, 2016.

With respect to credits, there was a $422.91 dispute. The parties stipulated and agreed that Petitioner was paid full temporarily total disability through August 31, 2015. The Respondent's Exhibit 1 demonstrates a payment of $70,615.30 but one such payment appears to be in a lump and while labeled "TTD", gives no reason why it would overpay for the period of time shown. The Temporary Total Disability which would have been owed at that period of time is $70,192.39, and the Arbitrator Awards a credit to the Respondent in such amount, as there is less trustworthiness to Respondent's Exhibit 1, since it does not simply reflect continuous payments, but rather a lump sum which may include other matters, such as interest on the prior Award and the like.

In Support of the Arbitrator's Decisions regarding "J" (Medical Expenses) the Arbitrator makes the following findings and conclusions:

In the original Trial the Petitioner was awarded $85,792.81 in bills, with an 8(J) Credit for group of $22,802.91, with Respondent to hold Petitioner harmless with respect thereto, pursuant to statute. The bills herein were introduced into evidence without objection, with the stipulation that Respondent would not have to pay double.

The Arbitrator notes all the bills list services which are orthopedic in nature relating to either the left knee or the right hip.

The Arbitrator further notes that Respondent's examiner, Dr. Cohen opined that all medical was reasonable and necessary with regard to the left knee, and Dr. Ho testified that all medical was reasonable and necessary and causally related with the respect to the left knee and right hip.

Accordingly, Respondent shall pay reasonable and necessary medical expenses of $301,220.21 as provided by Section 8(a) and 8.2 of the Act, itemized as follows, Respondent to receive credit for all sums previously paid hereunder, all bills to be paid pursuant to the medical fee schedule:

FACILITY	BALANCE
Joliet Radiological	$ 242.00
Liberty Physical Therapy	$ 31,271.19
Internal Medicine Family Practice	$ 1,733.14
" "	$ 154.00
St. Joseph Hospital	$ 1,807.61
University of Chicago Medical Center	$ 449.00
University of Chicago Medical Center	$ 16,744.00
University of Chicago Medical Center	$ 254.00
University of Chicago Medical Center	$ 0.00

(Billed with an 8(j) Credit of $550.00 with Respondent to hold Petitioner harmless

University of Chicago Medical Center	$ 373.00
University of Chicago Medical Center	$ 406.00
University of Chicago Medical Center	$ 373.00
University of Chicago Medical Center	$ 332.00
University of Chicago Medical Center	$ 1,653.00
University of Chicago Medical Center	$ 373.00
University of Chicago Medical Center	$ 365.00
University of Chicago Medical Center	$ 4,043.00
University of Chicago Medical Center	$ 331.00

University of Chicago Medical Center	$ 1,016.00
University of Chicago Medical Center	$ 17,967.22
University of Chicago Medical Center	$ 213.00
University of Chicago Medical Center	$ 272.00
University of Chicago Medical Center	$ 399.00
University of Chicago Medical Center	$ 3,473.00
University of Chicago Medical Center	$ 2,126.00
University of Chicago Medical Center	$ 14,467.00
University of Chicago Medical Center	$ 2,788.00
University of Chicago Medical Center	$ 391.00
University of Chicago Medical Center	$ 2,198.00
University of Chicago Medical Center	$ 497.00
University of Chicago Medical Center	$ 62,712.00
University of Chicago Medical Center	$ 2,658.00
University of Chicago Medical Center	$ 1,410.00
University of Chicago Medical Center	$ 1,410.00
University of Chicago Medical Center	$ 844.00
University of Chicago Medical Center	$ 754.58
University of Chicago Medical Center	$ 2,915.00
University of Chicago Medical Center	$ 2,081.00
University of Chicago Medical Center	$ 71,917.63
University of Chicago Medical Center	$ 291.00
University of Chicago Medical Center	$ 1,027.00
University of Chicago Medical Center	$ 6,010.00
University of Chicago Medical Center	$ 5,189.00
University of Chicago Medical Center	$ 1,721.00
University of Chicago Medical Center	$ 411.00
University of Chicago Medical Center	$ 2,334.00
University of Chicago Medical Center	$ 544.00
University of Chicago Medical Center	$ 1,496.00
University of Chicago Medical Center	$ 2,934.84

University of Chicago Medical Center $ 25,849.00

All subject to the Fee Schedule

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

Jozef Slodyczka,

Petitioner,

vs.

NO: 11 WC 22554

Masonry Solutions Inc and State Treasurer as Ex Officio Custodian of The Injured Workers' Benefit Fund,

17IWCC0341

Respondent,

DECISION AND OPINION ON REVIEW

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

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

17IWCC0341

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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 1 - 2017
o051817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SLODYCZKA, JOZEF
Employee/Petitioner

Case# **11WC022554**

MASONRY SOLUTIONS INC AND STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

17IWCC0341

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:

2553 JAMES P McHARGUE LAW OFFICE
BRENTON SCHMITZ
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

0000 MASONRY SOLUTIONS INC
2613 W EVERGREEN AVE
CHICAGO, IL 60622

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

17IWCC0341

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

Jozef Slodyczka
Employee/Petitioner

Case # 11 WC 22554

v.

Masonry Solutions, Inc. and
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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **July 22, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 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 **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **2** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$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 $400.00/week for 6 5/7^{ths} weeks, commencing May 27, 2011 through July 13, 2011, as provided in Section 8(b) of the Act

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $574.00 to Village of Wilmette, $2,943.13 to NorthShore University HealthSystem, $866.00 to Northshore Physicians Group, and $100.00 for out-of-pocket payments made to Northshore Physicians Group, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $360.00/week for 16.125 weeks, because the injuries sustained caused the 7.5% loss of use of the right leg, 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 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.

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

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

Walter Black

Signature of Arbitrator

AUG 9 - 2016

August 9, 2016

Date

STATEMENT OF FACTS

Petitioner testified that on May 27, 2011 he was 50 years old, married, with two dependent children. He had been working at Masonry Solutions, Inc., Respondent, since October 2010. Petitioner worked 8 hours per day and 40 to 45 hours per week. Additional hours were often worked, depending on the weather. He was paid approximately $600.00 per week either in cash or personal checks. At first, Petitioner was paid $13.00 per hour, though he was making $15.00 per hour at the time of his injury. Petitioner worked as an assistant of a brick mason, preparing cement and passing bricks and mortar. He used sharp cutting tools, including saws.

Respondent, Masonry Solutions, Inc. is a general purpose masonry contractor. The owner is Gzegorz Adamusik. Petitioner was hired in October 2010 through a friend, Mr. Wieslaw Siejko, who also worked there.

On May 27, 2011, Petitioner was performing a chimney repair on a roof in Northern Cook County, Illinois. Petitioner was working with Mr. Adamusik, and Mr. Siejko. Petitioner was operating an angled grinder, smoothing stones, when a stone inside the grinder broke off and hit him in the right thigh. This resulted in a deep laceration on his right thigh. Due to his blood loss, Petitioner immediately took off his belt to create a tourniquet on his right leg to stop the bleeding. Petitioner then climbed down from the roof on a ladder and sat in the work van to await an ambulance that had been summoned. Petitioner arrived at NorthShore University HealthSystem Evanston Hospital, where the wound was cleaned. Eight stitches were used to repair the quadriceps muscle, eight to repair the fascia, and thirteen into the skin to close the wound. X-rays were taken. Dr. Malya took Petitioner off of work due to the severity of his injury. Petitioner continued to follow up with the physicians at NorthShore follow his initial emergency visit.

Petitioner did not return to work for Respondent. One week after the accident Petitioner spoke with Mr. Asamusik, who told Petitioner not to tell anyone about the accident and that he would pay the medical bills. Petitioner is currently employed and working in the siding industry. He now sells and installs siding. Petitioner's pain has decreased, however he continues to feel pain when he exerts himself at work.

WAS RESPONDENT OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKERS' COMPENSATION ACT?

The Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act. Petitioner's testimony established that Respondent was involved in the erection, maintaining, removing, remodeling, altering or demolishing of a structure, in construction, with use of sharp edged cutting tools, and was a business or enterprise in which electric, gasoline or other power driven equipment was used.

WAS THERE AN EMPLOYER-EMPLOYEE RELATIONSHIP?

The Arbitrator finds that there was an employer-employee relationship between Petitioner and Respondent. Petitioner credibly testified that he worked set hours, worked under the supervision and control of Mr. Adamusik, and was paid on an hourly basis. Petitioner testified that the tools he used in his employment were provided by Respondent.

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

The Arbitrator finds that an accident did occur that arose out of and in the course of Petitioner's employment by Respondent. Petitioner credibly testified that on May 27, 2011, he was operating an angled grinder when a stone inside the grinder broke and struck Petitioner in the right thigh while working. Petitioner credibly testified that he injured his right thigh. He testified that he received medical treatment that day at NorthShore University HealthSystem Evanston Hospital, and the records from this facility are consistent with Petitioner's testimony.

WHAT WAS THE DATE OF THE ACCIDENT?

The Arbitrator finds that Petitioner's accident occurred on May 27, 2011. Petitioner testified that he suffered his injury on May 27, 2011, and the medical records from that date show that the injury was sustained on May 27, 2011.

WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO RESPONDENT?

The Arbitrator finds that the Petitioner gave timely notice of the accident to Respondent. Petitioner testified that he told Respondent's owner, Gzegorz Adamusik about the accident on the date it occurred and that Mr. Gzegorz witnessed the accident.

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

The Arbitrator finds that Petitioner's condition of ill-being, a deep right thigh laceration, is causally connected to his May 27, 2011 accident at work. The Arbitrator relies on the credible testimony of the Petitioner, which is corroborated by the records of his treating medical physicians. No medical evidence was presented by the Respondent.

Petitioner testified, and the medical records corroborate, that he was working full duty as a masonry assistant prior to an angled grinder accident while at work on May 27, 2011. Petitioner immediately presented to NorthShore University HealthSystem Evanston, where physicians noted a laceration of the right thigh. Petitioner was working full duty prior to May 27, 2011. He suffered an angled grinder injury on that date. He was unable to work after that date, in accordance with physician instruction.

WHAT WERE PETITIONER'S EARNINGS?

The Arbitrator finds that Petitioner's average weekly wage was $600.00. Petitioner testified that he was paid $15.00 per hour, in cash or personal checks. Petitioner testified that he worked five days per week from 9:00am until 5:00pm, on occasion longer depending on weather.

WHAT WAS PETITIONER'S AGE AT THE TIME OF THE ACCIDENT?

The Arbitrator finds that Petitioner was 50 years old on the date of accident. Petitioner testified that he was born on November 15, 1960, which would make him 50 years old on the date of accident.

WHAT WAS PETITIONER'S MARITAL STATUS AT THE TIME OF THE ACCIDENT?

The Arbitrator finds that Petitioner had two dependent children on the date of accident. Petitioner testified that at the time of the accident he was married with two children under age 18.

WERE 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 rendered to the Petitioner were reasonable and necessary, that Respondent has paid none of the charges for medical services, and that Petitioner is entitled to payment for all of the medical expenses.

Due to the severity of Petitioner's injury, he was transported from his work site to the hospital by a Village of Wilmette ambulance. Petitioner sought treatment with NorthShore University HealthSystem Evanston. Treatment consisted of stitches to close Petitioner's right thigh laceration, X-rays of the injury, and follow up appointments.

WHAT TEMPORARY BENEFITS ARE DUE?

The Arbitrator finds that Petitioner is entitled to Temporary Total Disability Benefits from May 27, 2011 through July 13, 2011. The Arbitrator relies on the credible testimony of the Petitioner and the records of his treating physicians. Petitioner was immediately taken off work from by Dr. Malya on May 27, 2011. The last off work note from Dr. Kelly Stein, takes Petitioner off work for four weeks after June 15, 2011.

WHAT IS THE NATURE AND EXTENT OF THE INJURY?

The Arbitrator finds that Petitioner has been permanently disabled to the extent of 7.5% loss of use of the right leg. The Arbitrator bases this finding on Petitioner's credible testimony and the corroborating records of the treating physicians.

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

Alicia Bettes,
Petitioner,

vs.

Fox News Chicago,
Respondent.

17IWCC0348

NOS: 11 WC 24138
13 WC 24542

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 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 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.

The party commencing 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: JUN 7 - 2017
o5/18/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0348

BETTES, ALICIA
Employee/Petitioner

Case# **11WC024138**

13WC024542

FOX NEWS CHICAGO
Employer/Respondent

On 2/18/2016, 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 0.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0533 ROSS TYRRELL LTD
JAMES E TYRRELL
111 W WASHINGTON ST SUITE 1120
CHICAGO, IL 60602-2733

0507 RUSIN & MACIOROWSKI LTD
JIGAR S DESAI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

ALICIA BETTES
Employee/Petitioner

Case #11 WC 24138
#13 WC 24542

V.

FOX NEWS CHICAGO
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 December 18, 2015, and January 28, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On April 29, 2010, and July 14, 2011, the respondent was operating under and subject to the provisions of the Act.
- On those dates, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of the July 14, 2011, accident was given to the respondent.
- In the year preceding the injuries, the petitioner earned $86,170.24; the average weekly wage was $1,657.12.
- At the time of injuries, the petitioner was 36 and 37 years of age, respectively, married with no children under 18.

ORDER:

- The petitioner's request for benefits is denied and both claims are dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

February 18, 2016

Date

FEB 18 2016

FINDINGS OF FACTS:

The petitioner, a right-handed, full-time producer since July 2005, received medical care at Rush Oak Park Physicians Group on April 29, 2010, for blood pressure, headaches and swollen ankles. April 29, 2010, is the date of injury for claim #11 WC 24138. The cursive notes in the treatment record are completely illegible. An assessment in cursive in a treatment note on October 5th possibly indicates bilateral carpal tunnel. Dr. Wysocki at Rush Oak Park Physicians Group saw the petitioner on October 20th and noted an insidious onset of bilateral wrist and hand pain, numbness and tingling for more than a year that she related to increased use of the computer but she also associated her symptoms with sleep and long distance driving. She reported radiating symptoms that involved her thumb through her ring finger and that her symptoms were worse with her right hand. She had a positive right median nerve compression test. His assessment was probable mild bilateral carpal tunnel syndrome.

She reported on December 1st that her hands were the same with the use of rigid wrist splints. Dr. Wysocki opined on December 10th that an EMG nerve conduction study on the 8th showed mild C5-6 radiculopathy but no evidence of compressive neuropathy of the median, ulnar or radial nerves. She was given a right carpal tunnel injection, which she reported by e-mail as providing only a few days of complete relief of pain and approximately three weeks of reduced symptoms. The petitioner also reported that she had been off of work close to ten weeks recovering from a myomectomy.

On March 8, 2011, the petitioner prepared and signed an "Employer's First Report of Injury" in which she indicated that her injury occurred doing repetitive typing several hours a days. Dr. Wysocki performed a right carpal tunnel release on March 17,

2011, and a left carpal tunnel release on April 28th. At her last follow-up with Dr. Wysocki on June 10th the petitioner reported the resolution of her tenderness and tingling, occasional 5/10 pain and some tenderness and sensitivity in both her palms.

July 14, 2011, is the date of injury for claim # 13 WC 24542. The petitioner saw Dr. Wysocki on September 7, 2011, for right trapezius, right shoulder and upper back pain and reported that she had been working with a poor ergonomic work station for six weeks and that her work environment was quite cold. Dr. Wysocki's assessment was right lateral epicondylitis. The petitioner saw Dr. Bigosinski on September 13th for right shoulder pain and reported returning to work ten weeks earlier, using less than ideal ergonomic work stations and developing right shoulder pain. The doctor's assessment was right shoulder tendinitis for which he prescribed therapy. The petitioner reported left lateral elbow pain on December 14th and Dr. Wysocki's assessment was left lateral epicondylitis.

She received a right shoulder injection from Dr. Bigosinski on December 16th, which provided only two weeks of pain relief. An MRI of her right shoulder on March 20, 2012, revealed rotator cuff tendinopathy. Dr. Nho saw the petitioner on April 9, 2012, and performed a right shoulder arthroscopic superior labral repair and subacromial bursectomy on April 26th. The petitioner reported ongoing stiffness in her right shoulder at her last follow-up on January 8, 2013.

The petitioner followed up with Dr. Wysocki for her bilateral lateral epicondylitis on March 16, 2012, May 18th and July 13th. Dr. Wysocki performed a right lateral epicondylitis debridement with epicondylectomy and common extensor repair on August 2, 2012 and a left lateral epicondylitis debridement on November 29th. The last treatment

record noted that the petitioner's bilateral elbows were better and that she had no pain with rest but that she felt occasional discomfort with heavy use.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF THE EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident on April 29, 2010, or July 14, 2011, arising out of and in the course of her employment with the respondent. Dr. Michael Vender and Dr. Wysocki both opined that the petitioner's work activities would not cause her bilateral carpal tunnel syndrome or her bilateral epicondylitis. Dr. Guido Marra opined that the petitioner's SLAP tear was pre-existing and was not aggravated by work duties that do not involve repetitive overhead work. The opinions of Drs. Vender, Marra and Wysocki are persuasive and credible. Moreover, it is not believable that, while keyboarding or typing, the petitioner would place her hands in a hperflexed or hyperextended position. Also, the petitioner's testimony of keyboarding/typing 99% of the day is not consistent with her report of injury of typing several hours a day or with the time required to perform the myriad duties the petitioner testified she performed as a news producer. The petitioner's request for benefits is denied and both claims are dismissed.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The petitioner's testimony that she gave a notice of a work injury to her supervisor, Carol Fowler, shortly after April 29, 2010, was unrebutted. The respondent received timely notice of the petitioner's claim of injury on April 29, 2010.

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

DON C. PASSMORE,

Petitioner,

vs. NO: 12 WC 000925

COMCAST ABB MANAGEMENT CO.,

Respondent.

ORDER

On a May 18, 2017, Commissioner Kevin W. Lamborn presided over a hearing pursuant to a Petition for Rule to Show Cause. Written notice of the hearing was mailed to the parties by the Commission on March 6, 2017. Counsel for Respondent, the petitioning party, appeared. Petitioner, representing himself, did not. The Commission finds as follows:

Petitioner filed a Petition for Review of the December 30, 2014, Arbitration Decision and requested four copies of the arbitration transcript. The Petition for Review of Arbitration form provides the party requesting the transcript(s) guaranteed payment for their production.

The transcripts, pursuant to Petitioner's guarantee of payment, were produced and payment requested. Petitioner never responded to the request for payment.

The Commission interprets Petitioner's failure to pay for the requested arbitration transcripts and subsequent failure to appear or cause to have counsel appear before Commission Lamborn for the hearing on Respondent's Petition for a Rule to Show Cause as an indication Petitioner has abandoned his claim against Respondent.

IT IS THEREFORE ORDERED BY THE COMMISION that Petitioner's Petition for Review of Arbitration Decision, filed with the Commission on December 30, 2014, is dismissed for lack of prosecution.

DATED: JUN 6 - 2017
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA GEAN,

Petitioner,

17IWCC0350

vs. NO: 12 WC 10740

UNIVERSITY OF ILLINOIS AT CHICAGO HOSPITAL,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision and finds that Petitioner sustained accidental injuries arising out of and in the course of her employment, but that Petitioner failed to prove her current condition of ill-being is causally related to her December 16, 2011work-related injury based upon her significant lack of credibility, her treating medical records which fail to corroborate her testimony as to her medical condition and treatment and her treating records immediately following her work-related injury.

Findings of Fact and Conclusions of Law

The Commission first addresses the Arbitrator's finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of employment with Respondent. The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone v. Industrial Comm'n*, 131 Ill.2d 478 (1989). An

17IWCC0350

employee's injury is compensable under the Act only if it arises out of and in the course of employment. 820 ILCS 305/2 (West 1998). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483, 546 N.E.2d 603 (1989). It is undisputed that the subject Petitioner sustained her injuries "in the course of" her employment. Thus, the sole issue is whether the claimant's injuries arose out of her employment.

Arising out of the employment refers to the origin or cause of the claimant's injury. In *Caterpillar Tractor Co. Industrial Comm'n*, 129 Ill.2d 52, 58 (1989), the Supreme Court held:

> 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. (*Jewel Cos. v. Industrial Comm'n* (1974), 57 Ill.2d 38, 40; *Chmelik v. Vana* (1964), 31 Ill.2d 272, 277.) Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. (*Howell Tractor & Equipment Co. v. Industrial Comm'n* (1980), 78 Ill.2d 567, 573.) If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment. (*Orsini v. Industrial Comm'n* (1987), 117 Ill.2d 38, 45; see, *e.g., Chmelik v. Vana* (1964), 31 Ill.2d 272, 278....However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable. *Material Services Corp. v. Industrial Comm'n* (1973), 53 Ill.2d 429, 433.

Risks are thus categorized into three groups: 1) risks distinctly associated with the employment, such as the risk of tripping on a defect at the employer's premises; 2) risk personal to the employee, such as idiopathic falls; and 3) neutral risks that have no particular employment or personal characteristics and to which the general public is equally exposed. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill.App.3d 102, 105-106, 853 N.E.2d 799 (2006); *Illinois Consolidated Telephone Co. v. Industrial Comm'n*, 314 Ill.App.3d 347, 352-53 (2000) (Rakowski, J., concurring).

Further, "[i]njuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1014, 944 N.E.2d 800, 804 (2011)." "Such an increased risk may be either qualitative, such as some aspect of the employment which contributes to the risk, or quantitative, such as when the employee is exposed to a common risk more frequently than the general public." *Id.*

In the case at bar, Petitioner testified that that she was in the operating room, at the control desk. Petitioner also testified she was behind a clerk who was seated on a rolling chair at

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the control desk. As Petitioner was walking out of the area, the clerk pushed her chair back and Petitioner's left foot got caught under the rolling wheels of the chair, and she landed on the floor hurting her right leg and left wrist. (T, p. 10)

The Commission finds that under a qualitative risk analysis, a co-worker pushing her chair backward into Petitioner's path at the control desk in an operating room is a risk of her employment. Therefore, Petitioner has met her burden of proving accident.

Petitioner testified that she hit her wrist on a copy machine and she hit the floor with her right knee. (T, p. 10) Petitioner testified multiple times that she hurt her right leg and left wrist. (T, pp. 10, 11, 18) Petitioner also testified that she had immediate severe pain in her right leg and left wrist. (T, p. 11) Petitioner testified that she went to the emergency room at University of Illinois Hospital, downstairs at the hospital. *Id.* Petitioner also treated with Dr. Harold Rees and at Loyola University. (T, p. 14) Petitioner testified that she notices that she still suffers pain in her right leg and left wrist. (T, p. 18)

The University of Illinois Medical Center emergency room records from the date of accident, December 16, 2011, document that the patient, a UIC employee, tripped and fell in the operating room just prior to arrival and injured her left knee and right wrist. The emergency room records document specifically that no other injuries were sustained. After x-rays confirmed no evidence of acute osseous abnormality, acute fracture or dislocation of Petitioner's left knee and right wrist, Petitioner was released. (Px1)

The December 16, 2011 emergency room notes document Petitioner's pain complaints were related solely to her left knee and right wrist, contralateral to the knee and wrist injuries referenced during her testimony. The December 16, 2011 emergency records belie Petitioner's testimony regarding her injuries.

Petitioner also testified that "to this day" she still suffer(s) pain in her right leg and left wrist and that she has a "nasty lump on the knee." (T, p. 18) Petitioner testified that she had a prior right leg work injury. (T, p. 22) Petitioner settled her prior right leg work-related case. (Rx1) The records from Loyola Center for Health dated August 21, 2009 document Petitioner's prior treatment for left thumb carpometacarpal osteoarthritis. (Px2A, 2B)

The Commission relies upon Dr. Michael Bednar's January 10, 2012 office note. (Px2A, 2B) Dr. Bednar documents that Petitioner's right wrist pain, which she reported at the emergency room, was resolved. Dr. Bednar diagnosed Petitioner with lateral epicondylitis, an unrelated condition. The Commission finds Petitioner's right knee and left wrist pain complaints are unrelated to the incident at bar.

The Commission finds Petitioner's testimony, specifically that she suffered injury to her right leg and left wrist at the time of the accident, and she still suffers pain in her right leg and left wrist, is not credible and lacking corroboration.

Based upon the foregoing, the Commission finds Petitioner is not credible and failed to prove that her current condition of ill-being is causally connected to her December 16, 2011 work-related injury. Furthermore, the Commission finds Petitioner failed to prove entitlement to

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temporary total disability benefits or a permanent partial disability award with regard to her alleged injuries, and the Commission therefore declines to award Petitioner temporary total disability benefits, medical expenses or permanent partial disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 19, 2016, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted, and Petitioner's claim for compensation is denied.

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

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

The Respondent is exempt from bonding requirement for removal of this cause to the Circuit Court based upon Section 19(f)(2). The party commencing 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: JUN 8 - 2017
KWL/bsd
O-04/25/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0350

GEAN, LINDA
Employee/Petitioner

Case# 12WC010740

U OF I AT CHICAGO HOSPITAL
Employer/Respondent

On 5/19/2016, 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 0.37% 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:

0222 GOLDBERG WEISMAN & CAIRO LTD
JOEL BLACK
ONE E WACKER DR SUITE 3800
CHICAGO, IL 60601

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

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
300 HAMILTON BLVD
PEORIA, IL 61602

0902 UNIVERSITY OF IL/CLAIMS MGMT
1737 W POLK - M/C 940 SUITE B9
CHICAGO, IL 60612

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

MAY 19 2016

Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0350

Linda Gean
Employee/Petitioner
v.
U of I at Chicago Hospital
Employer/Respondent

Case # **12** WC **10740**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **9/28/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On **12/16/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$43,056.00**; the average weekly wage was **$828.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner's Application for benefits under the Workers Compensation Act is denied for her failure to prove that she sustained accidental injuries that arose out of and in the course of her employment by Respondent.

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

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

Signature of Arbitrator

May 17, 2016
Date

ICArbDec p. 2

MAY 19 2016

Linda Gean v. University of Illinois at Chicago
12 WC 10740

INTRODUCTION

This matter proceeded to hearing on September 28, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***C:*** Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?; ***E:*** Was timely notice of the accident given to Respondent?; ***F:*** Is Petitioner's current condition of ill-being causally related to the injury?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; **K:** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?

STATEMENT OF FACTS

On December 16, 2011 Petitioner was employed by Respondent as a nurse tech. Her job duties, in part, included prepping patients for surgery and transferring them to the operating room. It was necessary for her to pass through nursing stations and the operating room control desk areas in the course of performing her duties.

On December 16, 2011 Petitioner was walking near the operating room control desk when her left foot caught under a rolling chair being used by a co-worker. She fell to the floor. She attempted to catch herself with her right hand. She fell against a copier with her left hand and then hit the floor with her right knee. She felt immediate pain in her right leg and left hand and wrist. Her supervisor was present and witnessed the incident.

Petitioner prepared an accident report the Monday after her fall, January 19.

Petitioner sought medical attention on December 16 at the University of Illinois Health Systems (PX #1), complaining of injuries to her right wrist and left knee. She reported to the triage nurse that she had fallen head-first when her foot stuck in a chair that was backed into her. X-rays did not show acute fracture was noted however there was a clinical suspicion for navicular facture in the right wrist. Petitioner was fitted with a thumb Spica splint for her wrist and an immobilizer for her knee. The discharge diagnosis was acute right wrist and left knee injury.

Petitioner was instructed to follow up with an orthopedic specialist and was taken off work on December 19, 2011 (PX #4).

Petitioner testified that she followed up at Loyola University Medical Center (Loyola) with her primary physician, Dr. Harold Rees. Petitioner followed up at Loyola (PX #2A & PX #2B) on January 10, 2012. At the time she was seen by Dr. Michael Bednar. She complained of pain in the right elbow and right wrist, although the elbow pain was more significant than the wrist pain. She gave a history of her fall onto her

right arm and knees at work on December 16, 2011. On examination she had full range of motion in the elbow forearm wrist and fingers. There was point tenderness over the lateral epicondyle. Dr. Bednar found lateral epicondylitis with wrist pain that had resolved. He noted no work restrictions related to the arms. Examination of her legs and any work restrictions were deferred to Dr. Rees.

Petitioner gave medical histories on January 10 and January 20, 2012. On both dates she disclosed a history of dizzy spells. On January 10 she disclosed a history back/neck problems, skeletal pain, and joint swelling. On January 20 she denied that part of her history.

Petitioner once again followed up at Loyola on January 20, 2012 and saw Dr. Rees. She gave a history of a fall onto her knees at work. Bilateral x-rays of the knees were taken, showing mild osteoarthritis of the patellofemoral joints of both knees. Dr. Rees ordered physical therapy. Dr. Rees's impression was patellofemoral syndrome bilateral knees aggravated by a fall at work. Dr. Rees stated Petitioner should remain off work.

Dr. Bednar wrote a return to work with restrictions note dated January 20.

Petitioner had her therapy at Loyola for 2 months. Loyola records (PX #2A) seem to indicate Petitioner saw Dr. Rees again on January 27, 2012. Those records appear to be duplicates of the January 20 clinical notes. Petitioner was released to return to work without restrictions by Dr. Rees on March 16, 2012 at Petitioner's request.

Petitioner had been authorized off work until her release to return to work at light duty by Dr. Bednar on January 20, 2012 (PX #2B). Trinnette Zahakaylo APN/CNP at University Health Service (PX #4) wrote a return to work with restrictions note on February 9, 2012 through March 5, 2012.

Petitioner testified about ongoing complaints with her left wrist and right knee since her work injury. She admitted she has been working full and regular work duties since March of 2012. She has had no medical treatment since March 2012 and has received no recommendations for further medical treatment for her work injuries.

On cross-examination Petitioner acknowledged a prior right leg work injury which was resolved for 1.9% loss of use of the right leg. Respondent's Exhibit #1 was a copy of Illinois Workers Compensation Commission records confirming the settlement of the prior right leg injury.

Petitioner's Exhibits #2A and #2B also contained records of Petitioner's consultations with other Loyola physicians over the period of her treatment for her accident injuries. These consultations were for unrelated medical issues but billings for this unrelated medical care were included in Petitioner's Exhibit #3.

Petitioner's Exhibit #3 has Loyola billing totaling $4,885.80. The Arbitrator notes that PX #3 billing entries for January 20 and 24, and February 6, 2012 are the only entries related to Petitioner's claimed injuries. On cross- examination, the

Petitioner admitted that she believed her group carrier, CIGNA, did satisfy those medical charges.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner failed to prove that she sustained an accidental injury arose out of her employment by Respondent.

In order to prove that her injury arose out of her employment Petitioner must prove Petitioner must still prove that she was injured as a result of risk that is either incidental to her employment or neutral, but that Petitioner was exposed to the risk to a greater degree than that of the general public by virture of her employment. Here, Petitioner was clearly within the course of her work day, thereby occurring in the course of her employment. However, Petitioner failed to prove that the activity that caused her injury was either incidental to her employment or that she was exposed to a neutral risk to a greater degree than that of the general public.

Petitioner failed to prove that tripping over a chair was in any way incidental to her employment. She testified to the opposite on cross-examination. She admitted that she was not using the chair to complete her work duties. She gave no evidence that she ever used a chair in the course of her work day. There was no evidence to suggest that an encounter with a wheeled chair was something Petitioner did in furtherance of her work for the University of Illinois. Therefore, Petitioner's injury did not result from of an activity that Petitioner was performing incidental to her work duties.

The Arbitrator has further finds that Petitioner also failed to prove that she was exposed to a neutral risk, that of tripping over a chair, to any degree greater than that of the general public. The Arbitrator finds that encountering a chair is a neutral risk to which the general public is exposed. The Petitioner presented no evidence that there was an increased risk of falling due to this chair. Furthermore, she presented no evidence that the chair was defective in any way. Rather, Petitioner testified that there was nothing defective about the chair over which she tripped. Further, there was no evidence of a defect in the floor where she was walking that may have created something more than a neutral risk of injury.

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

Petitioner's testimony that her supervisor witnessed her fall on Decemeber 16, 2011 was unrebutted. Petitioner's testimony that she made a written report the following Monday, January 19, was also unrebutted. Therefore, the Arbitrator finds that

Petitioner gave notice of her claimed accidental injury in compliance with §6(c) of the Act.

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

Petitioner did sustain minor soft tissue injuries to her wrist and knees a aresult of her fall on December 16, 2011. The fall apparently aggravated a pre-existing arthritic condition in her knees. However, he Arbitrator has previously found that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. Therefore, the issue of whether Petitioner current claimed condition of ill-being is causally related to the accident is moot.

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

The Arbitrator has previously found that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. However, the Arbitrator notes that Petitioner submitted her Exhibit #3, purporting to be billing charges for her claimed accidental injuries. The Arbitrator noted that Petitioner's Exhibits #2A and #2B, Loyola University Medical Center records, contained numerous records of medical consultations and testing for medical conditions unrelated to Petitioner's claimed injuries.

The Arbitrator finds that $1,184.60 of medical fee charges contained in Petitioner's Exhibit #3 were necessary and reasonable to assess and treat petitioners' claimed injuries. Any such charges must be reduced in accord with the medical fee schedule.

K: What temporary benefits are in dispute? TTD

Petitioner was authorized off work by the emergency room physician at the University of Illinois Medical Center from Decemeber 16, 2011 "until further notice." Further, physicians at Loyola University Medical Center also authorized Petitioner to be off work. Dr. Rees released Petitioner for work with restrictions on January 20, 2012 and for full duty on March 16, 2012.

However, the Arbitrator has previously found that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent, therefore whether Petitioner is entitled to temporary total disability benefits is moot. Petitioner's claim for temporary total disability benefits is denied.

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

The Arbitrator has previously found that Petitioner failed to prove that she was injured in an accident that arose out of and in the course of her employment by Respondent. Petitioner's claim for permanent partial disability benefits is therefore moot and is denied.

The Arbitrator does note Petitioner's inconsistent presentation at trial regarding right wrist versus left wrist detracted from Petitioner's credibility in describing her claimed continuing complaints. The contradictory and overlapping work restrictions notes further muddied the waters of the disability claim.

Steven J. Fruth, Arbitrator

May 17, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Victoria Garcia,
Petitioner,

v.

Case Nos. 13 WC 10775
13 WC 10776
14 WC 15686

Bimbo Bakeries USA,
Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition for Assessment of Penalties and Attorney's Fees, and her petition for hearing pursuant to Section 8(a) of the Workers' Compensation Act (Act). Due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing March 15, 2017, in Geneva, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, partially grants said Petition, for the reasons set forth below.

1. Petitioner filed three Applications for Adjustments of Claims, on 4/2/13 and 5/7/14, alleging dates of injury of 7/2/11 (actually 7/21/11), 12/8/12, and 1/8/14.
2. Petitioner's three applications, all related to right shoulder and neck injuries, were consolidated by the Commission.
3. The parties eventually agreed to settle all three cases, and a Lump Sum Settlement Agreement was approved by Arbitrator Cronin on 9/11/15. As part of this agreement, Respondent agreed to "pay all necessary and related medical expenses pursuant to the fee schedule or negotiated rate, whichever is less, incurred through the date of contract approval."
4. On 12/15/16, Petitioner filed the instant Petition for Assessment of Penalties and Attorney's Fees, which asserted that Respondent unreasonably, vexatiously, and in bad faith had failed to pay an emergency room medical bill related to the above-mentioned injuries. On the same day, she filed a petition for hearing pursuant to section 8(a) of the Act, seeking an order compelling Respondent to approve and pay for her emergency room treatment.
5. A hearing on the Petition was held before Commissioner Tyrrell on 3/15/17.

6. At the hearing, Petitioner testified that she began to feel nauseous immediately after waking from anesthetics administered as part of the outpatient shoulder surgery she had in connection with the above-mentioned claims. She further testified that in the two days following the surgery, she continued to feel nauseous and noticed swelling in both of her legs. As a result, Petitioner said, she went to the Valley West Community Hospital emergency room on 8/22/14. Petitioner recalled that emergency room professionals took her history of surgery and nausea before discharging her.
7. Hospital medical records of Petitioner's 8/22/14 emergency room visit noted Petitioner's recent surgery and her complaints of leg swelling. The history noted that the swelling had "increased from her knee on down over the course of" the previous two days. It further noted that she had undergone surgery but "[o]therwise ha[d] no other risk factors that she identifies for having" deep vein thrombosis (DVT). (PX9).
8. The records indicate that she was evaluated for deep vein thrombosis but found instead to have dependent edema. She was discharged with a note that her symptoms were improving. (PX9).
9. Hospital records indicate that the Petitioner accrued $3,293 in medical bills from her visit. (PX3). Petitioner testified that the hospital caused to be garnished from her wages those medical expenses, along with $150 in hospital attorney's fees and court costs of $182.
10. On September 8, 2016, Petitioner's attorney contacted Respondent's claims adjuster to demand payment for the Valley West Community Hospital bills, which she included with the correspondence. (PX3).
11. On September 12, 2016, Petitioner's representatives again contacted Respondent's claims adjuster to clarify that Petitioner sought payment for her 8/22/14 emergency room visit "for post-operative complications." Petitioner's representative's email explained that "her legs became very swollen post-op and she had to be evaluated for [deep vein thrombosis], a common post-op complication." (PX4).
12. On 10/3/16, Petitioner's representative sent Respondent's claims adjuster another demand for payment. (PX5).
13. On 10/11/16, Respondent's claims adjuster contacted Plaintiff's representative and stated that the medical bills had been "processed and paid." (PX6).
14. On 10/28/16, Petitioner's representative followed up with Respondent's claims adjuster to say that the hospital had not yet received payment, and the adjuster confirmed that she was sure payment had been submitted. (PX7).
15. On 11/18/2016, Respondent's claims adjuster sent Petitioner's representative a letter stating that the 8/22/14 hospital visit "appear[ed] to be unrelated to [Petitioner's] injury" because medical records revealed "no discussion of any relationship between lower extremity edema" and the injuries that were the subject of Petitioner's claims. For that reason, the claims adjuster denied payment of the 8/22/14 medical bills. (PX9).
16. On 12/4/16, Petitioner's representative wrote Respondent's claims adjuster to explain that the 8/22/14 emergency room visit "was to evaluate [Petitioner] for

post-op complications," and that there is a high risk of post-operative deep vein thrombosis.

17. At the review hearing, counsel for Respondent asserted that he did not have the Valley West Community Hospital medical records and thus could not agree the emergency room visit was related to Petitioner's shoulder surgery. Counsel did not otherwise contest Petitioner's entitlement to payment of expenses related to the 8/22/14 emergency room visit.

In her petition for hearing pursuant to section 8(a) of the Act, Petitioner seeks an order compelling Respondent to approve and pay for the above-described treatment. However, the Commission is an administrative agency of limited, rather than general, jurisdiction, and its powers are confined to those granted by the legislature. *Millennium Knickerbocker Hotel v. Illinois Workers' Compensation Comm'n*, 2017 IL App (1st) 161027WC, ¶19. By its 9/11/15 order approving the parties' settlement contract, the Commission dismissed this case. Although the Act authorizes the Commission to address certain collateral matters, such as the penalties issues discussed below, it confers the Commission no authority to reopen the case for a new hearing under section 8(a) or to enforce a settlement contract. *Millennium Knickerbocker Hotel v. Illinois Workers' Compensation Comm'n*, 2017 IL App (1st) 161027WC, ¶22. For that reason, the Commission must deny Petitioner's request for relief under section 8(a).

In a separate petition, Petitioner seeks penalties and fees pursuant to sections 16, 19(k), and 19(l) of the Act. The Commission has jurisdiction to interpret a lump sum settlement contract when reviewing a claimant's petition for penalties. *Loyola University of Chicago v. Illinois Workers Compensation Comm'n*, 2015 IL App (1st) 130984WC, ¶¶ 16-18.

Section 16 of the Act provides that, "[w]henever the Commission shall find that the employer" or an agent "has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of [section 19(k) of the 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."

Section 19(k) of the Act provides that, in cases "where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, ... which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to the otherwise payable under this Act equal to 50% of the amount payable at the time of such award."

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

In response to the evidence of unwarranted delay Petitioner presented at the hearing before the Commission, Respondent offered only that counsel did not have access to medical records and thus could not determine whether the medical expenses at issue are related to the accidental injury that was the subject of the parties' settlement. As counsel for petitioner noted at the hearing, this position is not tenable in light of the clear record showing that Respondent's claims adjuster both had access to the records and in fact cited those records as the basis for denying Petitioner's claim.

By making the above argument, Respondent avoids defending the adjuster's position that the 8/22/14 medical treatment was not related to the settled claim. In any event, the Commission rejects that position. As noted above, the parties' settlement required Respondent to pay all medical expenses "necessary and related" to Petitioner's right-shoulder and neck injuries, which led ultimately to her surgery on 8/20/14. Indeed, there is no medical evidence directly stating that Petitioner's need to rule out a DVT condition came about as a result of her surgery two days prior. However, her testimony and the emergency room records presented provide sufficient evidence to establish that the 8/22/14 treatment was, at the very least, related to the 8/20/14 surgical procedure. Petitioner testified that the condition that brought about her emergency room visit began shortly after the conclusion of her surgery. Likewise, the emergency room medical record indicates that Petitioner's leg swelling had "increased *** over the course of the last couple of days." The emergency room record also contained the observation that, aside from her recent surgery, Petitioner had no risk factors for DVT, a condition that the Commission notes often arises as a complication for this type of surgery. These pieces of evidence establish that the emergency room visit was part of the post-operative care that attended Petitioner's surgery. For these reasons, we agree with Petitioner that her 8/22/14 medical expenses are related to the claims the parties settled and should have been covered by Respondent.

The Commission also finds that Petitioner has carried her burden to demonstrate that Respondent's failure to pay the relevant claim was unreasonable and vexatious, so as to trigger penalties under sections 16 and 19(k) of the Act. Despite the evidence that the claim at issue was related to the settled claim, testimony and evidence presented at the hearing showed that Respondent's claims adjuster delayed payment or falsely reassured Petitioner that payment had been made for several months before finally shifting position and proffering a reason to deny the claim. Further, there is no indication in the record that the claims adjuster addressed Petitioner's explanation of the relationship between the emergency room visit and her covered claim. The Commission finds this behavior to constitute unreasonable and vexatious failure to pay the claim.

Section 16 of the Act allows imposition of "attorney's fees and costs" as a penalty. Under that section, we find that Respondent is liable for the $332 in costs—in the form of hospital attorney's fees and court costs—Petitioner was forced to pay in addition to her medical bills. Section 19(k) of the Act allows the Commission to award additional compensation "equal to 50% of the amount payable at the time of such award." Under that section, we find that Respondent is liable for $1,646.50 in penalties, an amount equal

to 50% of the medical bills Respondent unreasonably failed to pay. Thus, we award a total of $1,976 in penalties under sections 16 and 19(k) (50% of $3,293 in bills = $1,646.50, plus $332 in costs = $1976).

As for Petitioner's request for section19(l) penalties, that section provides in pertinent part that "[i]n case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay." 820 ILCS 305/19(l) (West 2000).

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

For the same reasons the Commission finds that Respondent's delay in payment was unreasonable for purposes of sections 16 and 19(k), it finds that Respondent lacked good cause for delaying payment for purposes of section 19(l). The record contains a written request, including an itemized bill, sent to Respondent for payment on September 8, 2016, and the record indicates that the bill was not paid through the date of the hearing on March 15, 2017. Petitioner is entitled to $30 per day in penalties to be assessed against Respondent for that 189-day delay, for a total of $5,670. (September 8, 2016 – March 15, 2017 = 189 days; 189*$30 = $5,670.)

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's petition for a hearing pursuant to section 8(a) of the Act is dismissed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation pursuant to section 19(k) in the amount of $1,646.50 and additional compensation pursuant to section 16 in the amount of $332 in costs, for a total of $1,976.50.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $5,670 as provided in Section 19(l) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,000.00. 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: JUN 2 - 2017

r-05/04/17
TJT/knc
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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Burgess Jr.,

Petitioner,

17IWCC0344

vs.

NO: 13 WC 20952

Illinois Department of Corrections Stateville 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 the nature and extent of the injury and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

After considering all of the evidence, we find the Arbitrator's award of 7.5% of the person as a whole is not supported by a preponderance of the evidence. Petitioner, a 47-year-old corrections lieutenant, was able to return to his pre-injury employment after the June 8, 2013 injury with no loss of wages or earning capacity and no medical treatment after October 10, 2013. As the Arbitrator noted, no impairment rating is in evidence. The Arbitrator found that Petitioner was entitled to 7.5% of the person as a whole based on increased headache frequency, blurry vision, and fearfulness and cautiousness at work. On review, we find that the treating medical records do not fully corroborate Petitioner's testimony. Petitioner experiences a few headaches per week; he testified that this represents an increase in headaches from his pre-injury condition, but we note that his headaches are managed with over-the-counter medications and the records show he was cleared of any neurological injury by Dr. Amine on October 10, 2013. Furthermore, there is no evidence corroborating Petitioner's testimony that he has prescription eyeglasses as a result of vision disturbance related to the injuries he sustained on June 8, 2013. We note that no symptoms of vision disturbance were reported to Dr. Amine on October 10,

2013. Finally, although Petitioner testified he has increased fearfulness and cautiousness performing his duties, the records show that Petitioner saw a social worker on one occasion within weeks of the injury and did not pursue any further counselling or treatment.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 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 3% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,004.65 for medical expenses under §8(a) and §8.2 of the Act.

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

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

DATED: JUN 2 - 2017
DLS/plv
o-5/18/17
46

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0344

BURGESS JR, JOHN
Employee/Petitioner

Case# **13WC020952**

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 11/1/2016, 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 0.50% 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:

0274 HORWITZ HORWITZ & ASSOC
TYLER BERBERICH
25 E WASHINGTON-ST SUITE 900
CHICAGO, IL 60602

5705 ASSISTANT ATTORNEY GENERAL
CAITLIN PAPADOPOULOS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SYSTEMS
RISK MANAGEMENT SERVICES
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

NOV 1 - 2016

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

17IWCC0344

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

- [ ] 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

John Burgess Jr.
Employee/Petitioner

v.

Illinois Department of Corrections
Employer/Respondent

Case # 13WC WC 20952

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 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. [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 [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **June 8, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$87,276.00**; the average weekly wage was **$1,678.00**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$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 $2,004.65, as provided in Sections 8(a) and 8.2 of the Act directly to the office of Petitioner's attorneys.

Respondent shall pay Petitioner permanent partial disability benefits of $712.55/week for 37.5 weeks, because the injuries sustained caused the 7.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Robert E Abrams — Signature of Arbitrator

October 21, 2016 — Date

NOV 1 - 2016

The Petitioner testified that he did in fact return to work as of October 16, 2013 and continued working as a correctional lieutenant through the date of hearing.

At hearing, the Petitioner testified concerning his current physical condition. He continues to have more frequent headaches than he had prior to the assault, explaining that he now has headaches a couple of times per week which he treats with Tylenol. This increase in headache frequency has been present since the assault on June 8, 2013.

The Petitioner further testified that his vision has never fully recovered after the assault. He continues to have a little blurred vision with close up vision, which he did not have prior to the assault. Although he testified that he has a prescription for glasses now, he simply bought a pair of reading glasses from a drug store to compensate for the blurry vision.

Finally, the Petitioner testified that he is now more fearful and cautious as he goes about his job duties than he was before the attack.

CONCLUSIONS OF LAW

I. On the issue of whether the Petitioner's current condition of ill-being is causally related to his accident, (F), the arbitrator hereby finds:

The Petitioner credibly testified at hearing that he continues to experience increased headaches, blurry vision, and fearfulness while working that he did not experience prior to being attacked by inmates on June 8, 2013.

The Petitioner's medical records corroborate that he sustained blunt trauma to his head and was treated for headaches, blurry vision and emotional distress due to his work related injuries.

The Respondent in this case has offered no evidence or testimony to dispute the Petitioner's credible testimony regarding his current condition or to dispute the medical records which clearly outline these conditions beginning after his June 8, 2013 incident.

Based upon all evidence and testimony in this case, the Arbitrator hereby finds that each of the conditions that the Petitioner was treated for following his accident, including headaches, blurry vision and photosensitivity, emotional distress, body aches, shin pain, jaw pain, and back pain were all causally related to his June 8, 2013 work accident. In addition, the Petitioner's current complaints of continued headaches, blurry vision and fearfulness or emotional distress are causally related to his June 8, 2013 work accident.

II. On the issue of unpaid medical bills (J), the arbitrator hereby finds:

After reviewing Petitioner's Exhibit 12, in conjunction with the medical records submitted into evidence, the arbitrator finds that the unpaid medical bills in this case are causally related to the Petitioner's June 8, 2013 work accident. Furthermore, as Respondent has offered no evidence or testimony to dispute the opinions of Petitioner's treaters regarding the need for those treatments, the arbitrator finds that all treatment rendered to the Petitioner in this case has been reasonable and necessary.

Therefore, the arbitrator hereby orders Respondent to pay reasonable and necessary medical services in the amount of $2,004.65 pursuant to Section 8(a) and 8.2 of the Act.

FINDINGS OF FACT

On June 8, 2013, the Petitioner, John Burgess Jr., was employed as a correctional lieutenant at Stateville Penitentiary by the Respondent, Illinois Department of Corrections. As a correctional lieutenant, the Petitioner explained that he was tasked with managing the staff and inmates in order to preserve safety and ensure that proper policies and procedures were followed. In performing his job duties the Petitioner had direct contact with inmates when taking them to the yard, to and from the lunch room, or for other inmate movements.

On June 8, 2013, the Petitioner was acting as the lieutenant responsible for feeding time with the inmates. During the inmates' lunch on that date, the Petitioner witnessed another officer asking an inmate for his ID card when the inmate was attempting to leave the dining room. The Petitioner went to assist the other officer and also asked the inmate for his ID. When the Petitioner instructed the inmate to give the officer his ID, the inmate struck the Petitioner in the head with a closed fist. The Petitioner testified that his memory of the attack after first being struck is blurry, but he believed that three or four inmates became involved in the attack, which is supported by the accident reports filled with the Respondent. (PX 3).

Following the assault, the Petitioner was taken to Provena St. Joseph Medical Center where he was seen with blurry vision in the left eye, a cut under his left eyelid, headache and jaw pain. A CT scan of the brain was performed, which did not reveal any abnormalities. The Petitioner was discharged and instructed to follow up with his primary care physician. (PX 4).

On June 11, 2013, the Petitioner was seen by Dr. King Leong at RMG Lincoln Park Internal Medicine. At that time, the left side of the Petitioner's face was swollen and he was suffering from headaches, photo sensitivity, and jaw pain. X-rays of the Petitioner's jaw did not show fracture. The Petitioner was told to follow up with a neurologist if his symptoms did not subside within another week. (PX 9).

On June 16, 2013, the Petitioner went to the Little Company of Mary Emergency Room with body aches, headaches and shin pain. The Petitioner was diagnosed with a closed head injury and concussion and was given Ultram to treat his pain. (PX 5).

On June 17, 2013, the Petitioner was seen by Cheryl Bristor Wilson, a licensed clinical social worker and employee assistance counselor for the State of Illinois. The Petitioner testified that he saw Ms. Wilson due to his anxiety from the attack. The records from Ms. Wilson reflect that the Petitioner was also upset and angry about being attacked. (PX 8).

On June 21, 2013, July 5, 2013 and September 4, 2013, the Petitioner was seen by Dr. Roy Lacey. Although Dr. Lacey's records are mostly illegible, it is clear that the Petitioner was seen during that time for right shin pain, mid and lower back pain and headaches following his work accident. On September 4, 2013, Dr. Lacey recommended that the Petitioner return to a neurologist for his headaches. (PX 7).

On September 9, 2013, the Petitioner was again seen by Ms. Wilson. At that time, Ms. Wilson indicated that the Petitioner continued having emotional problems following the assault, but declined to continue on with therapeutic treatment. (PX 8).

On October 10, 2013, the Petitioner was seen by Dr. Abdul Amine, a neurologist. Dr. Amine diagnosed the Petitioner as status post blunt head injury and noted that he continued to have headaches several time per week, which had been ongoing since his accident. Dr. Amine stated that the Petitioner could return to work as of October 16, 2013. (PX 6).

III. On the issue of temporary total disability benefits (K), the arbitrator hereby finds:

The records reflect that the Petitioner was kept off work by his treating physicians from June 8, 2013 through October 16, 2013. (PX 4-9). Respondent has offered no evidence or testimony to dispute the Petitioner's temporary total disability status during this time.

Therefore, the arbitrator finds that the Petitioner was temporarily and totally disabled from June 8, 2013 through October 16, 2013, a period of 18 5/7 weeks.

However, the arbitrator also notes Respondent's Exhibit 1, which reflects that the Petitioner received extended benefits in the amount of his full salary during his time off work. (RX 1). As the Petitioner continued receiving his full salary while off work due to this injury, the Respondent is due credit for these payments and the Petitioner is not due any additional temporary total disability benefits.

IV. On the issue of the nature and extent of Petitioner's injuries (L), the arbitrator hereby finds:

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 Petitioner was employed as a correctional lieutenant at the time of the accident and that he was able to return to work in his prior capacity after said injury. The Arbitrator notes however, that the Petitioner has increased anxiety while performing his job duties due to the assault he suffered on June 8, 2013. The Petitioner sought treatment with an employee assistance counselor due to his increased anxiety following the attack and credibly testified that he continues to be fearful and cautious when performing his job duties. Because the Petitioner did return to his previous occupation, but with continued symptoms occurring while performing his duties, the Arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. Because of the Petitioner's relatively young age and ability to work for a number of additional years, with increased headaches and anxiety from this attack, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes the Petitioner returned to the same position and has sustained no wage loss or loss of earning capacity due to his work related injuries. Therefore, the Arbitrator 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 that when the Petitioner was seen on October 10, 2013 and was released from care by Dr. Amine, it was noted that he continued to have headaches multiple times per week. In addition, when the Petitioner was last seen by Ms. Wilson on September 9, 2013, it was noted that his emotional condition after the assault had not improved, but that he would not receive any additional treatment for it. The issues with the Petitioner's headaches, vision, and emotional difficulties following the assault are clearly delineated throughout his medical records. Based upon the clear and undisputed issues reflected in the Petitioner's medical records, in conjunction with the Petitioner's credible testimony concerning his continued symptoms, the Arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the person as a whole pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Willie Vaughn,
Petitioner,

vs. NO: 13 WC 38665

17IWCC0352

Heath Consultants, Inc.,
Respondent.

DECISION AND OPINION ON REMAND

This case now comes before the Commission on remand from the Circuit Court of Cook County. Briefly, this claim involves a disputed injury to the claimant's left ring finger with an asserted accident date of October 15, 2013. This matter proceeded to hearing on April 9, 2014. At the hearing, the claimant testified that while working for the respondent, he tripped and struck his hand on a wrought iron gate, and the ER record from that night (see PX1) noted that the claimant "states he jambed [sic] his finger while hopping over a fence." The respondent, in turn, called three of the claimant's co-workers to testify; these witnesses related that the petitioner had told them that he had injured his finger in an altercation that had happened at his home.

The Arbitrator elected to accept the claimant's rendition of events, and on June 23, 2014, issued a decision finding that the petitioner did suffer an accident arising out of and in the course of his employment with the respondent, and awarded medical expenses, prospective treatment, and temporary total disability (TTD) benefits. Respondent timely petitioned the claim for review by the Commission.

On June 15, 2015, the Commission issued its decision (case 15 IWCC 0451). The Commission noted credibility concerns with the petitioner and chose to place more stock in the co-workers' testimony. In a 3-0 decision, the Commission found that the claimant had failed to credibly demonstrate a compensable accident, reversed the Arbitrator's decision on that issue and denied benefits accordingly. The petitioner timely appealed the Commission's decision to the Circuit Court of Cook County.

On August 9, 2016, the Circuit Court of Cook County issued an Order (case number 15 L 50477), finding the Commission's decision as to accident was against the manifest weight of the evidence and determining that accident had been proven. The Court further found that "[t]he Commission ended its analysis without addressing medical expenses, TTD benefits and prospective medical treatment." Rather than address those issues directly, the Court remanded the case to the Commission "for calculation of benefits due Plaintiff."

The Respondent appealed the Circuit Court's order to the Appellate Court. In a November 1, 2016 order (case 1-16-2456WC), the Appellate Court noted the remand order, found a lack of jurisdiction given the interlocutory nature of the instant appeal, and dismissed the appeal. This case was remanded to the Commission pursuant to the Circuit Court order.

The Commission notes the holding in *Terry Noonan v Illinois Workers' Compensation Commission*, 2016 IL App (1st) 152300WC. "Where a cause is remanded by a court of review to a lower court with directions to enter a certain order or decree, the latter court has no discretion but to enter the decree as directed." *Id.*, internally citing *Northwestern University, v. Industrial Comm'n*, 409 Ill. 216, 219, 99 N.E.2d 18, 20 (1951) and *People ex rel. Campo v. Matchett*, 394 Ill. 464, 469, 68 N.E.2d 747, 749 (1946). Accordingly, while the Commission remains skeptical of the claimant's credibility, the Commission finds accident (and notice thereof) as ordered by the Circuit Court.

Medical expenses incurred by the claimant were originally ordered by the Arbitrator to the extent of $28,609.35 ($3,285.00 from Bone & Joint Physicians and $25,224.35 from Ingalls Memorial Hospital; see PX3). While the circumstances of the injury were in dispute, no evidence disputing the reasonableness and necessity of the medical care obtained is evident. Accordingly, the respondent is ordered to satisfy these charges subject to the limits of Sections 8(a) and 8.2 of the Act. The claimant further requested ongoing medical care. The Commission notes a prescription for eight sessions of physical therapy (twice per week for four weeks; see Dr. McClellan's 3/19/14 office note). The respondent is ordered, subject to the limits of Sections 8(a) and 8.2 of the Act, to pay incurred medical bills associated with those therapy sessions.

With regard to TTD, the Commission again notes a discrepancy between the respective parties' introduction of the records from Bone & Joint Physicians. Being certified copies, these exhibits should have been identical, but PX2 includes off work slips and RX3 does not. Moreover, the Commission observes that Dr. McClellan's March 19, 2014 record in RX4 notes the petitioner "was unable to have physical therapy due to his family and domestic situation" whereas Dr. McClellan's March 19, 2014 record in PX2 lacks that phrase and indicates that any problems the claimant may have had regarding obtaining therapy may have been due to insurance coverage disputes. No explanation for these discrepancies is immediately obvious. The Commission finds these discrepancies concerning, but while the respondent correctly notes that the claimant worked full duty for a week after the accident date (and was then terminated for reasons unrelated to physical impairment), there is no contrary medical opinion or indication that the claimant had achieved Maximum Medical Improvement post-operatively. Accordingly, the claimant is deemed eligible for TTD benefits from October 28, 2013 (date of surgery), through April 9, 2014 (date of trial). This is a total period of 23 & 1/7 weeks of TTD.

17IWCC0352

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $382.67 per week for a period of 23-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $28,609.35 for medical expenses under §8(a) of the Act, subject to the limits of Section 8.2 of the Act. The respondent shall further pay the expenses related to the prescribed medical expenses as discussed in the above decision, as they appear reasonably medically necessary to cure or relieve the claimant's medical condition pursuant to Section 8(a) of the Act, subject to the limits of Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980), but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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 $37,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 12 2017

Joshua D. Luskin

o-06/07/17
jdl/ac
68

L. Elizabeth Coppoletti

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Donovan,
Petitioner,

vs.

NO: 14 WC 08970

Illinois Bell Telephone Co D/B/A AT&T,
Respondent.

17IWCC0340

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, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 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.

JUN 1 - 2017

DATED:
o051817
DLG/mw
045

David L. Gore

Stephen Mathis

Deborah Simpson

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

DONOVAN, MICHAEL
Employee/Petitioner

Case# **14WC008970**

ILLINOIS BELL TELEPHONE CO D/B/A AT&T
Employer/Respondent

17IWCC0340

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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17IWCC0340

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

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

Michael Donovan
Employee/Petitioner

v.

Illinois Bell Telephone Co., d/b/a AT&T
Employer/Respondent

Case # **14** WC **8970**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **September 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. [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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, January 30, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding these injuries, Petitioner earned $47,840.00; the average weekly wage was $920.00.

On this date of accident, Petitioner was 59 years of age, *married* with no dependent children.

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

Respondent shall be given a credit for $0 for TTD, $0 for TPD, $0 for maintenance, and as agreed for other benefits (i.e., non-occupational indemnity disability benefits), for a total credit as agreed[1].

As agreed, Respondent is entitled to a credit for all bills paid through its group medical provider ($89,414.41 BCBS;$83,440.72 BCBS; $22,833.27 Arcadia Health) under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury on January 30, 2014 or any causal connection between the alleged injury at work and any ongoing condition. By extension, all other issues are rendered moot and all requested compensation and 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

November 16, 2016
Date

NOV 2 8 2016

ICArbDec19(b) p. 2

[1] The parties stipulated on the Request for Hearing form as follows: **"The parties stipulate that Petitioner has been paid non-occupational indemnity benefits to which Respondent is entitled to a Credit under Section 8(j) of the Act, in the event of an adverse decision."** AX1.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
19(b) & 8(a)

Michael Donovan
Employee/Petitioner

v.

Illinois Bell Telephone Co., d/b/a AT&T
Employer/Respondent

Case # 14 WC 8970

Consolidated cases: N/A

FINDINGS OF FACT

The issues in dispute include whether Petitioner sustained a compensable accident on January 30, 2014, whether Petitioner provided proper notice, whether there is a causal connection between Petitioner's current condition of ill being and his alleged accident, whether Respondent is liable for payment of certain medical bills, whether Petitioner is entitled to temporary total disability benefits commencing on February 21, 2014 through September 22, 2016, whether Petitioner is entitled to prospective medical treatment in the form of ongoing pain management, and whether Respondent is liable for penalties and fees pursuant to Sections 19(k), 19(l) and 16 of the Illinois Workers' Compensation Act ("Act"). Arbitrator's Exhibit[2] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background & Prior Medical Treatment

Michael Donovan (Petitioner) testified that he was employed by AT&T (Respondent) on January 30, 2014 as a Premises Technician and had been so employed for approximately three years in that capacity. He was originally hired on June 15, 2001. Petitioner explained his job duties to include installing and repairing the "U-verse" television and internet system. In so doing, he could be working on telephone poles or in backyards and crawl spaces, etc.

Petitioner testified that he had no prior incidents or accidents involving his cervical spine, but did have some prior medical treatment including cervical spine injections in 2012 – 2013. Petitioner testified that he was able to return to his regular job duties and perform his work thereafter. Also, Petitioner testified that no doctor had recommended a cervical spine fusion prior to his alleged date of accident. He explained that, prior to January 30, 2014, any symptoms including soreness and stiffness related to his cervical spine were remedied by a couple of Tylenol pills.

The medical records reflect that Petitioner saw John Prunskis, M.D. (Dr. Prunskis) between February 14, 2012 and July 9, 2013. RX2. At his initial visit on February 14, 2012, Petitioner reported "a chief complaint of pain principally between his shoulder blades and neck area, left greater than right. He also has pain in his lower back as well. His lower back pain is more in the middle. He describes the pain as burning and spasm. He also feels some lightheadedness when he moves his head. Pulling his shoulders back makes the pain better. Bending forward makes the pain worse. The pain is about an 8 out of 10. He can only walk about five minutes before he must stop due to the pain. It is difficult for him to do and be engaged in work." *Id.* Dr. Prunskis noted that Petitioner had cervical disc disease and osteophytes in the cervical spine as well as cervical facet arthropathy. *Id.* Dr. Prunskis also noted myofascial pain of the rhomboid muscles medial to both scapulae and the left

[2] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

trapezius muscle. *Id.* Dr. Prunskis ordered a cervical spine injection. *Id.*

Dr. Prunskis then ordered and administered epidural steroid injections, facet joint injections, nerve branch blocks, and radiofrequency ablations in the cervical spine. RX2. At Petitioner's last visit with Dr. Prunskis on July 9, 2013, Petitioner reported that he was feeling greater pain on the right side of his neck after his last left cervical radiofrequency ablation. *Id.* Petitioner was instructed to return after a lumbar MRI for a low back condition. *Id.*

January 30, 2014

Petitioner testified that he was working as a Premises Tech for Respondent in Pingree Grove, Illinois on January 30, 2014. He testified that he was driving westbound on Route 20 traveling 45-50 mph slowing down for a curve in the road. Then, Petitioner testified the wind came up and all he could see in front of him was two headlights coming toward him. So, Petitioner testified that he moved over to the right to avoid the accident and the next thing he knew he was being bounced all over the inside of the cab as he went off the road and came to a sudden stop in a ditch. Petitioner described the bouncing around to be "almost like sitting on a bronco buck where you were going one direction and the next and trying to hold yourself in place. I had my foot buried on the brake pedal. I was trying to hang on and keep the brakes applied and just, you know, being tossed around."

Petitioner testified that he experienced something like an adrenaline rush and was not too sure about what happened until it was over. He was a little shaken up and stiff, but thought he would be okay. Petitioner described the weather conditions on January 30, 2014 to be extremely windy and snowy.

Following the incident, Petitioner testified that he called Eric White (Mr. White) and told him that he went off in a ditch to avoid a head-on accident and that he needed a tow truck. He testified that Mr. White told him to call "fleet services" to have his truck towed and put back on the road. On cross-examination, Petitioner testified that it was the tow truck driver who told him not to stay on route 20 and to pull into the lot because there was so much traffic.

Petitioner testified that he call fleet services and, quite some time later, a tow truck arrived. Then, Petitioner testified that after his vehicle was towed out of the ditch, he drove straight down the road to get it off of the curve in the road and pulled into the lot at the police station. Petitioner described that he could barely get the truck turned into the lot.

Petitioner explained that he inspected the vehicle and was going to make a police report, but then Mr. White showed up in the parking lot. He testified that did not submit a police report because Mr. White looked at the truck and said there was no damage and suggested that he go on with his day. Then, Mr. White left and Petitioner tried to drive the truck, but he could not steer it. So, Petitioner testified that he called Mr. White back to which Mr. White told him to call the tow truck back and have the truck towed to the garage. Petitioner testified that the tow truck came back.

The following day, on January 31, 2014, Petitioner testified that he reported for work and requested that an accident report be completed. Petitioner testified that he went to give Mr. White the red book that he (Petitioner) had filled out and he asked Mr. White to fill out an accident report. According to Petitioner, Mr. White said that there was no damage to the truck and if it was under $500, there was no accident so he did not need a right book and further stated that as far as he was concerned Petitioner could shred or throw out the red book. See RX3 (blank red book). Petitioner testified that there is a garbage can with a slit in it that is locked for personal information to be shredded.

Petitioner testified that he was not allowed to fill out any type of accident or incident report on that date. Petitioner also testified that his truck was in the garage on January 31, 2014. There was a note inside the truck for him from the mechanic indicating that the truck was ready to go. He explained that "[i]t had to thaw out overnight because the engine compartment was packed with snow."

On cross-examination, Petitioner testified that he is familiar with Respondent's policies and procedures requiring him to notify his manager of a work injury. He also acknowledged that if his own manager was not available, should notify another manager. Petitioner testified that he had a prior workers' compensation claim against Respondent, which was settled.

February 14, 2014

On cross-examination, Petitioner testified that he was working on February 14, 2014. He had previously requested an accommodation from Respondent with respect to blood pressure or stress issues so that he did not have to work extra overtime.

Petitioner acknowledged that he was involved in a verbal altercation with Louis Sacco (Mr. Sacco), his on-duty manager, on February 14, 2014 regarding leaving work early that day. Petitioner did not remember whether he used profanity, although he said it was possible, and did not remember if he was upset with Mr. Sacco because he was not being given an accommodation with regard to the number of hours that he was supposed to work, but said that was also possible.

Later, however, Petitioner testified that he did not recall the verbal altercation with Mr. Sacco. He also did not recall contacting Mr. White after the discussion with Mr. Sacco, or whether there was any reason to feel that his job might be in jeopardy.

February 15, 2014

Petitioner testified that he continued to work for Respondent through February 15, 2014. During that time, he testified that he noticed that his cervical spine was getting "sorer and sorer every day." He explained that the soreness was on the left side of his neck and he could barely turn his neck to the left. Petitioner testified that he used the same work truck between January 31, 2014 and February 15, 2014.

Petitioner testified that he was at work on February 15, 2014 and he experienced stroke-like symptoms. He testified that he understood that he had a stroke, but does not remember experiencing it and did not recall much of this day.

On cross examination, Petitioner acknowledged that the first time he went for medical care and treatment after the accident on January 30, 2014 was February 15, 2014. Petitioner explained that he did not recall much from this day, but testified that his wife says that he called her that day.

The medical records reflect that Petitioner was admitted in the emergency room at St. Alexius Medical Center on February 15, 2014. PX1 at 3-4. Petitioner was referred for a neurologic consultation from the emergency room because of a stroke alert called for acute stroke, which was performed by Daniele Anderson, M.D. (Dr. Anderson). *Id.* Dr. Anderson noted that Petitioner the following history:

> The patient is a 59-year-old gentleman with a history of a previous stroke in February 2012, at which

time he was seen at Alexian Brothers Medical Center. He reports similar stroke symptoms at that time with left-sided weakness in speech difficulty. The patient also has a history of diabetes mellitus, hypertension, hyperlipidemia, hyperthyroidism, and depression. The patient was home with his wife this morning. She left the house at 7:15, and he was in a normal state of health. The patient's wife attempted to call him on the telephone as the patient was driving to work sometime before 9:30 this morning, and the patient's wife noted that the patient had difficulty attempting to speak with some slurred speech. She told him to pull his car over and was able to communicate with him enough to find out where he was. She called 911 and paramedics arrived. They brought this patient to St. Alexius Medical Center as a stroke alert.

When the patient arrived at St. Alexius, he had dysarthria, as well as mild left-sided weakness of the arm. He reported tingling and numbness of the left face, arm, and leg. His NIH Stroke Scale Score was 5. The patient was considered for intravenous tPA. A CT scan of the brain showed no acute abnormality. The patient met all criteria for administration of intravenous tPA, and this was administered at 10:10 a.m. So far, the patient has shown some improvement, as he can now speak more clearly. He does still have some mild left arm weakness, and here ports numbness and tingling in the left face, arm, and leg.

Testing at this point includes a CT of the head showing no acute abnormality. His CBC is normal, coagulation profile is normal, CMP shows glucose 142, otherwise normal.

Id. After a physical examination, Dr. Anderson diagnosed Petitioner with stroke or transient ischemic attack causing initially dysarthria and left-sided weakness and numbness of the face and arm, possibly leg. *Id.* She ordered following stroke protocol, MRIs of the brain and cervical spine, MRAs of the head and neck, a 2-D echocardiogram, and therapies and labs per stroke protocol. *Id.*

Petitioner underwent the recommended diagnostic tests. Petitioner's cervical MRA was unremarkable. *Id.*, at 16. The intracranial MRA, which was compared with one from February 5, 2012, was also unremarkable. *Id.*, at 17. Petitioner's brain MRI showed non-specific white matter disease which may represent chronic small vessel ischemic change and no acute intracranial abnormality or evidence of acute infarction. *Id.*, at 17-18. The plain head CT was negative. *Id.*, at 23.

Petitioner's cervical spine MRI showed: (1) severe spinal stenosis with narrowing of the bilateral neuroforamina at C5-C6 and C6-C7 with no significant change from prior study on March 13, 2012 and no evidence for cord compression; (2) posterior disc bulge resulting in moderate spinal stenosis at C3-C4; and (3) a posterior disc bulge resulting in moderate spinal stenosis at C3-C4 and C4-C5 which are new findings since his prior exam on March 13, 2012 with no evidence for cord compression. *Id.*, at 19-20.

On February 18, 2014, Reinhold Llerena, M.D. (Dr. Llerena) noted Petitioner's follow up after his hospitalization for possible stroke on February 15, 2014. PX1 at 12-15. Dr. Llerena noted his review of Petitioner's diagnostic test results from the emergency room at St. Alexius Medical Center and diagnosed Petitioner with spinal stenosis in the cervical spine with severe restriction of extension, no evidence for CVA, and he noted this could be the cause of his symptoms. *Id.* He referred Petitioner for a neurosurgical consultation. *Id.* Petitioner testified that Dr. Llerena indicated that he did not sustain a cerebral accident or TIA, and referred him to neurosurgery for treatment.

Petitioner's Return to Work

On cross examination Petitioner testified that he returned to work on February 20, 2014 and reported to his supervisor, Mr. White. The following day, February 21, 2014, Petitioner testified that he attended a disciplinary

meeting with Mr. White, Mr. Sacco, and a representative from his union. The purpose of the meeting was to discuss the altercation between Petitioner and Mr. Sacco on February 14, 2014 and Petitioner testified that he was told that he threatened Mr. Sacco, which he did not recall. Petitioner understood that allegations were being raised against him, but he testified that he was in so much pain that he finally told them that he was going to see a doctor because his neck hurt.

On re-direct examination, Petitioner testified that no discipline resulted from the meeting. On re-cross examination, Petitioner testified that he has not been back to work since this meeting.

Continued Medical Treatment

Petitioner saw Bryan Bertoglio, M.D. (Dr. Bertoglio) on February 21, 2014. PX1 at 43-53, 66-69. He completed a form entitled "Spine Patient Health Assessment Form[.]" PX1 at 47-53. In response to a question whether the problem was associated with an injury, Petitioner described the injury as follows: "PUT WORK TRUCK IN DITCH TO AVOID HEAD ON ACCIDENT[.]" *Id.*, (EMPHASIS in original). Dr. Bertoglio noted the following history:

> Michael is a 59yo RHD mail who presents today for evaluation of severe neck pain. He has a h/o bilateral UN transposition, bilateral carpal tunnel release, and bilateral radial nerve decompression between 2004-2005 with supposed electrophysiologic resolution on post-procedure EMG per pt. He noted partially subjective improvement postoperatively as well. His residual UE symptomatology as well as his neck pain has been severely exacerbated by a MVA 2-3 weeks ago when he drove into a ditch to avoid a head-on collision with an errant vehicle. He will be filing work comp.
>
> He describes a constant aching and sharp neck pain into the upper thoracic spine. It radiates into the bilateral scapula and shoulders, as well as down the left posterolateral upper arm. He also note paresthesias of the left UE below the elbow. L>>>>R UE. His pain is provoked by any cervical ROM as well as general activity. He denies alleviative factors.
>
> He denies imbalance. No bowel or bladder difficulty.
>
> He has undergone conservative measures over the years, including PT and the procedures as noted above. He is under the care of Dr Prinskis who performs injections on a regular basis. He last underwent a radiofrequency ablation in 08/2013. He has had no new injections since the MVA.

PX1 at 43-46. In pertinent part, Dr. Bertoglio diagnosed Petitioner with an acute cervical strain, chronic cervical pain, and severe cervical stenosis at C5-C6 and C6-C7. *Id.* Dr. Bertoglio noted his review of Petitioner's films and that "[Petitioner] had a preexisting condition of cervical stenosis which has been secondarily exacerbated by the recent MVA. It is therefore felt beyond a reasonable degree of medical certainty to be a work related injury via indirect mechanism. Due to the severity of stenosis is recommended that the pt undergo cervical decompression with an ACDF C5-6/C6-7. His symptoms are multifactorial, which makes complete relief uncertain, but the severity of stenosis alone warrants surgical decompression." *Id.* Petitioner was placed off of work. PX1 at 70.

On February 24, 2014, Petitioner saw Dr. Llerena for pre-operative clearance for the scheduled cervical spine surgery with Dr. Bertoglio. PX1 at 9-11. Dr. Llerena diagnosed spinal stenosis in the cervical spine with severe restriction of extension, no evidence for CVA, and he noted this could be the cause of his symptoms. *Id.*

On February 27, 2014, Petitioner underwent the recommended surgery with Dr. Bertoglio. PX1 at 64-65. Pre-

and post-operatively, Dr. Bertoglio diagnosed Petitioner with C4-C5, C5-C6, and C6-C7 cervical spondylosis and stenosis with myelopathy and radiculopathy. *Id.* He performed the following procedures: (1) C4-C5, C5-C6, and C6-C7 intercervical discectomy and fusion with microdissection with the operating microscope, structural allograft, and instrumentation; and (2) intraoperative fluoroscopy, electromyogram, and somatosensory evoked potentials monitoring. *Id.*

Petitioner was discharged from the hospital on March 1, 2014 with a diagnosis of cervical spinal stenosis and spondylosis with myelopathy and radiculopathy post C4-C7 surgery with discectomy and fusion. PX1 at 62-63. The attending physician, Taeksoo Shin, M.D. (Dr. Shin) noted Petitioner had a "questionable history for CVA. He had similar symptoms 2 years ago, but MRI was negative according to the patient. He has hypertension, depression, and thyroid disease , and history of diabetes." *Id.*

Petitioner saw Dr. Llerena on March 18, 2014 reporting that he felt a little better. PX1 at 9, 26-28. Dr. Llerena noted that Petitioner's headaches were much improved after the surgery and instructed him to follow up with Dr. Bertoglio as well. *Id.* Petitioner was kept off of work. PX1 at 73. Dr. Bertoglio also kept Petitioner off of work at his follow up visits on April 15, 2014 and May 27, 2014. PX1 at 74-75.

On June 2, 2014, Petitioner returned to Dr. Llerena reporting severe pain, unusual symptoms including sensation of shortness of breath when he bends forward in a certain way, and mild dizziness. PX1 at 28-30. Dr. Llerena diagnosed cervical spine stenosis noting that Petitioner would undergo an MRI under anesthesia that week. *Id.* He also diagnosed Petitioner with headaches noting Petitioner's complaint of constant pain mainly in the back of the head, which had improved somewhat after using the cervical collar, but subsequently returned. *Id.*

On September 11, 2014, Petitioner saw Lukasz Chebes, M.D. (Dr. Chebes) at Alexian Brothers Medical Center for pain management. PX11 at 1-4. Petitioner reported persistent neck and radicular pain after his surgery with no significant relief from a cervical epidural steroid injection on August 20, 2014. *Id.* Dr. Chebes diagnosed Petitioner with cervicalgia, for which he prescribed narcotic pain medications, and cervical radiculitis. *Id.* On September 19, 2014, Petitioner underwent an interlaminar cervical epidural steroid injection with Dr. Chebes. PX11 at 6-7. On October 2, 2014, Petitioner returned to Dr. Chebes reporting 30% relief after his recent injection. PX11 at 9-12. Petitioner received another interlaminar cervical epidural steroid injection performed by Dr. Chebes on October 17, 2014. PX11 at 12. On October 30, 2014, Petitioner reported to Dr. Chebes approximately two weeks of relief after his recent injection. PX11 at 13-16. He also reported "new upper thoracic pain just below the fusion without radiation." *Id.* Dr. Chebes added a diagnosis of thoracic spine pain and ordered a thoracic MRI. *Id.*

Petitioner underwent the recommended thoracic MRI on November 7, 2014. PX11 at 16-17, 25-26. The interpreting radiologist noted mild degenerative anterior marginal osteophyte formation in the mid-and lower thoracic spine with no central canal or neuroforaminal stenosis at any thoracic level. *Id.*

On November 13, 2014, Dr. Chebes noted that there was no significant upper thoracic finding in Petitioner's recent MRI and he recommended cervical nerve blocks. PX11 at 18-20. On December 5, 2014, Dr. Chebes performed bilateral diagnostic medial branch nerve blocks at C4, C5, C6, and C7. PX11 at 21-22.

Records Review – Dr. Mirkovic

On January 6, 2015, Srdjan Mirkovic, M.D. (Dr. Mirkovic) issued a report at Respondent's request rendering opinions regarding the relatedness, if any, of Petitioner's medical conditions to his alleged accident at work. RX1. He reviewed Petitioner's treating medical records from St. Alexius Medical Center, Dr. Bertoglio, Illinois

Pain Institute (Dr. Prunskis), Dr. Llerena, Dr. Chebes, Dr. Anderson (neurology), Petitioner's cervical MRIs of February 4, 2012, October 9, 2012 and February 15, 2014, Petitioner's November 7, 2014 thoracic MRI, Petitioner's February 27, 2014 surgical report, and a post-surgical report dated February 31, 2014. *Id.*

Dr. Mirkovic opined that the events on January 30, 2014 did not cause, aggravate, accelerate or exacerbate Petitioner's pre-existing degenerative condition in the cervical spine or his long-lasting pre-existing chronic neck pain. *Id.* He also opined that the events of January 30, 2014 did not cause Petitioner's need for surgical intervention. *Id.*

In so concluding, Dr. Mirkovic indicated that Petitioner had a clearly documented history of chronic neck pain going back as far as 2007, which continued to be symptomatic in 2008. *Id.* He noted that in 2012, Petitioner underwent aggressive, non-operative pain management treatment with Dr. Prunskis that extending into 2013 during which Petitioner underwent 25 cervical spine injections without improvement. *Id.* Dr. Mirkovic also noted Petitioner's complaints of pain at levels of 8/10 or 9/10 at visits with Dr. Prunskis on February 4, 2012 and June 18, 2013. *Id.* Petitioner's records also showed that Petitioner underwent epidural steroid injections, cervical facet injections, cervical median nerve branch blocks, and cervical rhizotomies. *Id.* Dr. Mirkovic noted that "[t]he extent and aggressive nature of the nonoperative care that [Petitioner] underwent during that period of time, without significant improvement, also emphasizes the inability to identify a clear pain generator, to explain the patient's symptoms." *Id.*, (emphasis in original).

Dr. Mirkovic further noted that, based on his understanding that Petitioner's "vehicle was traveling at approximately 5 to 10 miles per hour, due to traffic, secondary to the snow… the patient's vehicle got stuck in the snow and that subsequently, there was no evidence of damage to the vehicle. The mechanism of the events described would not have been of sufficient magnitude to permanently cause, aggravate, accelerate or exacerbate [Petitioner's] pre-existing chronic cervical condition." *Id.* Dr. Mirkovic indicated that Dr. Llerena's February 18, 2014 noted post-hospitalization for a stroke work-up reflects that Petitioner did not present with complaints of increased neck pain or any new clinical or neurological findings in relation to the cervical spine. *Id.* He also noted, among other significant findings in Petitioner's medical records, that Petitioner's February 15, 2014 cervical MRI was compared to the prior March 13, 2012 cervical MRI and the comparison did not show any structural change at C5-C6 or C6-C7, cord compression, which is consistent with a lack of clinically objective findings to suggest an ongoing cervical myelopathy to explain Petitioner's symptoms or a clear pain generator, and only showed moderate changes from C3-C4 and C4-C5, which was more likely than not progressive degeneration. *Id.*

Continued Medical Treatment

On January 12, 2015, Petitioner reported 75% improvement after his December 19, 2014 left atlantoaxial joint injection with remaining upper neck pain radiating to the cervical, but no radiation down the arm. PX11 at 27-30. He also reported that his lower neck pain remained resolved after his nerve blocks. *Id.*

Petitioner did not return to Dr. Chebes until March 11, 2016 for injections and Dr. Chebes noted Petitioner's report of 70% improvement thereafter at a follow up visit on March 24, 2016. PX11 at 31-36. He returned on April 12, 2016 at which point Dr. Chebes noted that Petitioner's cervicalgia was stable and decreased Norco was indicated. PX11 at 36-40.

On May 13, 2016, Petitioner saw Dr. Bertoglio reporting continuing pain in the upper-mid cervical region to the base of her neck on the left, and he began complaining of dizziness, dimming vision, and presyncope when turning his head in certain positions. PX11. Dr. Bertoglio noted that this was concerning for dynamic posterior

circulation compromise as assessed by Dr. Aranas. *Id.* Dr. Bertoglio diagnosed Petitioner with possible dynamic vertebral artery compression, C3-C4 spondylosis, and adjacent segment degeneration status post C4-C7 ACDF symptomatic with pain. *Id.* He recommended a dynamic angiogram and reviewed the case with another physician, Dr. Malisch. *Id.* Dr. Bertoglio indicated that if dynamic compromise was demonstrated at C3-C4, or no dynamic compromise was identified, then he would consider a C3-C4 ACDF for radicular pain and degeneration or at a different level if dynamic compression was identified. *Id.*

Petitioner returned to Dr. Bertoglio on June 10, 2016. PX11. Dr. Bertoglio noted that Petitioner's dynamic angiogram ruled out VA compression with head position, but Petitioner continued to report pain in the neck to the proximal shoulders/base of the neck posteriorly without significant change. *Id.* He diagnosed Petitioner with C3-C4 spondylosis/stenosis from adjacent segment degeneration. *Id.* Dr. Bertoglio discussed the option of another surgery vs. further pain management and noted that Petitioner would be considering his options including treatment with another pain management specialist since Dr. Chebes was leaving the practice. *Id.*

On July 13, 2016, Petitioner saw Arpan Patel, M.D. (Dr. Patel) for neck pain, upper back pain, and bilateral shoulder pain. PX11. Dr. Patel recommended a C4-C5 epidural steroid injection followed by dual diagnostic medial branch blocks at the two, C3, and C4 to determine if facet arthropathy is resulting in Petitioner's occipital headaches. *Id.* He also recommended considering radiofrequency ablation and trigger point injections to address the myofascial component of Petitioner's neck pain. *Id.*

Eric Steven White

Eric White (Mr. White) testified that he is employed by Respondent as a Senior Technical Professional Process and Quality Manager (Manager). He has been employed by Respondent for 16 years. On cross examination, Mr. White testified that he began working in this position at the end of March of 2014, which was a lateral move. Previously, Mr. White was a Manager of Network Services.

Mr. White testified that he is familiar with Petitioner, who was employed by Respondent from January of 2013 through March of 2014. Mr. White explained that he was Petitioner's supervisor.

Mr. White testified that there were severe snow storms and white-out conditions on January 30, 2014. He sent Petitioner out to work on this date and did not have any conversation with Petitioner until later in the day at approximately 11:30 a.m. or 12:00 p.m. Mr. White explained that he received a call from Petitioner while he (Mr. White) was at another location with another technician. Mr. White testified that he answered the call and the person calling identified himself as Petitioner. Mr. White testified that Petitioner told him that he had an incident regarding his vehicle. According to Mr. White, Petitioner told him that he had a car coming into his Lane as he was approaching a turn on route 20 and, to avoid a collision, Petitioner decided to go toward the right hand shoulder that had snow in it and he was stuck in the snow. Mr. White responded by asking Petitioner whether he was ok, to which Petitioner responded that he was. Mr. White testified that he asked whether everyone else was ok, to which Petitioner replied that there were no other vehicles involved, but he was unable to get out of the ditch. Mr. White told Petitioner to call "fleet," Respondent's automobile repair maintenance department.

Mr. White testified that he told Petitioner to have fleet pull him out of the ditch then, if it was possible to drive the vehicle, to go down the block to find a side-street parking lot or something and to stay out of traffic. Mr. White testified that he told Petitioner that he would then be there.

When Mr. White arrived, he testified that he found Petitioner in the parking lot of the Pingree Grove fire

house/police station. Mr. White testified that he saw the truck and Petitioner. He asked Petitioner again if he was ok, to which Petitioner responded, yes, that he had a little bit of a rush.

Mr. White testified that they looked at the vehicle and he asked Petitioner if anything was wrong with the vehicle. According to Mr. White, Petitioner responded that when the tow truck pulled him out of the ditch, he drove the truck in a straight line and there was something funky with the steering of the vehicle. Mr. White testified that he did not observe any damage to the vehicle. Next, he and Petitioner popped the hood of the vehicle and looked in the engine compartment, tire wells, and the whole front end of the vehicle where there was snow. Mr. White testified that he told Petitioner that since the vehicle could not be driven that he should call fleet and have it towed to the Elgin garage, where both he and Petitioner worked.

Next, Mr. White testified that an hour or so went by and he received a phone call from Petitioner. According to Mr. White, Petitioner stated that the mechanic looked at the vehicle and the issue was that the snow built up in the suspension area causing it to drive funny. Mr. White testified that he sent Petitioner back out to work in the same vehicle.

Mr. White was presented with Respondent's Exhibit 3, which is a blank booklet entitled "Motor Vehicle Accident Report." RX3. Mr. White testified that this form is used when a motor vehicle accident occurs with damage to Respondent's vehicle, a non-company vehicle, or any non-company property. He testified that they are known as "red books." Mr. White testified that these red books are filled out by the vehicle driver. Mr. White testified that Petitioner asked if he could fill out a red book on January 31, 2014 and they discussed that there was no property damage, motor vehicle damage, or non-company vehicle damage so it would be unnecessary to fill one out because there was no accident. Mr. White testified that Petitioner did not give him a filled out red book on January 31, 2014.

On cross examination, Mr. White testified that no pictures were taken of the vehicle on January 30, 2014. He maintained that there was no property damage, company vehicle damage, or no non-company property damage that would require completion of a red book. Mr. White testified that there was no accident. He also maintained that Petitioner did not give him a completed red book and that he did not instruct Petitioner to shred any red book. Mr. White testified that he contacted his supervisor, the area manager, and "because there was no injur[y], no property damage, no company vehicle damage, no non-company vehicle damage, that they considered it an incident and to record it as a non-medical incident."

Mr. White also testified about a "morning tailgate," which is a weekly meeting during which achievements are awarded and important company issues and topics are discussed. All U-verse technicians and managers attend these meetings. Mr. White testified that safety and work-place injuries are also discussed at these meetings. Mr. White explained that there was a morning tailgate on January 31, 2014 at which time he asked Petitioner to speak. Mr. White testified that he asked Petitioner to speak at that morning tailgate because they try to use "near miss incidents" as examples where an accident could occur, such as in severe snowstorm/white-out conditions, and he wanted Petitioner to share his story with the other technicians about how he avoided the accident. According to Mr. White, Petitioner went into detail of exactly what happened with the incident describing that he was driving on route 20 basically in a flat plain area that was very windy going 10 miles per hour because, he believed Petitioner said that, he could not see in front of him more than three feet and as he was coming up to a turn her, he saw headlights and a vehicle approaching his lane at which time he had to decide whether to continue on that path or toward the roadside median. Mr. White testified that Petitioner "ended the meeting saying that he went to the road side. The vehicle did not go back into its lane and with his quick thinking, that he walked away injury free."

Mr. White testified that Petitioner did not report any injury or physical complaints from January 31, 2014 through February 14, 2014 and he continued to work his regular duties operating the same vehicle that went into the ditch on January 30, 2014.

Mr. White explained that Respondent's policy is that once an injury occurs, the employee is supposed to notify the supervisor immediately or, if unavailable, another supervisor. Mr. White testified that if Petitioner had reported a workplace injury, Mr. White would have reported it in the Safety Injury Reporting (SIR) system. Mr. White testified that in his capacity as a manager, he has reported four workplace accidents in 18 months and he has never deviated from this process. On cross examination, Mr. White testified that the 18 month period was while he was a Manager of Network Services. He also testified that none of the metrics on which manager bonuses are based are attributable to safety. Rather, Mr. White testified that managers receive bonuses based only on efficiency, productivity, and dispatch efficiency metrics as well as attendance and whether his employed complete their training courses, etc.

Mr. White also testified that regarding the incident between Petitioner and Mr. Sacco on February 14, 2014. Mr. White testified that Mr. Sacco is a member of Respondent's management as of September of 2013. On February 14, 2014, Mr. Sacco was the Duty Manager after 4:00 p.m., which is the person that all technicians can contact after 4:00 p.m. with any work-related issues or questions. Technicians call also contact the duty manager to see if all work is completed that day.

On February 14, 2014, Mr. White testified that he left work at approximately 3:45 p.m. After leaving work, Mr. White testified that he did not have any contact with Petitioner other than a voicemail received on his company cell phone. Mr. White testified that Petitioner stated that he had an argument with Mr. Sacco and that he was probably going to lose his job and he also heard laughter as Petitioner hung up the phone. Mr. White testified that he tried to contact Petitioner, but the call went directly to voicemail so he then called Mr. Sacco. The following day, on February 15, 2014, Mr. White testified that Petitioner was working and subsequently stopped working because he understood that Petitioner possibly had a stroke. Petitioner did not return to work until February 20, 2014. On cross examination, Mr. White testified that he did not receive any paperwork regarding a stroke, but Petitioner provided a medical note stating that he was cleared for work.

On February 21, 2014, Mr. White testified that he had a meeting with Petitioner, Mr. Sacco and the union steward, Ed Bash (Mr. Bash) at approximately 8:15 a.m. The meeting took place in the sub-office at the Elgin garage and was in reference to Petitioner's actions on February 14, 2014 with Mr. Sacco. Mr. White testified that the meeting was an investigation into insubordination and violence in the work place. Mr. White testified that Petitioner seemed upset, stared at Mr. White during the whole meeting, and he did not want to answer questions. There was also argument among the meeting attendees. Mr. White testified that the meeting ended with Petitioner and the union steward, Mr. Bash, stating that they needed a couple of minutes after which they left the room. Mr. White testified that five minutes later Petitioner told him that he was leaving work, that they were causing him stress, and that he'd had it. According to Mr. White, Petitioner did not give any other reason.

On cross examination, Mr. White testified that no formal action has been taken because Petitioner has not returned to work. On re-direct examination, Mr. White explained that the collective bargaining agreement requires involvement by several departments and completion of investigation. As of February 21, 2014, Mr. White testified that Petitioner's work status was pending an investigation of a suspension pending termination. The investigation has not been concluded because Petitioner has not returned to work.

Mr. White maintained that Petitioner made no reports of work injuries whatsoever. Mr. White also testified that if an employee came to him with a completed red book, and it was refused, then that employee would likely

report it to the union steward. Mr. White denied that he ever told any employee to throw out a completed red book.

Then on March 3, 2014, Mr. White testified that he received a call from an unknown number and a woman identified herself as Terry, Petitioner's wife. Mr. White testified that Mrs. Donovan told him that she was having trouble submitting a workers' compensation claim to the claim department. Mr. White asked Mrs. Donovan why Petitioner was not making the claim himself. He also asked Mrs. Donovan when Petitioner was hurt, to which she responded that Petitioner "can't call and that [Petitioner] really hurt himself on January 30th but he didn't want to let you know." Mr. White testified that he told Mrs. Donovan that he would contact the claim department after he contacted his supervisor, and did so.

Louis Sacco

Louis Sacco (Mr. Sacco) testified that he is employed by Respondent as an Internet Entertainment and Field Services (IEFS) employee. Mr. Sacco was Petitioner's manager in this role, and had been so employed for three years since September of 2013. On cross examination, Mr. Sacco testified that while he was previously a technician working with Petitioner he was also a garage union steward and elected chairman.

On February 14, 2014, Mr. Sacco was a manager in Petitioner's garage. He testified that on February 14, 2014 he was the Evening Duty Manager, which is the manager that takes responsibility at 4:00 p.m. to ensure that the work is covered and all technicians are out of the field safely at the end of the evening. On this evening, Mr. Sacco testified that he received a voicemail from Petitioner on his company cell phone between 5:00 p.m. and 6:00 p.m. Mr. Sacco testified that he did not listen to the voicemail, but returned Petitioner call. On cross examination, Mr. Sacco testified that he was at home at that point because he had been at work since 7:00 a.m. that day and there is a rotation between the 11 managers to be the evening duty manager on any given day.

Mr. Sacco described the phone conversation. He testified that he asked Petitioner what was going on and apologized for missing his phone call. Mr. Sacco responded, "[n]othing. I'm going home." Mr. Sacco asked Petitioner what the process was going home at the end of the evening to which Petitioner responded "[t]o contact the duty manager and I did that, and you did not answer your [expletive] phone." He testified that he then asked Petitioner what he was supposed to do if he could not get a hold of the duty manager, to which Petitioner responded "that he had called [Mr. Sacco and Mr. Sacco] did not do [his] job as the duty manager and he was [expletive] going home." Mr. Sacco testified that he apologized to Petitioner explaining that he was on the phone with another technician at the time returning his call as quickly as he could. Mr. Sacco added that he asked Petitioner "[j]ust to make sure we're clear, what is the expectation for going home at the end of the evening[?]" According to Mr. Sacco, Petitioner "told [him that] he was not going to answer any more of [his expletive] duty questions."

Mr. Sacco testified that he asked Petitioner to please stop swearing at him at which point Petitioner said "when [Mr. Sacco] first got promoted into the garage, [Petitioner] tried to have everybody get along with [Mr. Sacco]. Now, he's going to have everybody turn [their backs] on [Mr. Sacco]." Mr. Sacco testified that he told Petitioner that he understood his feelings to which Petitioner responded "[t]his is why I want to leave the [expletive] garage because you're an [expletive] manager on a power trip." Mr. Sacco testified that he reiterated that he understood Petitioner's feelings but wanted to make sure that they were clear on the expectation. According to Mr. Sacco, Petitioner proceeded to talk and swear at him at which point he told Petitioner that if they could not continue the conversation without swearing or raising their voices, he would have to end the conversation. Petitioner then said "[y]ou're the reason for my high blood pressure. I'm going to file EEOCs and lawsuits against you to put your [expletive] on the hot seat." Other than the reference to his high blood

pressure, Mr. Sacco testified that Petitioner did not report any injury.

Mr. Sacco testified that he later received a text from Petitioner's work phone to Mr. Sacco's work phone asking who the duty manager was in Elgin the following day, to which he responded that he (Mr. Sacco) was the duty manager.

Mr. Sacco also testified about a text message exchange with Petitioner on February 15, 2014. Mr. Sacco testified that Petitioner sent him a text message, which stated that he had no "WAP," a wire access point for the wireless set top boxes. Mr. Sacco testified that he asked Petitioner whether anyone had one on their truck, to which Petitioner responded "[n]o[, n]obody has more than one." Mr. Sacco testified that he responded, ok, "[w]hen you need one, we'll cross that bridge when we get there."

Subsequent to this exchange, Mr. Sacco testified that he received a phone call from a woman who identified herself as Petitioner's wife. Mr. Sacco testified that Mrs. Donovan sounded frantic and she asked him whether he had spoken with Petitioner recently, to which Mr. Sacco testified that he spoke with Petitioner about 45 minutes to one hour ago. Mrs. Donovan stated that Petitioner was at the Moretti's parking lot on Route 20 slurring his words and mildly unresponsive. Mr. Sacco asked Mrs. Donovan if she had called 911, which she stated she had. Mr. Sacco testified that he then called Petitioner on another phone and he answered. Mr. Sacco explained that Petitioner was not very responsive and he was slurring his words. Then, Mr. Sacco heard sirens and then some people knocking on Petitioner's vehicle. A couple of seconds later the call ended. Afterward, Mr. Sacco drove to the company vehicle to ensure it was locked and secured and drove to the hospital where Petitioner was received.

At the hospital, Mr. Sacco testified that Mrs. Donovan introduced herself and he asked her how Petitioner was doing after which they went outside to smoke and Mrs. Donovan asked Mr. Sacco if he could drive her back to her car located at the Moretti's parking lot. Mr. Sacco did so.

Mr. Sacco also testified that about a meeting held on February 21, 2014 to discuss what happened on the phone between him and Petitioner. On cross examination, Mr. Sacco testified that he is not aware of any EEOC filing from Petitioner filed prior to February 14, 2014. He denied every telling Petitioner that he could work Petitioner as many hours as he wanted to and that he could work him like a dog.

Theresa Donovan

Theresa Donovan (Mrs. Donovan) testified that she understands that there was an incident where Petitioner's work vehicle went off the road.

Mrs. Donovan testified that she contacted Mr. White on one occasion via telephone on the day that the workers' compensation claim was filed, on or about March 3, 2014. Mrs. Donovan testified that she told Mr. White that they needed to get the workers' compensation claim filed for Petitioner's accident to which Mr. White responded that Petitioner had back problems prior and the accident did not have anything to do with Petitioner's current back problems. Mrs. Donovan responded that if he (Mr. White) would not file the claim, then they would have to do that on their own. She also testified that Petitioner had tried to file the claim 2-3 times and Mr. White completely ignored that part of the conversation. Mrs. Donovan testified that the conversation ended with Mr. White telling her that he would call her back and he did so 20 minutes later with the workers' compensation claim number.

On cross examination, Mrs. Donovan testified that she has been married to Petitioner for 35 years and she was

aware that he was involved in disciplinary action at work involving Mr. Sacco stemming from an incident or altercation. Mrs. Donovan denied that Mr. White asked her why Petitioner did not report the workers' compensation claim himself.

Additional Information

Petitioner testified that from March 1, 2014 to the date of the hearing he has continued to undergo pain management, currently with Dr. Patel. Petitioner has also undergone various injections and pain management modalities. In addition, Petitioner testified that he has had three in-patient stays at medical facilities. He explained that none of his physicians have released him to full duty work or back to work in any capacity. Petitioner has applied for social security disability benefits and he received benefits as of February of 2014. PX7. Petitioner testified that he has not sustained any additional injuries after January 30, 2014.

Petitioner testified that he had not received any temporary total disability payments from Respondent. However, he did receive either short or long term disability benefit payments from Respondent. In addition, Petitioner's medical bills have been paid by Respondent's group health insurance carrier.

Regarding his current condition of ill-being, Petitioner testified that he has limited motion in his neck to the left as well as up and down. He described that some days are good and a couple of hydrocodone tablets are sufficient whereas other days he cannot get out of bed or his recliner because of the discomfort. Petitioner takes up to four hydrocodone tablets per day. He testified that he uses heat packs and tries to do some exercise and as much as he can, but he stops when he feels pain.

On cross examination, Petitioner testified that he has not operated a motorcycle since his accident.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at the hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

Given the totality of this record, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury on January 30, 2014 as claimed. In so concluding, the Arbitrator does not find Petitioner's testimony to be credible, as it is controverted by the testimony of Mr. White and Mr. Sacco as well as unsupported by his reports to his own medical providers. The Arbitrator also finds the opinions of Respondent's records reviewer, Dr. Mirkovic, to be persuasive regarding the cause of Petitioner's cervical condition compared to Dr. Bertoglio. First, the Arbitrator addresses Petitioner's testimony.

Petitioner did not receive any medical treatment for his cervical spine condition until after receiving treatment for stroke-like symptoms on February 15, 2014. The medical records prior to January 30, 2014 reflect that Petitioner's cervical spine condition was severely degenerated. The medical records also reflect that Petitioner did not report that he was in an accident at work on January 30, 2014 while being treated in the emergency room. Mrs. Donovan, who also provided information when Petitioner's history was being taken by the attending physician, did not report any accident at work on January 30, 2014. It was not until February 18, 2014, after Dr. Llerena told Petitioner that he did not suffer from any cerebral event on February 15, 2014 and that his cervical condition likely stemmed from degeneration that Petitioner first reported any traumatic event causing the symptoms in his neck. It is in this context that Petitioner's testimony is considered.

Petitioner also described a more rigorous event when his truck skidded into a ditch on January 30, 2014 than what was described by Mr. Sacco or reflected in the condition of the truck thereafter. Petitioner testified that on January 30, 2014 he was driving his work truck at about 45-50 mph, but slowing down for a curve in the road, when he saw oncoming headlights coming into his lane. He explained that he swerved to avoid an accident ending up in a ditch on the side of the road. Despite the decreasing speed coming up to the curve in the road, Petitioner described that he was bouncing around in the cab of the truck "almost like sitting on a bronco buck[, and...] being tossed around."

However, several facts are undisputed when considering Petitioner's and Mr. White's testimony. Petitioner's work truck had to be retrieved by a tow truck from the ditch and placed back onto the side of the road. Petitioner drove the truck to the parking lot of a police station from where it was towed back to Respondent's garage and repaired. The following morning, on January 31, 2014, Petitioner resumed use of the same truck. There is simply no evidence of any mechanical problems as a result of the January 30, 2014 incident requiring repairs beyond thawing out snow. Petitioner's contention that he was involved in a vehicular incident sufficient to bounce him around the cab of the truck like a bucking bronco at a rate of speed higher than 10 miles per hour is unlikely, but there are other indications in the record that Petitioner's testimony is less than reliable.

According to Petitioner, he was going to file a police report, but did not after speaking with his supervisor, Mr. White, who went to the police parking lot to inspect the truck with Petitioner. Petitioner testified that he completed a red book with details about the accident on January 30, 2014, which he presented to Mr. White the

following day when he asked Mr. White to complete an accident report. At a minimum, Petitioner and Mr. White agree that Mr. White told Petitioner that there was no need to fill out a red book. However, Mr. White repeatedly denied that Petitioner presented him with any red book or that there was any need to fill one out. Petitioner and Mr. White's testimonies, taken together, along with the functionality of Petitioner's truck the morning after the incident on Route 20, support Mr. White's testimony that according to Respondent's policies there was no need to complete a red book because there was no evidence of damage to the truck, Petitioner, or any non-company property or other individual.

Petitioner had also previously filed a workers' compensation claim and was familiar with Respondent's policies regarding such claims. Petitioner asserts that for two weeks after his accident he continued to work despite increasing soreness in the neck through February 15, 2014 to the extent that he could barely turn his neck to the left. This relatively short period of time between the accident, as described by Petitioner, and his first medical treatment of any kind thereafter is not dispositive on the issue of whether Petitioner's alleged trauma in his work truck on January 30, 2014 would be sufficient to cause a compensable aggravation of his already severe cervical spine condition. However, Petitioner's hospitalization for stroke-like symptoms on February 15, 2014 was preceded by an unpleasant conversation with his supervisor, Mr. Sacco, the day before. The history that Petitioner or his wife provided in the emergency room does not refer to any incident in his truck at work on January 30, 2014 or any increased soreness in the neck over several weeks thereafter.

Petitioner followed up with Dr. Llerena on February 18, 2014. He did not report any accident at work at this time. Dr. Llerena diagnosed Petitioner with cervical spinal stenosis with severe restriction of extension and no evidence for CVA, which Dr. Llerena indicated could be the cause of Petitioner's symptoms. Petitioner admitted that he understood from Dr. Llerena that he did not sustain a cerebral accident or TIA. The medical records of Dr. Llerena are devoid of any reference by Petitioner of his reportedly severe neck pain at that time to the events of January 30, 2014. It was only after Dr. Llerena informed Petitioner that the degeneration could be a cause of his symptoms—and after Petitioner's conversation with Mr. Sacco—that Petitioner first reported that the events of January 30, 2014 could have caused his condition and when Petitioner did so on February 21, 2014 it was on the same day that he was told about impending disciplinary action at work.

On February 21, 2014, Petitioner completed a form for Dr. Bertoglio in which he described his injury after he "PUT WORK TRUCK IN DITCH TO AVOID HEAD ON ACCIDENT[.]" PX1 (EMPHASIS in original). While it might be wholly plausible given another global set of facts that Petitioner was simply a patient awaiting diagnoses from his physicians to understand the cause of his physical condition to that point, Petitioner had previously filed an workers' compensation claim and was, therefore, not wholly unfamiliar with the process. Petitioner was aware of the pending disciplinary action against him at work when he went to the emergency room on February 15, 2014 for stroke-like symptoms. Mrs. Donovan was also aware of the discipline when she called Petitioner's supervisor, Mr. White, on March 3, 2014 to report that he did not want to tell him about the accident at work and was having difficulty filing a workers' compensation claim.

Petitioner was able to work after dozens of cervical injections, nerve branch blocks and ablations that ended approximately six and a half months before his alleged trauma on January 30, 2014. Petitioner was also able to work for two weeks despite purportedly increasing soreness, but did not report any trauma attributable to the January 30, 2014 events until after he was subjected to discipline at work that might include termination—and, consequently, a termination of his workers' compensation and group insurance benefits—and after his own physician told him that it was not likely a stroke that caused his symptoms, but rather his cervical degenerative disease. Petitioner's wife, not Petitioner, also testified that he was having trouble filing a workers' compensation claim, but he had filed and settled such a claim previously without a problem. The involvement of Mrs. Donovan between her husband and his supervisor might be explained by the fact that he had a stroke on

February 15, 2014, but that was not her testimony. Moreover, Petitioner's memory was suspiciously clear on direct examination, when it served to support his theory of recovery, compared to cross examination. Petitioner was notably unable to remember the discussion during the disciplinary meeting on February 21, 2014 or specifics about the conversation that generated the discipline with Mr. Sacco on February 14, 2014, the day before he was taken to the emergency room. Petitioner's testimony under these circumstances is questionable.

Mr. Sacco also provided testimony in contravention of Petitioner's version of events about the discussion they had on February 14, 2014. While Mr. Sacco explained his statements to Petitioner with more finesse than he described Petitioner's statements during the conversation, Mr. Sacco had a clear memory of events on both direct and cross examination. Notwithstanding, it is not solely Mr. Sacco's testimony, or Mr. Sacco and Mr. White's testimonies taken together, that diminish the reliability of Petitioner's testimony; it is the totality of the record including the sequence of events, comparison of Petitioner's testimony to his reports as reflected in the medical records, and comparison of Petitioner's testimony to that of both Mr. White and Mr. Sacco that brings Petitioner's testimony into question. In light of the record as a whole, the Arbitrator does not find Petitioner's testimony to be credible.

Next, the Arbitrator addresses the medical records and physicians' opinions. Respondent did not require Petitioner to submit to a Section 12 examination. Instead, it engaged Dr. Mirkovic to perform a review of Petitioner's treatment records. Mr. Mirkovic rendered various opinions regarding the relatedness, if any, of Petitioner's cervical spine condition to the events of January 30, 2014. Dr. Mirkovic plausibly determined that it was Petitioner's severe cervical degenerative disc disease that caused Petitioner's need for medical treatment and not a vehicular incident at work on January 30, 2014.

Dr. Mirkovic noted the extensive and aggressive nature of Petitioner's pre-2014 nonoperative care for the cervical spine ending in mid-2013 noting that Petitioner's own physician at that time was unable to identify a clear pain generator to explain his symptoms. Dr. Mirkovic also noted that, based on his understanding that there was no evidence of damage to Petitioner's vehicle as a result of the January 30, 2014 incident, the mechanism as described was of insufficient magnitude to permanently cause or aggravate Petitioner's pre-existing cervical condition. Dr. Mirkovic further highlighted that Petitioner's February 15, 2014 cervical MRI was compared to the prior March 13, 2012 cervical MRI. This comparison failed to show any structural change at C5-C6 or C6-C7 or cord compression, which he believed was consistent with a lack of clinically objective findings suggesting ongoing cervical myelopathy explaining Petitioner's symptoms and failing to suggest a clear pain generator. Dr. Mirkovic also stated that the MRI comparison only showed moderate changes from C3-C4 and C4-C5, which was more likely than not progressive degeneration rather than an acute process.

By contrast, Petitioner's treating physician, Dr. Bertoglio, opined that Petitioner's pre-existing cervical stenosis was exacerbated by the recent motor vehicle accident at work and the cervical spine condition was, therefore, work-related. Dr. Bertoglio noted Petitioner's report on February 21, 2014 of "neck pain has been severely exacerbated by a MVA 2-3 weeks ago when he drove into a ditch to avoid a head-on collision with an errant vehicle[.]" However, this history of the onset of Petitioner's symptoms is undermined by the lack of Petitioner's neck complaints for weeks after a purportedly traumatic, acute exacerbation of severely degenerative cervical disease on January 30, 2014 until after a breakdown in his employment relationship. Petitioner also had attended a disciplinary meeting the very same day that he first reported neck symptoms purportedly stemming from his truck incident at work. Petitioner barely remembered the conversation, but testified that he was accused of threatening Mr. Sacco, which he also failed to recall. Petitioner admitted that there were allegations being raised by Respondent against him at that time, but explained that it was the amount of pain that caused him to state that he was going to see a doctor. Petitioner did exactly that in seeing Dr. Bertoglio, but the motivation to do so is not likely a traumatic bucking bronco-type vehicular incident at work

on January 30, 2014 that would have likely caused severe symptomatology and a more timely search for medical attention, but rather a work-related disciplinary dispute that could lead to his termination of employment. The Arbitrator does not find Dr. Bertoglio's opinion based on Petitioner's reports to be persuasive when considering the record as a whole.

In sum, given the sequence of events including Petitioner's lack of cervical complaints after an accident he described as bouncing him around like a bucking bronco, the lack of damage to the truck, the lack of medical treatment until the day after a verbal altercation with his supervisor that lead to discipline possibly including termination, and the lack of cervical complaints during emergency room treatment or until after his own physician (Dr. Llerena) told him that his symptoms were likely degenerative in nature, the Arbitrator finds that Dr. Mirkovic had a fair understanding of the mechanism of Petitioner's alleged injury and the most likely, medically plausible source of his cervical spine condition thereafter. The Arbitrator finds the opinions of Dr. Mirkovic to be persuasive in this case.

Based on all of the foregoing, the Arbitrator finds that Petitioner has failed to establish that he sustained a compensable injury at work on January 30, 2014 as claimed. By extension, all other issues are rendered moot and all requested compensation and benefits are denied.

In support of the Arbitrator's decision relating to Issue (M), whether penalties and fees should be imposed on Respondent, the Arbitrator finds the following:

Given the facts presented in this case, and after considering the parties' motion and response, the Arbitrator finds that Respondent had a reasonable dispute as to whether Petitioner's alleged injury on January 30, 2014 was compensable and arose out of his employment as alleged. The testimony of Respondent's witnesses, Mr. White and Mr. Sacco, refute Petitioner's version of events. Moreover, the opinions of Respondent's records reviewer, Dr. Mirkovic, plausibly establish that Petitioner's cervical condition was due to his severe, documented cervical degenerative condition rather than his incident in a truck at work. Respondent's conduct was not unreasonable, vexatious and/or in bad faith. Thus, Petitioner's claim for penalties and fees under Sections 19(k), 19(l) or 16 of the Act is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANAGMON)

☐ 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

MICHAEL MARTIN,

Petitioner,

vs. NO: 14 WC 025763

CITY OF SPRINGFIELD,

17IWCC0351

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

As noted in the Decision of the Arbitrator, the Arbitrator placed significant weight on Petitioner's testimony, his demonstration of some of his work activities during the arbitration hearing, and the medical opinions expressed by Dr. Mark Greatting, one of Petitioner's treating physicians, to find that Petitioner sustained compensable injuries to both elbows and both wrists. The Commission places less weight on all three than did the Arbitrator and finds Petitioner misrepresented to both Dr. Greatting and the Arbitrator the work activities and also the extent he performed those activities.

Petitioner retired from Respondent's employ as a troubleman, a position he held for the last fifteen years of his career with Respondent. Prior to becoming a troubleman, Petitioner worked for Respondent as coal handler, an apprentice lineman, and a journeyman lineman. The Commission, in reviewing the evidence, finds Petitioner conflated his work activities as a

17IWCC0351

troubleman with those he performed fifteen years earlier as a journeyman lineman to give the impression that the work he performed as a troubleman was more physically taxing than it was.

Petitioner repeatedly testified that his work activities as a troubleman required him to pull, push, finger, and grasp with his hands while performing repetitive tasks. He testified to both over half of his work activities involved grasping, twisting, and pulling as well as to just about everything he did involved grasping and pulling. The Commission notes Petitioner "guessed" that he agreed that a troubleman performed the thirteen activities Respondent identified as the work activities of a troubleman. It is also noted Petitioner offered no testimony as to performing any specific work activity either daily or even regularly but did offer that the work activities varied so often that they could change daily or even hourly. Petitioner's work activities appear comparable to that of the claimant in Williams v. Industrial Commission, 244 Ill.App.3d 204, 614 N.E.2d 1777, 185 Ill.Dec. 43 (1st Dist. 1993).

In Williams, the claimant testified to about one-third of his shift involving items weighing between 60 and 70 pounds, to using sledgehammers two to three hours a day, and to using pipe wrenches, chainsaws, and box wrenches. Williams, 244 Ill.App.3d at 206. The Appellate Court affirmed the Circuit Court decision which had confirmed the Commission decision, noting that the claimant hadn't performed a specific task either regularly or on a daily basis and also did not use any particular tool or object on a daily basis. Williams, 22 Ill.App.3d at 204. The Appellate Court appears to have found the claimant's use of sledgehammers for several hours over his shift sufficient to consider his complaints to be compensable.

Petitioner, in this instant matter, testified to using a skimming knife, Klein linesman pliers, channel locks, a cutter, Insulink tool, and hand slicers daily. He specifically testified to use the skimming knife "every day all day." The Commission views that testimony to be hyperbolic as not all of the thirteen work activities would necessitate him using a skimming knife, particularly given Petitioner's testimony of the skimming knife being used to cut cable sheathing. Petitioner testified that the Klein linesman pliers were the next most frequently used tool, but he offered no testimony as to how often that was. He testified that he used the channel locks probably twenty times a day, the cutter probably a couple times a day, the Insulink tool probably four or five times a day, and hand slicers a couple times a day. The Commission not only notes Petitioner's qualifying the number of times all but the hand slices were used over the course of a day but also that no indication as to how long each of the tools were used when they were used. The length of time each of these tools was used could have ranged from seconds, minutes, or hours. Petitioner's testimony doesn't address this. Petitioner's testimony concerning these tools also does not inform the Commission whether these tools were used to complete a single task or multiple tasks. Given the lack of specificity as to the actual number of times these tools were used and for how long, the Commission cannot reasonably ascertain the impact such usage had upon Petitioner's elbows and wrists and, therefore, finds it has a less clear picture of Petitioner's work activities than it does of the work activities performed by the claimant in Williams.

The Commission finds Petitioner improperly attempted to bolster the number of activities

he performed as a troubleman when testifying before the Arbitrator. He testified that grinders were used but didn't testify that he actually used them. He testified to sledgehammers being used to set poles but then testified that he only occasionally used sledgehammers himself. He testified to using jackhammers as a lineman but, on cross-examination, acknowledged that he almost never used them as a troubleman. He testified to using a chainsaw twice a week and also to only a week going by without him using one but stated during his Section 12 examination with Dr. Mitchell Rotman that a chainsaw might be used once a week for twenty minutes. His treating physicians made no record of chainsaw usage. He testified to the bayonet tool being used regularly, only to admit, on cross-examination, that he didn't use it often as a troubleman. A photograph of bolt cutters was introduced into evidence only to have Petitioner admit that he didn't use them. Petitioner appears to have impressed the Arbitrator with testimony and evidence that, to a large degree, did not accurately reflect the actual work activities he engaged in over the last fifteen years of his career with Respondent.

The Commission also finds Petitioner was less than forthcoming with respect to his testimony concerning his hobby of motorcycle riding. He was asked if he informed his treating physicians that he rode motorcycles, and he answered that he had. When asked which of his treating physicians he had made his hobby known to, he answered that he didn't know. He then offered that each of his physicians knew of his riding motorcycles because he wore a Harley Davidson shirt and hat and "stuff." Petitioner's testimony strayed from his original statement that he had told each of his physicians that he rode motorcycles into testimony that those same physicians had what amounted to constructive notice of his riding motorcycles by his clothing and accessories. Absent from Petitioner's testimony was him actually testifying that he was clothing indicative of motorcycle riding when he was seen by his physicians. The Commission notes that none of Petitioner's treating physicians' records indicated that Petitioner engaged in any hobbies and that Petitioner indicated that reading was his only hobby on Dr. Rotman's intake form.

The Commission takes particular note of the testimony of Petitioner's treating physician, Dr. Greatting. Greatting testified regarding the substantially different and tasks that Petitioner performed from one day to the next and the impact that the performance of such tasks in such a manner could have on the alleged repetitive nature of Petitioner's job. The performance of these tasks, in such a manner, could substantially reduce the possibility of Petitioner aggravating carpal or cubital tunnel syndrome. Petitioner himself testified that his job duties and tasks changed from day to day, hour to hour and moment to moment.

The Commission recognizes that Petitioner has been diagnosed with and treated for bilateral carpal and cubital tunnel syndrome. The Commission finds that Petitioner has failed to prove that either the carpal or cubital tunnel syndrome are in any manner related to or caused by his employment. The Commission reaches this conclusion based upon several factors. First, the Petitioner was never candid with either his treating or examining physicians. Second, the Petitioner was not candid with the arbitrator. Third, Petitioner's symptoms continued for several months after he was taken off work for other unrelated issues. It is for these reasons that the Commission believes that Petitioner's bilateral carpal and cubital tunnel syndrome may

be related to something other than Petitioner's work activities.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed with the Commission on July 25, 2016, is reversed and all compensation denied.

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

DATED: JUN 12 2017
KWL/mav
O: 04/11/17
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

The record shows that Petitioner worked for Respondent almost his entire adult life, having started with Respondent as a coal handler shortly after graduating high school. He testified that this job involved shoveling coal and cleaning under conveyor belts. Thereafter, he worked the next 34 years as a journeyman lineman as well as a "troubleman." The arbitrator found Petitioner's testimony as to the repetitive nature of his job duties to be credible, noting that Mr. Martin "...was not merely occasionally forcefully using his hands, but was constantly exerting force through the hands and arms during his work day." The Arbitrator also discounted Petitioner's motor cycle riding activities and other health conditions, noting that the former "... did not seem nearly as upper extremity intensive and extensive as his job duties for Respondent which began in 1977."

This case presents a similar set of circumstances as that found in a case this panel issued less than a year ago -- namely, *Sherry Campbell v. White County Coal, LLC*, 16 IWCC 5230. In that case the claimant worked for a mining operation where she was required to use a shovel, pick axe and sledge to break up rock and shovel coal onto and off conveyor belts. During the course of her employment, she was also required to lift, load and open fifty-pound bags of rock dust as well as use a three-inch hose. This panel found the claimant's testimony as to the repetitive nature of her job activities to be entirely credible, and as a result determined that she sustained accidental injuries arising out of and in the course of her employment and that her current condition of ill-being was causally related to said accident.

I see no appreciable difference between that case and the present one, and indeed would argue that the facts in this case – particularly the constant and repetitive use of tools requiring forceful grasping, pulling and twisting -- present an even stronger case for finding that Petitioner

sustained accidental repetitive trauma-type injuries arising out of and in the course of his employment on July 3, 2014, and that a causal relationship exists between said injury and Petitioner's current condition of ill-being.

Accordingly, I dissent from the majority opinion and would affirm the Arbitrator's thorough and well-reasoned decision in its entirety.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, MICHAEL
Employee/Petitioner

Case# **14WC025763**

CITY OF SPRINGFIELD
Employer/Respondent

17IWCC0351

On 7/25/2016, 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 0.43% 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:

2217 SHAY & ASSOCIATES
TIMOTHY M SHAY
1030 DURKIN DR
SPRINGFIELD, IL 62704

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

17IWCC0351

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

Michael Martin
Employee/Petitioner

Case # 14 WC 025763

v.

Consolidated cases: N/A

City of Springfield
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 **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on **May 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 3, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$94,317.28**; the average weekly wage was **$1,813.79**.

On the date of accident, Petitioner was **54** years of age, single with **0** dependent children.

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

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

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

Respondent is entitled to a 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's medical bills as set forth in Petitioner's Exhibit 9. Respondent is ordered to pay the medical bills as set forth in Petitioner's Exhibit 9, directly to the providers, according to the fee schedule provided, as set forth in the Act. Respondent shall receive a credit for all medical bills paid by Respondent's group health carrier, Health Alliance, according to Section 8(j) of the Act, and Respondent shall indemnify and hold Petitioner harmless for any subrogation efforts made by Health Alliance in relation to said charges.

Respondent shall pay Petitioner permanent partial disability of **$721.66/week** for a period of **10.9 weeks** and **$721.66/week** for an additional period of **10.9 weeks**, as the injuries sustained caused **10% loss of use of Petitioner's right hand** and the **10% loss of Petitioner's left hand** as provided in Section 8(e) of the Act.

Respondent shall further pay Petitioner permanent partial disability of **$721.66/week** for a period of **12.65 weeks** and **$721.66/week** for an additional period of **12.65 weeks**, as the injuries sustained caused **5% loss of use of Petitioner's right arm** and **5% loss of Petitioner's left arm** as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from July 3, 2014 through May 24, 2016 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

July 20, 2016
Date

JUL 25 2016

FINDINGS OF FACT and CONCLUSIONS OF LAW

Petitioner alleges repetitive trauma injuries to his hands and elbows. Respondent does not dispute the date of manifestation but does dispute whether Petitioner sustained an accident arising out of and in the course of his employment with Respondent.

The Arbitrator finds:

Petitioner was referred to Dr. Cecile Becker on April 13, 2006 for purposes of a nerve conduction study and EMG. Petitioner was complaining of left shoulder pain radiating down into his arm with some numbness into the hand and fingers. Petitioner reported having symptoms for the preceding year but worsening in the last two weeks. Petitioner had undergone neck surgery 14 years earlier. He also mentioned some right hand numbness. Dr. Becker found electrodiagnostic evidence for a "very mild" median mononeuropathy at the right wrist (carpal tunnel syndrome). (RX 4, pp. 91-92)

On November 22, 2006 Dr. Becker authored a letter to Dr. Morton regarding her examination of Petitioner on November 10, 2006. This visit had to do with a two year history of progressive leg problems. Petitioner was noted to work as lineman for Respondent. His medical history included a C4-5 discectomy, right shoulder surgery for a separated shoulder, and two left knee surgeries. She recommended further testing for Petitioner's lower extremity muscle weakness. An EMG she performed on Petitioner's lower extremities that day was normal. (RX 4, pp. 193 – 198 and 226-228)

On July 28, 2009 Petitioner presented to his primary care physician, Dr. Scott Morton, with complaints of ongoing right elbow pain that was becoming more constant and uncomfortable. Petitioner gave a history of a similar problem a few years earlier at which time he underwent injections for lateral epicondylitis with minimal relief. Ultimately he was referred to Dr. Wottowa. Dr. Morton wrote, "He thought he had a posterior interossseus nerve entrapment and recommended surgery." Petitioner, however, didn't really want to pursue surgery. Now, the discomfort was increasingly worse. Petitioner was noted to do a "lot of repetitive motion stripping wire and gripping firmly with his right arm which increases his discomfort." On exam Petitioner was tender over the posterior interosseous nerve, but only minimally so over the lateral epicondyle. Tinel's and Phalen's signs were negative. Dr. Morton's diagnosis was posterior interosseous nerve syndrome and he recommended Petitioner follow up with Dr. Wottowa or Dr. Greatting for an orthopedic consultation. He was to continue his Naproxen. (RX 4)

Petitioner was seen by PA-C Purves in Dr. Wottowa's office on August 26, 2009 with ongoing right elbow complaints. In a "Patient History" form completed prior to the exam, Petitioner gave a history of constant right elbow pain for the preceding six years. Petitioner acknowledged he was working and indicated that the problem was interfering with his job, stating "cutting wire." He felt it was a work-related problem. On his pain drawing, he noted both bilateral hand/wrist symptoms and right elbow symptoms. (RX 4, pp. 200-201) Petitioner described his pain as being directly over the lateral aspect of his elbow, especially with activity. If he holds his hand in a neutral position with some resistance or if he is turning a screw driver or cutting wire at work it really bothers him. He also noted difficulty lifting a jug of milk out of the refrigerator. Petitioner also reported occasional numbness and tingling to his fingertips especially at night and when performing overhead activities for any lengthy period of time. On physical examination Petitioner displayed tenderness over the right lateral epicondyle but not the left. The medial epicondyles bilaterally lacked tenderness as did the ulnar nerves bilaterally. Some mild tenderness over the posterior interosseous nerve was noted. Tinel's and Phalen's signs were positive over the carpal tunnels bilaterally. Dr. Morton's diagnosis was right lateral epicondylitis with mild irritation of the posterior interosseous nerve and carpal tunnel syndrome. Dr. Morton sent Petitioner to Dr.

Wottowa that day for an exam. An injection in the lateral epicondyle was recommended. He recommended observation for the bilateral carpal tunnel syndrome. The injection was given. (RX 4)

Petitioner returned to Dr. Morton's office on November 1, 2005 with a couple of problems including heart palpations and some left arm numbness in his arm in different positions, especially if he slept with his arm over shoulder level. Dr. Morton felt Petitioner had some mild irritation of the left arm. Testing was ordered for the other problem. (RX 4)

On June 8, 2013 Petitioner was working for Respondent when he slipped and fell in a customer's yard injuring his right shoulder and left knee. (RX 2, #2)

Petitioner presented to Dr. Borowiecki on August 1, 2013 regarding his work-related injury to his left knee. He mentioned that he was also being treated by Dr. Wottowa for a rotator cuff problem. Petitioner was being given prednisone but it was not helping the knee condition. Petitioner was diagnosed with degenerative arthritis of his knee and a recent exacerbation/aggravation of the arthritis secondary to a work injury on June 8, 2013. Dr. Borowiecki performed an injection and Petitioner was to return in 4-6 weeks. Therapy was also initiated. (RX 4)

Petitioner underwent right shoulder surgery on May 28, 2014. (RX 2, #2)

On June 18, 2014, Petitioner presented to Dr. Scott Morton, his primary care physician, regarding a "few issues." The doctor noted Petitioner had right carpal tunnel syndrome noted in 2006 as confirmed by a nerve study with Dr. Becker. Petitioner reported "it still comes and goes." Petitioner reported some discomfort in the nerves and numbness in his hands. Petitioner was planning on retiring and "just wanted to get all of his ducks in a row before he retires." His second issue was recurrent lateral epicondylitis of his left elbow for which he had undergone injections. Petitioner told the doctor "It still hurts all the time." He denied any parestehesias. Petitioner also reported low testosterone and needed it checked. He also noted high blood sugars and wanted that checked. On examination Petitioner had positive Tinel's and Phalen's in the right wrist along with some "bony hypertrophy" across the right wrist. He also had skin atrophy and soft tissue atrophy in the subcutaneous layer in the left elbow area where he had undergone numerous injections for epicondylitis. Petitioner was also tender over the proximal forearm adjacent to the lateral epicondyle but it wasn't really very tender right on the epicondyle. Petitioner had good range of motion. Petitioner was assessed with hypogonadism, type 2 diabetes mellitus, right carpal tunnel syndrome; and left lateral epicondylitis. With regard to the latter two conditions, Petitioner was referred to Dr. Greatting. (PX 4)

On July 1, 2014 Petitioner completed an "Employee Accident Report" for Respondent. Petitioner indicated that his left elbow and both hands had been "hurting for years" and he had been performing 36 years of hard labor involving twisting, cutting, pulling, and grasping. (PX 1)

Petitioner's last day of work for Respondent was July 3, 2014. He then retired.

Petitioner signed his Application for Adjustment of Claim in this matter on July 24, 2014. He alleged repetitive trauma injuries to both hands and his left elbow. (AX 2)

On August 7, 2014, Petitioner presented to Dr. Greatting. Petitioner completed a "Patient History" form for the doctor stating he had retired as of July 3, 2014. He felt his hands, wrists, and left elbow complaints were a work-related problem. Petitioner had previously undergone left knee replacement surgery and surgeries to both shoulders. When examined by Dr. Greatting he noted Petitioner was 55 years old and had worked many

years for Respondent. Petitioner reported a ten year history of tingling in both hands and left elbow pain. He described pain and aching in the morning and decreased grip strength. He further reported left lateral elbow pain. He reported that in the morning he has numbness in tingling involving the entire hands, as well as significant bilateral hand pain and left lateral elbow and forearm pain. Dr. Greatting further noted that Petitioner was on prednisone for polymyalgia rheumatic (a condition that was diagnosed a year and a half earlier) but that he was on a tapering dose. At the time of the evaluation Petitioner was taking 10 milligrams of prednisone daily. Dr. Greatting further noted that Petitioner was diabetic. Dr. Greatting performed a physical exam. The exam revealed decreased flexion and extension of the right wrist compared to the left and some tenderness over the dorsal aspect of the right wrist. Examination further revealed positive Tinel's over both his cubital tunnel areas, as well as a positive Tinel's and Phalen's over both carpal tunnels. Dr. Greatting diagnosed Petitioner with bilateral carpal tunnel syndrome, with possible bilateral cubital tunnel syndrome. He recommended Petitioner undergo an EMG/nerve conduction study of his upper extremities. (PX 4)

Beginning on August 23, 2014 Petitioner started taking classes at Lincoln Land Community College in auto repair and body welding. (RX 3)

On October 2, 2014, Petitioner underwent an EMG/nerve conduction study with Dr. Edward Trudeau. According to Dr. Trudeau's report, Petitioner had been working for many years using gripping tools, digging post holes, and climbing up poles. He gripped and clipped wires and twisted wires. Dr. Trudeau further noted his lengthy discussion with Petitioner regarding his job duties and how Respondent has been utilizing newer methods of performing jobs that didn't necessarily involve the hard impact on the hands and repetitive gripping and usage that he had to undergo. The EMG/nerve conduction studies showed bilateral median neuropathies at the wrists, moderately severe bilaterally, right greater than left. The studies also showed bilateral ulnar neuropathies at the elbows, mild and neurapraxic bilaterally and essentially equal in severity. (PX 3)

On October 8, 2014, Petitioner returned to Dr. Greatting. Dr. Greatting reviewed the EMG/nerve conduction studies and agreed the tests showed moderately severe bilateral median neuropathies at the wrists, and mild bilateral ulnar neuropathies at the elbow. Dr. Greatting examined Petitioner and noted positive Tinel and elbow flexion tests at the cubital tunnels and positive Tinel and compression tests over the carpal tunnels. Dr. Greatting discussed Petitioner's job duties with him, noting that he had worked for Respondent for 36 years performing multiple repetitive activities with his upper extremities, including climbing, pulling wires, using chain hoists, cutting, twisting, and stripping wires. Dr. Greatting opined that the work activities Petitioner described doing over a period of many years likely caused or contributed to Petitioner developing bilateral carpal and bilateral cubital tunnel syndrome. Dr. Greatting recommended Petitioner undergo bilateral carpal and cubital tunnel releases. (PX 4)

On November 17, 2014, Petitioner presented to Dr. Mitchell Rotman at the request of Respondent for a Section 12 Examination. Dr. Rotman concurred with Dr. Greatting's diagnoses but did not think either the carpal tunnel syndrome or cubital tunnel syndrome was causally related to Petitioner's job duties for Respondent. He concurred on the need for surgery to the hands and wrists but thought Petitioner's elbows would respond to conservative treatment.[1]

On December 8, 2014, Petitioner returned to Dr. Morton for a pre-surgical physical. Dr. Morton cleared Petitioner for surgery for both upper extremities. (PX 4)

[1] The substance of the doctor's examination will be more thoroughly discussed when summarizing his deposition.

Petitioner underwent a right hand carpal tunnel release and right elbow ulnar nerve release with Dr. Greatting on December 19, 2014. (PX 4; PX 5) Subsequently, Dr. Greatting performed the left-sided carpal tunnel release and left elbow ulnar nerve release on January 13, 2015. (PX 4; PX 5)

Petitioner returned to Dr. Greatting in follow up on January 28, 2015. Petitioner reported improvement of his numbness and tingling. On examination, Dr. Greatting noted some cellulitis around some of the subcutaneous sutures of the left elbow. Petitioner testified that the suture had poked through his skin and caused an infection. Dr. Greatting removed the suture and placed Petitioner on Cephalexin, an antibiotic. (PX 4)

Petitioner's final visit with Dr. Greatting took place on February 9, 2015. Dr. Greatting noted the cellulitis was markedly improved. He further noted there was one suture exposed, which he removed. Dr. Greatting instructed Petitioner to complete his course of antibiotics. He was discharged to return on an as-needed basis. (PX 4)

The deposition of Dr. Rotman was taken on June 15, 2015. (RX 1) Dr. Rotman is an orthopedic hand surgeon who performs IMEs weekly, charging $1,800.00 per IME and $1,800 per deposition, and earns over $400,000.00 per year from medical-legal work. (RX 1, pp. 4-5, 62) Dr. Rotman testified that 90 percent of his IMEs are on behalf of respondents. (RX 1) Dr. Rotman testified that he received a job description from Petitioner and reviewed Petitioner's previous medical records prior to examining him and had reviewed the City of Springfield's written job description. Petitioner had been off work for some time when he examined him as he had undergone a total knee replacement by one of Dr. Rotman's partners and a rotator cuff repair by one of his former partners, and thereafter had retired. (RX 1, pp.6, 9-14)

Dr. Rotman testified Petitioner provided him with a work history of changing out house service, running wire from the house to the pole, and changing out electrical connections. (RX 1, p. 10) He testified Petitioner would have to cut wire and work with meters and that he did about 10 houses per day with driving between houses. (RX 1, p. 11) He testified that Petitioner might use a chainsaw one time per week for 20 minutes and used a hand saw for 30 minutes per day. (RX 1, pp. 11-12) He testified that Petitioner would use a knife to skin insulation and that bothered him as he had to squeeze or wiggle it. (RX 1, p. 12) Dr. Rotman testified he reviewed Petitioner's job description and noted there were a lot of different tasks he may do. (RX1, p. 14)

Dr. Rotman examined Petitioner and noted irritability over both elbows over the cubital tunnel syndromes. (RX 1, p. 21) Further, he noted that Petitioner's hands went numb after his elbows were bent for a long period of time. (RX 1, p. 21) Dr. Rotman noted findings for carpal tunnel, right worse than left with numbness and tingling tests. (RX 1, p. 21) Dr. Rotman also noted he took x-rays which showed arthritis in both elbows. (RX 1, p. 22) Dr. Rotman testified that if a person has bone spurs in the elbow, the bone spurs cause pressure on the nerves over them. (RX 1, p. 22)

Dr. Rotman had a NeuroMetric study performed on Petitioner as Petitioner was unable to tolerate an EMG with one of Dr. Rotman's partners. (RX 1, p. 24) The NeuroMetric study showed bilateral carpal tunnel syndrome, left worse than right. (RX 1, p. 24) He testified that the motor and sensory latencies were "borderline" but that he would expect an EMG with his partner to show mild carpal tunnel syndrome in both hands, similar to those performed 8 years prior by Dr. Becker. (RX 1, p. 24) He testified that Dr. Trudeau's exam showed severe carpal tunnel syndrome "twice as bad" as the findings of the NeuroMetric exam. (RX 1, pp. 24-25)

Dr. Rotman diagnosed Petitioner with bilateral mild carpal tunnel and cubital tunnel. (RX 1, p. 26) He testified that Petitioner "seems to be tolerating" the cubital tunnel symptoms and stated "he knows to hold [his elbows] straight." (RX 1, p. 26) Dr. Rotman testified that Petitioner's cubital tunnel syndrome was caused by

positioning, and that his carpal tunnel syndrome was "idiopathic" but was worsened by his prednisone usage. (RX 1, p. 28) He testified prednisone would cause Petitioner to retain water and place pressure on the carpal tunnel. (RX 1, pp. 28-29) He further testified that on open release, he may see more fluid in the area if there was retained water. (RX 1, p. 45) Dr. Rotman testified that the cause of carpal tunnel is idiopathic and that "when I talk about work-related carpal tunnel, I'm talking about an aggravation." (RX 1, pp. 29-30) Dr. Rotman agreed Petitioner required surgery for his carpal tunnel syndrome, but indicated "if he doesn't lean on his elbows or hold his elbows flexed for a long time" the cubital tunnel synddrome "may go away." (RX 1, pp. 31-32)

Dr. Rotman opined that for cubital tunnel syndrome "a job that might require repetitive elbow flexion past 90 degrees would be the kind of job that would bother cubital tunnel, or somebody that was sitting at a desk with their elbows on their desk all day or talking on the phone all day with their elbows flexed." (RX 1, p. 15) He testified that Petitioner would have to have his elbow bent greater than 90 degrees for 50 percent of the day for it there to be causation from work. (RX 1, p. 50) He further testified that his 90 degree 50 percent rule was not supported by any scientific literature and it was his own rule. (RX 1, pp. 50-51) He further testified that cubital tunnel syndrome may be caused by "doing something all day repetitive over and over again in one particular kind of activity." (RX 1, p. 15) Dr. Rotman was presented with Petitioner's job description, which noted 50 percent lifting. (RX 1, p. 49) He testified that lifting could require bending at the elbows, but it depending on how high he was lifting. (RX 1, p. 49)

Dr. Rotman testified that Petitioner had been diagnosed with carpal tunnel syndrome by nerve studies "several years back" but that it was so mild that he did not need any surgery. (RX 1, p. 18) He testified that Petitioner started having hand numbness on occasion, but the symptoms became more regular after he began taking Prednisone. (RX 1, p. 19) Dr. Rotman provided no testimony regarding how he came to the conclusion that Petitioner's symptoms became "more regular" after taking Prednisone. He testified that Dr. Trudeau did a final nerve study that showed very advanced findings after Petitioner began taking Prednisone. (RX 1, p. 19)

During his physical examination of Petitioner Dr. Rotman found Petitioner unable to fully flex or extend his elbows and to have a loss of motion in some of his fingers with puffiness in the fingers. He testified that Petitioner's wrists were not particularly painful, but he had irritability over the funny bone of both elbows, which was the cubital tunnel. Other tests confirmed the presence of cubital tunnel as well. There was no evidence of lateral epicondylitis on examination. His exam also confirmed the presence of carpal tunnel bilaterally. (RX 1 pp.20, 21)Dr. Rotman further testified that x-rays showed osteoarthritis in the knuckles of Petitioner's hands as well as the elbows, and wrists, with the bone spurs in the elbow causing pressure on the nerves, and the bone spurs in the hands not being too bad. He tried to have nerve studies conducted by Dr. Phillips as part of his examination but Petitioner could not tolerate the discomfort so he did a less painful test, a NeuroMetrix test, but it does not provide a complete nerve study, just giving basic findings. That test indicated mild carpal tunnel bilaterally, with the left being a little worse than the right. He felt this was more in line with the nerve studies previously done by Dr. Becker than the studies of Dr. Trudeau, which showed severe carpal tunnel and which could cause loss of muscle strength. Dr. Rotman noted that during his examination he had not seen any atrophy of muscles. (RX 1 pp.22-25)

Dr. Rotman was of the opinion that Petitioner had bilateral elbow arthritis, bilateral cubital tunnel syndrome and mild bilateral carpal tunnel syndrome as well as arthritis in the hands. He was of the opinion that Petitioner's work had nothing to do with the conditions and that he would have these symptoms whether he was working or not as his complaints had not changed since his retirement. He testified that if work had been an aggravating factor he would have had more symptoms while working and would have been better after retiring.

He felt Petitioner's cubital tunnel syndrome was positionally caused or aggravated in that going around with his elbows hyperflexed or leaning on his elbows would bring on his symptoms, as would his arthritis. Dr. Rotman testified that Petitioner had idiopathic carpal tunnel syndrome not caused from an accident which got worse when he was taking steroids for polymyalgia rheumatica. He also testified that steroids cause water retention which adds pressure to the carpal tunnel, placing pressure on the nerve and causing carpal tunnel symptoms. He testified that Petitioner had been on prednisone for a while and the water retention and pressure on the nerve would be worse in a person who took it on a long-term basis. (RX 1 pp.26-29)

Dr. Rotman did not believe Petitioner's work, as described to him by Petitioner and in the job description document, would have caused Petitioner's carpal and cubital tunnel syndromes as the cause was idiopathic, unknown. He did not believe that work aggravated the conditions as Petitioner did not do repetitive elbow flexion activities past 90 degrees, he did not lean on his elbows all day at work at a desk, he did not do repetitive heavy gripping all day (just once in awhile), and he only used a chainsaw for half an hour a week, not for prolonged periods of time. He did recommend carpal tunnel surgeries, but felt Petitioner did not need cubital tunnel surgeries as he could get a brace for the elbow at night, pad them during the day, and not put weight on them. (RX 1 pp.29-32)

Dr. Rotman testified he did not find Dr. Trudeau's studies credible. (RX 1, p. 35) However he testified that Dr. Trudeau's studies were consistent with his clinical examination with regard to the ulnar neuropathies and that Dr. Trudeau's studies were consistent with his clinical examination for carpal tunnel syndrome in that it showed the right was worse than the left, whereas the NeuroMetrix exam showed the left side was worse. (RX 1, pp. 35-36) Dr. Rotman agreed that the NerouMetrix exam had limited value for diagnosing carpal tunnel syndrome as it did not record palmar sensory latency. (RX 1, pp. 43-44)

Dr. Rotman testified that carpal tunnel syndrome would be associated with repetitive hand grasping, such as "if your [sic] on an assembly line or a job where you're using a grinder all day where you're doing something over and over again and you don't have the appropriate amount of time between that job activity to give your hand a rest." (RX 1, p. 15) He testified that if the job allows different types of activities "then you're not doing the same thing over and over again." (RX 1, p. 15) He testified carpal tunnel syndrome would not be aggravated if you can break up heavy activities throughout the day. (RX 1, p. 16) Dr. Rotman agreed that Petitioner's job description noted that fingering was required 30% of the time and grasping 20% of the time. (RX 2, p. 57)

Dr. Greatting was deposed on October 26, 2015. Dr. Greatting is a board certified orthopedic surgeon with additional qualifications in hand surgery. (PX 7, pp. 4-5) Dr. Greatting testified that his clinical practice is limited to treatment of upper extremity problems. (PX 7, p. 5)

Dr. Greatting testified that when he first examined Petitioner he was 55 years old and had worked many years for Respondent. Petitioner reported a history of tingling in both hands and left elbow pain. He described pain and aching in the morning and decreased grip strength. He further reported left lateral elbow pain. He reported that in the morning Petitioner had numbness in tingling involving the entirety of his hands, as well as significant bilateral hand pain and left lateral elbow and forearm pain. Dr. Greatting further noted that Petitioner was on prednisone for polymyalgia rheumatica, but that he was on a tapering dose. At the time of the evaluation Petitioner was taking 10 milligrams of prednisone daily, which Dr. Greatting testified was a moderate dose. (PX 7, p. 8)

Dr. Greatting testified that he performed a physical exam that revealed decreased flexion and extension of the right wrist compared to the left and some tenderness over the dorsal aspect of the right wrist. Examination

further revealed positive Tinel's over both cubital tunnel areas, as well as a positive Tinel's and Phalen's over both carpal tunnels. Dr. Greatting diagnosed Petitioner with bilateral carpal tunnel syndrome and possible bilateral cubital tunnel syndrome. He recommended Petitioner undergo an EMG/nerve conduction study of his upper extremities. (PX 7, pp 13-15)

Dr. Greatting re-examined Petitioner on October 8, 2014. Dr. Greatting reviewed the EMG/nerve conduction studies and agreed the tests showed moderately severe bilateral median neuropathies at the wrists, and mild bilateral ulnar neuropathies at the elbow. Dr. Greatting examined Petitioner and noted positive Tinel's and elbow flexion tests at the cubital tunnels and positive Tinel's and compression tests over the carpal tunnels.. Dr. Greatting discussed Petitioner's job duties with him, noting that he had worked for Respondent for 36 years performing multiple repetitive activities with his upper extremities, including climbing, pulling wires, using chain hoists, cutting, twisting, and stripping wires. Dr. Greatting opined that the work activities Petitioner described doing over a period of many years likely caused or contributed to Petitioner developing bilateral carpal and bilateral cubital tunnel syndrome. Dr. Greatting reiterated this opinion in his deposition. (PX 7, pp. 17 - 20) Dr. Greatting testified that Petitioner related to him that his symptoms had developed over a period of many years and that they bothered him and were symptomatic while he was still working. (PX 7, p. 18) He also noted that Petitioner's symptoms bothered him more while he was performing his work activities. (PX 7, p. 18) Dr. Greatting recommended Petitioner undergo bilateral carpal and cubital tunnel releases. Dr. Greatting testified it was his opinion within a reasonable degree of medical certainty that the surgeries were reasonable and necessary. (PX 7, p. 21)

Dr. Greatting testified that he did not note any swelling or water retention in the area of the carpal or cubital tunnels during the releases. (PX 7, pp. 22-25) Dr. Greatting also testified that he did not find any signs of osteoarthritis in the elbow region during either of his surgeries. (PX 7, p. 37) He further testified the findings on surgery were consistent with the electrical studies of Dr. Trudeau. (PX 7, pp. 22-25)

Dr. Greatting testified that Petitioner returned for follow-up on January 28, 2015. Petitioner reported improvement of his numbness and tingling. On examination, Dr. Greatting noticed some cellulitis around some of the subcutaneous sutures of the left elbow. Dr. Greatting removed the suture and placed Petitioner on Cephalexin, an antibiotic.

Petitioner's final visit with Dr. Greatting took place on February 9, 2015. Dr. Greatting noted the cellulitis was improved. Petitioner was doing well and he was released from care and advised to return as needed. (PX 7, p. 26)

Dr. Greatting was shown Petitioner's job description as a "troubleman." He noted that that 30 percent of Petitioner's job consisted of troubleshooting electrical service complaints. (PX 7, p. 27) When asked if he was familiar with the types of tools referenced in the job description, the doctor replied "yes and no." (PX 7, p. 28) He didn't know much about electrical equipment but was familiar with chain saws, hand saws, crescent wrenches, screwdrivers, pliers, cable cutters, allen sets, and socket sets. (PX 7, p. 28) He further noted the job required the ability to occasionally exert in excess of 100 pounds of force, and requires the ability to climb, reach, pull, finger, push, grasp, and perform repetitive motions in performing the tasks of maintaining electrical conductors and equipment. (PX 7, pp. 28-29) Dr. Greatting also understood from the job description that Petitioner was reaching 90 percent of the time, pushing 20 percent, pulling 20 percent, lifting 50 percent, fingering 30 percent, and grasping 20 percent. PX 7, pp. 29 -30)

Dr. Greatting was also shown an intake form completed for the IME physician, Dr. Rotman, in which Petitioner was asked to describe his job. Dr. Greatting noted Petitioner had indicated his job requires cutting

wire with pliers, skin insulation off wire with skinning knife, pull wire with hands, bolt and unbolt electrical connectors, tension wire by jacking on chain hoist come along, climb poles and ladders, bend and shape large wires, and work live seven thousand volt wire with 10 foot fiberglass hot sticks. (PX 7, p. 31)

Dr. Greatting was presented with a hypothetical that Petitioner had been employed by Respondent since 1980 starting as an apprentice lineman, becoming a journeyman lineman in 1984, becoming a troubleman in 2001, retiring in 2014. (PX 7, p. 31) Dr. Greatting was instructed to assume that as a troubleshooter his job description was consistent with Deposition Exhibit 2, and as Petitioner explained his job duties as set forth in the intake form completed for Dr. Rotman. (PX 7, pp. 31-32) Using this hypothetical, Dr. Greatting testified it was his opinion that Petitioner's work activities, over that period of years, could contribute to the development of bilateral carpal and cubital tunnel syndromes. (PX 7, pp. 32-33)

Dr. Greatting testified that, while job duties including the bending of the arm at or greater than 90 degrees for 50 percent of the work day could contribute to the development of carpal tunnel syndrome, there is not an absolute necessity that a Petitioner's job duties must include such activities for his job to be contributory. (PX 7, pp. 32-33) Dr. Greatting testified that the job duties Petitioner described "would require sufficiently repetitive elbow flexion/extension and also force over time to contribute to the development of [cubital tunnel syndrome]." (PX 7, p. 33) He further testified that Petitioner's work activities over a period of years "is sufficiently forceful and repetitive enough to contribute to the development of carpal tunnel syndrome." (PX 7, p. 34) Dr. Greatting testified that a person does not need to be performing the same tasks over and over on an assembly line for cumulative trauma to take place in an employment setting. (PX 7, p. 36) Rather, Dr. Greatting testified "even if you are varying tasks, I think a lot of the tasks, using different tools or doing different things, you are still using the same motions with your elbows and wrists and hands and you are still applying force, so even though you are not standing in one place doing the same thing over and over many of the activities are still identical or very similar." (PX 7, p. 36)

Dr. Greatting testified he held these opinions despite Petitioner's diagnosis of diabetes. (PX 7. p. 34) Dr. Greatting testified diabetes may make an individual susceptible to the development of both carpal and cubital tunnel, but he opined that Petitioner's work activities were "the primary cause or contributing factor." (PX 7, p. 34) Dr. Greatting also addressed Petitioner's prior diagnosis of polymyalgia rheumatica, and testified that Petitioner's carpal and cubital tunnel symptoms pre-dated his diagnosis of polymyalgia rheumatica and therefore he did not believe it significantly contributed to his carpal or cubital tunnel syndrome. (PX 7, p. 35) Dr. Greatting further testified that Petitioner's carpal and cubital tunnel symptoms predated the time Petitioner began taking prednisone, and therefore did not believe it was contributory. (PX 7, p. 36) Additionally, Dr. Greatting testified he was aware Petitioner had previously undergone injections for lateral epicondylitis, but that these injections should have no effect on the ulnar nerve as the lateral epicondyle is "nowhere near the ulnar nerve." (PX 7, p. 43)

Dr. Greatting testified that he had encountered "absolutely" no situations where he has questioned the reliability of Dr. Trudeau's EMG/nerve conduction findings and has no hesitation about referring patients to Dr. Trudeau. (PX 7, p. 15) He further testified that Dr. Trudeau's findings were consistent with his clinical examination. (PX 7, p. 16) Additionally, Dr. Greatting testified he reviewed the prior EMG performed by Dr. Becker in 2006, and noted the findings at that time were minimal. (PX 7, p. 55) He testified that eight years had passed between Dr. Becker's EMG and Dr. Trudeau's EMG, and that nothing about Dr. Becker's prior EMG in 2006 cast a negative light on the qualifications of Dr. Trudeau. (PX 7, p. 55)

On January 11, 2016 an AMA Impairment Rating was performed by Dr. Lawrence Li at the request of Respondent. Dr. Li, after reviewing medical records, taking a history and QuickDASH questionnaire from

Petitioner, and performing a physical examination upon Petitioner pursuant to the AMA Guidelines, 6th edition arrived at an impairment rating for the combined right carpal tunnel and cubital tunnel conditions of 3% of the right arm and 2% of the whole person, and for the combined left carpal tunnel and cubital tunnel conditions of 3% of the left arm and 2% of the whole person. (RX 2)

Dr. Li was deposed on February 11, 2016. Upon evaluation, Petitioner reported weakness in both hands. (RX 2, p. 18) Dr. Li found Petitioner to be credible and agreed that as Petitioner had reached maximum medical improvement (MMI) and underwent surgery over a year and a half prior to evaluation, that his symptoms would likely be permanent. (RX 2, pp. 18-19) Dr. Li testified that he did not measure grip strength, although the Guidelines use weakness as part of the grade modifiers. (RX 2, p. 20)

Dr. Li evaluated the carpal and cubital tunnel syndromes separately, but noted that per the guidelines, if there is both an evaluation for carpal tunnel and cubital tunnel in the same extremity, then the evaluator is to give 100 percent of the highest rating and only 50 percent of the lower rating. (RX 2, pp. 24-25) Dr. Li testified that, however, if the injuries occurred at different times and a rating for cubital tunnel was given after the rating for the carpal tunnel had been established, or vice versa, then the procedure for rating would be different. (RX 2, p. 25) Rather than only giving 50 percent of the rating for the second injury, "the second impairment rating would be given to an extremity that is less than 100 percent." (RX 2, p. 25) In other words, if the prior rating had been 5 percent, and the second rating was also 5 percent, the second rating would be 5 percent of 95 percent. (RX 2, p. 25) Dr. Li agreed that if the injuries were rated at the same time, it would result in a lower rating for the second injury than if they were rated at different times. (RX 2, pp. 25-26)

Dr. Li explained his rating as follows. For carpal tunnel of the left wrist, the EMG showed conduction slowing, which placed Petitioner in the grade modifier one. There were significant intermittent symptoms, which gave a Grade 2 modifier, and the physical examination, because he had normal sensation according to Dr. Greatting, was 1. (RX 2, p. 26) Dr. Li was apprised to the fact that, under the Guidelines, when a person has weakness in the hand, that qualifies as a Grade Modifier 3 for carpal tunnel. (RX 2, p. 27) Dr. Li admitted that Petitioner had noted weakness in his hands during his evaluation. (RX 2, p. 27) Dr. Li testified, after looking at the Guidelines, that "Grade Modifier 3 would be in this case, if it's physical findings, I would base it on atrophy because it's more reliable than weakness" although the guidelines specifically stated atrophy *or* weakness can place Petitioner in a Grade Modifier 3. (RX 2, p. 28) Dr. Li testified that he did not perform any grip testing and indicated that even using the Jamar grip test is not "an objective means" even though it involves performing the testing on multiple occasions. (RX 2, p. 28) Dr. Li performed a similar evaluation of the right wrist, finding a 2% impairment of each wrist. He further found 2% impairment for each elbow, which was halved to 1% of each elbow per the guidelines, making a total impairment rating of 3% loss of each upper extremity for the bilateral carpal and bilateral cubital tunnel. (RX 2, Ex 2, p. 3) Dr. Li agreed that impairment does not equal disability. (RX 2, p. 33)

Petitioner's case proceeded to arbitration on May 24, 2016. Petitioner was the sole witness testifying at the hearing. At the time of arbitration Petitioner amended his Application for Adjustment of Claim, without objection, to allege July 3, 2014 as the accident date and to include a right elbow injury. (AX 2)

Petitioner is a high school graduate who worked for Respondent almost his entire adult life. He testified that he began working for Respondent on June 8, 1977, shortly after graduating from high school. He began as a coal handler. He testified that in this job he shoveled coal and cleaned under the conveyer belts. In 1980, Petitioner began a four year program as an apprentice lineman, which he completed and subsequently became a journeyman lineman. From 1980 until his retirement on July 3, 2014, Petitioner held the title of journeyman

lineman. Petitioner testified that in his job as a journeyman lineman, he set poles, framed poles, hung cross arms, strung wire, repaired and dug underground conductors, and set transformers.

Petitioner testified that approximately 15 years ago he became a "troubleman," which is a lineman who works alone and performs mostly emergency work. He testified that he investigates problems, attempts to correct the problem, and if he is unable to do so, he assigns the issue to a crew. Petitioner testified that as a troubleman he did a lot of high voltage switching for crews and for load distribution.

Petitioner was provided with Petitioner's Exhibit 2, which is Respondent's job description for a "troubleman." Petitioner testified that he agreed with the job duties, but did not know if the percentages were right. Petitioner was directed to the section titled "Equipment, Aids & Tools" and agreed that those tools were used in his job. Specifically, the tools listed include a gas chainsaw, hand saw, crescent wrench, screwdrivers, pliers, meter band tool, meter ban pin extractor, load break tool, primary fuse puller, underground elbow puller, manhole cover remover, pole climbers, bolt biters, hot cutters, cable cutters, allen set, socket set, rubber gloves, leather gloves, pole extension saw, and nice press crimpers. PX 2. Petitioner further agreed that his job "required the ability to occasionally exert in excess of 100 pounds of force" and "requires ability to climb, balance, stoop, stand, reach, pull, finger, push, grasp and perform repetitive motions and performing the tasks of maintaining electrical conductors and equipment." PX 2. Petitioner was directed to the "Position Attribute Worksheet" section, and noted that he believed that the grasping percentage of 20% was low, because almost everything he did involve grasping, pulling, and twisting. PX 2.

Petitioner brought a number of tools with him to the hearing which are depicted in Petitioner's Exhibit 8. Petitioner testified that the tools set forth in Exhibit 8 were all tools he used as part of his employment with Respondent. Petitioner also identified Exhibit 10 as a photograph of various types of wires he would use. Petitioner identified photograph 8A as a hand-held cable slicer, which he had brought with him. He testified that the hand-held cable slicer is used for cutting large stranded wire in confined areas and around hot, or electrified, conductors, where larger slicers cannot be used. Petitioner testified he tried to use his right hand to use the cable slicer because it was the strongest, but sometimes he had to use both hands. Petitioner testified that he used the cable slicer to cut all three high voltage wires shown in Petitioner's Exhibit 10 and demonstrated cutting the 2 ot concentric underground cable, which is the second cable to the right in the exhibit. It took Petitioner over 30 repetitions of squeezing the cable slicer grips to cut through the cable. The Arbitrator notes that while cutting Petitioner had to brace the tool against his leg. He testified he did this because his hands are not as strong as they used to be.

Petitioner identified photograph 8B as a pair of Klein lineman's pliers. Petitioner testified that he used his Klien's the most, using them all day every day. He testified the Klein's are used to cut smaller wire up to #2 solid. Petitioner testified that he would use the Klein's to cut the two wires furthest to the left on Petitioner's Exhibit 10, which are #6 and #2 gauge. Petitioner demonstrated cutting the #6 wire, which he was able to do in one grasp, but had to maneuver a bit. He also demonstrated on the #2 wire, which he testified is the wire he used the most. Petitioner had difficulty cutting it with one hand, although he used to be able. He testified he had been instructed to cut the #2 wire with one hand in order to cut it quickly. Petitioner was eventually able to cut the #2 wire, but it took approximately 30 seconds. Petitioner testified that he generally used the pliers with his right hand.

Petitioner identified photograph 8C as a pair of channel locks. He testified that he used channel locks a lot to tighten and loosen nuts or bolts on connectors and polls. Petitioner demonstrated using the channel locks on a connector. Petitioner testified that in his demonstration he was grabbing the connector with his left hand and using the channel locks with his right hand. He testified he was tightening the connector down to make a good

connection between the wires to conduct electricity. In doing so, he twisted his arm and wrist while pulling and gripping tightly. Petitioner testified he performed this duty "probably 20 times per day."

Petitioner identified photograph 8D as a bayonet tool used on underground elbows and photograph 8H as an underground elbow. Petitioner testified that the bayonet is placed inside the elbow and it twisted to make the connection. Petitioner testified that he had to twist it hard. He further testified that he was performing this duty on a regular basis while working underground. He testified he worked underground quite a bit in his earlier years. As a troubleshooter, he performed this duty five times per week.

Petitioner identified photograph 8E as a ratcheting wrench with an allan socket, which he testified was used for tightening multi-connectors. He testified that he would use either hand to use the ratcheting wrench. Petitioner next identified photograph 8F as someone loosening or tightening a transformer bolt or lid bolt. He testified that to close underground transformers, he had to screw the bolt down tight and put a lock through and break it off. He testified the force required to perform this job depended on the age of the transformer. New transformers did not require much force, but if the transformer was a couple years old, which most were, they would get rusty and became difficult to close. He testified that he performed that activity every other day.

Petitioner identified photograph 8G as a skinning knife. He testified that was probably his "number 2 tool," indicating he used it the most after the Klein's. Petitioner demonstrated using the skinning knife on a 2 ot poly-concentric wire underground cable, depicted second to the right on Exhibit 10. He testified he could use both his right and left hand to do this job, but it was easier with the right. He testified that he had to grasp the knife really solidly and pull the knife towards himself. He testified it took a lot of force to skin the wire. He testified that wires are skinned to get down to the electrical connector. He testified he used his skinning knife "all day everyday."

Petitioner identified photograph 8I as a pair of hand slicers. He testified he used the hand slicers to cut small stranded wire. He testified he used the hand slicers a couple of times per day. He identified photograph 8J as a flat head screwdriver, which he testified he used probably 10 times per day. Petitioner identified photograph 8K as 24-inch bolt biters. He testified the bolt biters were mainly used on big downed guy wires, which is a hard tough wire. He further testified they were used to cut locks off of underground transformers.

Petitioner identified photograph 8L as a Lok banding tool, which is used for locking meters onto meter bases. He testified that photograph 8N depicted a lock band on a meter base. He testified these did not require a lot of physical exertion. However, the meter base is held to a wall by a pin, and if the pin has been in more than a year, which he testified most have, the Lok banding tool won't work. He testified that if the Lok banding tool doesn't work, the pins have to be removed. He testified generally he would pry them off. He testified that photograph 8W depicted a pin puller, which grabs onto the pin, but they did not work well as they would slide off the pin, so he stopped using them. He further testified that photograph 8Y was a grinder, which can be used to cut the band in two, but he testified that he was only provided with a grinder approximately a year before his retirement. Petitioner identified photograph 8O as a Lok band that had been unpinned.

Petitioner identified photograph 8P as an Insulink tool. Petitioner testified there was a period of time approximately 15 to 20 years prior that he was not allowed to use the Insulink tool for approximately a year. Petitioner testified that George Perco the superintendent of electric distribution stated in a safety meeting that the Insulink tool was causing carpal tunnel and he did not want them to be used anymore. Petitioner testified that the Insulink was useful because it is small and powerful and can get into small places. Petitioner testified that the Insulink was a commonly used tool and that he used it four to five times per day. He testified that the

Insulink was used on the #2 aluminum wire that use used for house services. Petitioner demonstrated using the Insulink, which required over ten repetitions. He testified that squeezing the Insulink took all the force he had.

Petitioner identified photograph 8Q as showing nut drivers, which were used for hand tightening connectors or bolts. Petitioner testified he used nut drivers fairly frequently. Petitioner identified photograph 8R as a socket set. Petitioner testified he used socket wrenches often. Petitioner identified photograph 8S as different sized wrenches, which he testified he did not use often. Petitioner next identified photograph 8T as a pipe wrench, which he also did not use much. Petitioner identified photograph 8U as a pair of hand slicers used for smaller wire, which only require one squeeze to cut. Petitioner testified he used that tool a couple of times per day.

Petitioner identified photograph 8V as a sledge hammer. He testified a sledge hammer was used for putting in ground rod next to poles. He testified the ground rod is an 8 foot steel rod one half inch in diameter which his copper coated. He testified that the handle of the sledge hammer is a hollow steel pipe and that he slid the handle over the rod and slid it up and down to beat the rod in as far as the handle, and then would hammer the rest of the rod into the ground. He testified he did not set poles as a trouble shooter, but as a journeyman he could set six to eight poles per day. As a Troubleshooter he sometimes used the sledge hammer to hammer down ground rods that were sticking up.

Petitioner identified photograph 8X as a manhole hook used for lifting manhole covers off underground vaults. He testified when he was working in underground he would lift manhole covers 4 to 5 times per day.

Petitioner identified photograph 8Z as a jackhammer. He testified when he was working underground during his lineman years, he would use jackhammers to break open the street and break open concrete conduit encasements to access conduit. Petitioner identified photograph 8A-1 as a chain saw. He testified he used a chainsaw as a troubleshooter for trimming trees away from wires. He testified he used a chain saw twice per week. He testified that he could use the chainsaw for up to two hours at a time.

Petitioner identified photograph 8B-1 as high voltage rubber gloves. He testified he used the high voltage rubber gloves anytime he was working near high voltage. He testified that his job was much harder to perform with these gloves on and it was like wearing boxing gloves. Petitioner identified photograph 8C-1 as cold weather mittens. He testified they were used to keep his hands warm in cold weather. He testified that the mittens also made his job harder. Petitioner identified photograph 8D-1 as Kunz gloves that he testified he used all the time. He testified they are made of thick buck skin, and they insulate low voltage.

Petitioner identified photograph 8E-1 as traffic signal wire. He testified he did not work with traffic signal wire much, but when signals would get knocked down by cars, as a troubleshooter he would have to cut each individual wire, tap it up and move the signal out of the street. Petitioner identified photograph 8F-1 as 350 wire, which was the same as the far right wire on Exhibit 10. He testified that he cut the 350 wire with slicers, which is a tool that is approximately two feet in length with each handle. He testified it required approximately 60 to 70 pounds of force to cut the wire and he had to use both arms. Petitioner testified that he demonstrated cutting the wire on the ground, but most of the time the wire is up in the air or lying on a rack in a manhole.

Petitioner testified that as a journeyman lineman he worked 8 hours per day straight time and would often work overtime. As a troubleshooter he worked 8 hours per day, but also worked a lot of overtime. He testified if they were busy and work backed up, he would be kept on until the work was caught up. Petitioner testified he got a 20 minute lunch, and although he was entitled to take other breaks, he did not do so because he wanted to stay caught up on work.

Petitioner testified that leading up to his appointment with Dr. Morton on June 18, 2014 his hands were going numb especially at night. He testified that he specifically noticed numbness in his hands when he was working with his skinning knife and his Klein's. He testified that his normal everyday work of cutting wire, skinning wire, pulling services, pulling blocks caused difficulty with his hands. He testified when he quit working his hands would vibrate, which made his symptoms worse.

Petitioner testified that since retiring from his job with Respondent, he has worked for two construction companies for short periods of time. He testified he worked for Asplundh Line Construction for approximately four months in 2015. He testified he was hired as an observer, but he started doing work for them as it was not very labor intensive. He testified he had a little bit of trouble tightening bolts and cutting wire. Petitioner also testified he worked for L.E. Myers digging holes using a big vacuum sprayer. He testified he worked this job for two months. Petitioner also testified that he has been taking some classes at Lincoln land Community College. Petitioner explained that he likes old cars and took some automotive classes in case he restores a car down the road. Petitioner has taken several classes but has done very little physical work as part of the classes. He acknowledged that some of the courses involve class room discussion/lecture followed by shop work. Students would help him with sanding or hammering if his hands were bothering him.

Petitioner testified that he continues to have problems with his hands. He testified that he is not as strong as he used to be and he cannot grasp or lift things as much as before. He testified that his surgeries had resolved the symptoms of numbness. Petitioner further testified that his elbows are "freer" and they work "just fine," but they are also not as strong as they used to be and he has trouble lifting things. Petitioner testified that he occasionally gets pain in his elbows, as he reported to Dr. Li on January 11, 2016.

On cross-examination Petitioner acknowledged that there were five different shifts he might work on as a "troubleman." He also agreed that the work would vary somewhat per shift but not much. He agreed that he didn't have to work with the larger wire as much as a "troubleman" as he did as a lineman. He also testified that he used the bayonet tool quite a bit. He acknowledged not using the jackhammer in probably the last fifteen years. He also rarely had to cut 350 wire as a "troubleman." He still had to climb pulls as a "troubleman." While bucket trucks are now used, that wasn't the case when he "come up." He also explained there are some situations where you can't use a bucket truck.

Petitioner was asked about his diabetes and he explained that when he started taking prednisone he was told it would raise my blood sugar but that it should eventually go away when the prednisone was ended. Petitioner also agreed that when he retired in July of 2014 he was recovering from his knee and shoulder surgeries. He had been planning on retiring for about a year and a half before he actually did so.

Petitioner agreed that he started the automotive classes within about two months of his retirement and the classes did require physical "hands on" work with autos. Petitioner did a very little amount of it himself, however.

Petitioner also agreed that his hands would go to sleep when he drove and when he would wake up in the morning. He didn't recall if he told Dr. Trudeau about his diabetes.

Respondent's counsel asked Petitioner if he agreed that as a "troubleman" his duties were a good deal different from the ones he had as a journeyman lineman and Petitioner testified that "that's what you [Respondent's counsel] keep saying" but there were a lot of similarities. He agreed he didn't stay in a ditch all day putting in conduit and he wasn't hanging new transformers as much but he was stringing new wire to

houses and secondary wires. He would also do new service installation to single houses, including splicing wires if necessary. When counsel asked him if some of the tools he was demonstrating during the hearing were exclusively used by regular lineman or underground lineman, Petitioner strongly disagreed stating that "You keep trying to say that a troubleman is not a lineman." Petitioner then testified that he was basically doing the same thing – pulling in wire and doing "hot stick work" which required twisting and reaching. If he needed help he would call another troubleshooter; however, usually one troubleshooter was trying to handle the situation. He acknowledged that part of his work day would be spent diagnosing a problem and included walking and driving and talking to customers but it was a very small part of the work day. He agreed that the vast part of his work was done in a bucket at heights.

Petitioner denied taking prednisone for arthritis, clarifying that he has polymyalgia rheumatic which is primarily a hip problem that causes stiffness and pain but his whole body will hurt all the time. When asked if it was the polymyalgia, his age, or the carpal tunnel syndrome that has resulted in his lack of strength he agreed one could say that but he had a lot more strength before his surgery. According to Petitioner, the polymyalgia only affected his hips. He hopes to soon be off the prednisone which is currently at a very low dose.

Petitioner acknowledged he was hired by Asplundh Line as an observer and occasionally he helps out with very light duty work which involves a bucket. He also worked for L.E. Myers digging holes using a big vacuum and sprayer piece of machinery. He did that for about two months. He stopped when winter came. In the winter Petitioner goes to Florida.

Petitioner acknowledged that he rides a motorcycle and has a 1450 cc. Harley. Years ago he took a road trip to California and he often rides to St. Louis, Tennessee, Kentucky, and Iowa. He uses both hands to grip the motorcycle but "it's not like wrestling an alligator." He also acknowledged that the motorcycle vibrates and when he was young he would ride it for hundreds of miles in a day. He testified that he told his doctors about riding his motorcycle but they didn't seem interested in it like Respondent's counsel was. Petitioner often wears a Harley shirt, hat, and "stuff" so they all knew about it. Petitioner still rides his motorcycle twice a week in good weather.

Petitioner acknowledged that he was off work for extended periods of time with his total knee replacement and rotator cuff repair before seeing Dr. Morton in June of 2014.

On redirect examination Petitioner testified that he underwent his knee and shoulder surgeries in 2013. He traveled to Iowa 20 years ago, Kentucky and Tennessee fifteen years ago, and California, back in 1977. He has not taken any extended motorcycle trips in the last ten years and has ridden maybe a couple of times a week in the last five years but it is hard to do. He has been taking steroids since 2013. It's a tapering dosage. Petitioner testified to having issues with his hands and elbows at work long before the prednisone began as he had the EMG in 2006.

Petitioner testified that while he would have symptoms driving and when waking up he really noticed it when working with his knife or his Klein's as his hands would vibrate when he was done working. Petitioner testified that all of his activities involved grasping, twisting and pulling whether tightening connectors, pulling up house services, pulling in new services, or climbing up into a bucket. Petitioner described the majority of his job as involving grasping, pulling, and twisting. Both the "troubleman" position and lineman position involve those motions.

Petitioner testified that his examination with Dr. Rotman lasted about fifteen minutes. Petitioner also explained that he was "trying to get his ducks in a row" when he saw Dr. Morton because he was looking to

move to Missouri when he retired and if he needed any surgery or medical care he wanted it done before he moved.

The Arbitrator concludes:

Issues C and F: Did an Accident occur that arose out of and in the course of Petitioner's employment by Respondent and is Petitioner's current condition of ill-being causally related to the injury?

After a review of the totality of the evidence, the Arbitrator concludes that Petitioner did sustain a repetitive trauma accident with a manifestation date of July 3, 2014, which arose out of and in the course of Petitioner's employment by Respondent. The Arbitrator relies primarily on the credible testimony and demonstration of Petitioner's job duties, Petitioner's job description, and the testimony of Dr. Greatting in rendering this decision. The Arbitrator had the opportunity to the observe Petitioner use the tools of his trade. A number of these tools required significant force of the hands. Others required repetitive twisting and squeezing while applying force. Petitioner testified that the majority of everything he did involved grasping, pulling, and twisting. The Arbitrator finds Petitioner to be a credible witness, relying both on Petitioner's own in-hearing appearance and the testimony of Dr. Li. Petitioner's job description specifically states that individuals in the position of troubleman are required to pull, finger, push, grasp and perform repetitive motions. (PX 2) The Arbitrator finds that Petitioner was not merely occasionally forcefully using his hands, but was constantly exerting force through the hands and arms during his work day.

Dr. Greatting provided persuasive testimony regarding causal connection. He testified that Petitioner became symptomatic with regard to his carpal and cubital tunnel syndromes before he retired and that Petitioner's symptoms had developed over a period of years. (PX 7, p. 18) He testified that Petitioner's work activities, of which he had an extensive understanding, caused of contributed to Petitioner's development of both carpal tunnel syndrome and cubital tunnel syndrome. (PX 7, p. 18) Dr. Greatting opined that Petitioner's job duties would require sufficiently repetitive elbow flexion and extension and force that, over time, it could contribute to the development of carpal tunnel syndrome. (PX 7, p. 33) He further testified that Petitioner's job required forceful and repetitive griping that would contribute to the development of carpal tunnel syndrome. (PX 7, p. 34) Specifically, Dr. Greatting testified that even though Petitioner performed varying tasks, a lot of the tools and tasks required the same motions with the elbows, wrists and hands and all required the application of force. (PX 7, p. 36) Further, Dr. Greatting addressed Petitioner's prior medical treatment and pre-existing conditions and testified that these did not change his opinion as Petitioner's symptoms pre-dated his comorbidities. (PX 7, p. 36)

The Arbitrator finds the opinions of Dr. Rotman less persuasive. First, the Arbitrator gives greater weight to Dr. Greatting as Petitioner's treating physician who has had more opportunities to evaluate and treat Petitioner and is more familiar with Petitioner, his habits, and his job. Second, Dr. Rotman's testimony shows as significant lack of knowledge regarding Petitioner's job duties. He testified that Respondent cut wire and worked with meters, working on approximately 10 houses per day. (RX 1, p. 11) It does not appear that Dr. Rotman discussed Petitioner's specific job activities or the tools that he used, other than a chainsaw, hand saw, and knife. (RX 1, p. 11-12) While Dr. Rotman had a copy of Petitioner's job description, including a list of tools, he did not ask Petitioner about those tools, how they were used, or the force required in using those tools. The doctor spent only fifteen minutes with Petitioner.

Third, the Arbitrator finds that Dr. Rotman was unreasonably critical of the EMG performed by Dr. Trudeau, which caused him to rely on findings of a NeuroMetrix exam, which he testified had little use in the diagnosis of carpal tunnel syndrome. Dr. Rotman relied on the NeuroMetrix exam despite the fact that it

showed no electrodiagnostic carpal tunnel findings, where was both contrary to Dr. Rotman's exam and a previously EMG performed by Dr. Becker in 2006. Further, the NeuroMetrix exam showed that the left carpal tunnel was greater than the right, which is contradicted by all other evidence in this matter. (RX 1, p. 24) Dr. Rotman assumed if another EMG was performed it would be consistent with the findings in 2006, with absolutely no evidence to support. He appeared to take issue with the fact that Dr. Trudeau's EMG showed "severe" carpal tunnel, which is simple false as the EMG showed "moderately severe" carpal tunnel. However, Dr. Greatting testified he had no reason to doubt the reliability of Dr. Trudeau's studies, and in fact the findings on surgical examination were consistent with Dr. Trudeau's report.

Finally, Dr. Greatting's surgical findings are inconsistent with Dr. Rotman's opinions. Dr. Rotman opined that the cubital tunnel syndrome was caused, at least in part, by osteoarthritis in the elbows. However, Dr. Greatting testified that on surgical examination, he found no signs of osteoarthritis in the elbows. (PX 7, p. 37) Further, Dr. Rotman testified that Petitioner's carpal tunnel had been worsened by his taking prednisone, because it would cause water retention in the wrists and therefore place additional pressure on the carpal tunnels. Dr. Rotman further testified on open surgical examination, fluid may be visible if water retention was a problem. Dr. Greatting testified that if prednisone was causing a problem, he would be able to see fluid and swelling in the surgical area. He further testified that he saw neither during his surgeries.

The Arbitrator has given consideration to Petitioner's motorcycle riding activities and other health conditions. She finds Petitioner's testimony on both of these issues very credible. Petitioner testified the physicians were aware of his motorcycle activities. Furthermore, Petitioner's testimony regarding his involvement in same did not seem nearly as upper extremity intensive and extensive as his job duties for Respondent which began in 1977. This is a classic case of cumulative trauma. With regard to Petitioner's conditions of diabetes, pre-diabetes, and polymyalgia rheumatic she found his testimony on cross-examination and redirect credible.

For the reasons set forth above, the Arbitrator concludes that Petitioner sustained an accident arising 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.

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?

As the Arbitrator has determined that Petitioner did sustain repetitive trauma injuries to his bilateral wrists and elbows in the form of bilateral carpal tunnel and bilateral cubital tunnel syndrome, and that Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator awards all related reasonable and necessary medical treatment.

There is no issue as to the reasonableness and necessity of the medical treatment for Petitioner's bilateral carpal tunnel syndrome. Both Dr. Greatting and Dr. Rotman agree that Petitioner required a bilateral carpal tunnel release. Dr. Greatting testified that all of his treatment of Petitioner was reasonable and necessary. Therefore, the Arbitrator awards all charges for medical treatment relating to the bilateral carpal tunnel syndrome.

Further, the Arbitrator finds that the treatment for bilateral cubital tunnel syndrome was reasonable and necessary. Dr. Greatting testified that cubital tunnel releases were reasonable and necessary treatment for Petitioner's condition. Dr. Rotman testified that he did not believe that the cubital tunnel releases were necessary and that the symptoms "may go away" if Petitioner "doesn't lean on his elbows or hold his elbows

flexed for a long time." RX 1, pp. 31-32. The Arbitrator finds that Dr. Rotman's testimony that the condition "may" resolve is not persuasive and further, would leave Petitioner with permanent activity restricitons regarding leaning on the elbows and flexing the elbows. Further, as Petitioner would have required surgery if the condition did not simply resolve, the Arbitrator finds it reasonable that the procedure was performed in tandem with the carpal tunnel releases to avoid additional medical costs of multiple surgeries and the risk to Petitioner of being placed under anesthesia on multiple additional occasions.

Petitioner's medical bills are set forth in Petitioner's Exhibit 9. Respondent is ordered to pay the medical bills as set forth in Petitioner's Exhibit 9, directly to the providers, according to the fee schedule provided, as set forth in the Act. Respondent shall receive a credit for all medical bills paid by Respondent's group health carrier, Health Alliance, according to Section 8(j) of the Act, and Respondent shall indemnify and hold Petitioner harmless for any subrogation efforts made by Health Alliance in relation to said charges.

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

For accidents occurring after September 1, 2011, the Arbitrator must look to the five factor test in determining permanent partial disability.

With regard to the first factor, Dr. Li performed an AMA Guidelines review. The Arbitrator notes Respondent had Petitioner examined for such an evaluation by Dr. Lawrence Li on January 11, 2016. Dr. Li, after reviewing medical records, taking a history and QuickDASH questionnaire from Petitioner, and performing a physical examination upon Petitioner pursuant to the AMA Guidelines, 6th edition arrived at an impairment rating for the combined right carpal tunnel and cubital tunnel conditions of 3% of the right arm and 2% of the whole person, and for the combined left carpal tunnel and cubital tunnel conditions of 3% of the left arm and 2% of the whole person. (RX 2 Petitioner did not introduce any AMA impairment examination report conducted at his request. The Arbitrator first notes that the Guides themselves limit the amount of impairment available for Petitioner's cubital tunnel syndrome as it was rated in conjunction with carpal tunnel syndrome. The Arbitrator notes that if Petitioner's carpal tunnel syndrome and cubital tunnel syndrome had occurred at different times and had been rated differently, Dr. Li would have placed a higher rating on both upper extremities for cubital tunnel syndrome. Further, the Arbitrator finds that Dr. Li improperly rated Petitioner's cubital tunnel syndrome as the Guides required Dr. Li to place Petitioner in a Grade Modifier three for physical findings as Petitioner reported weakness. Dr. Li's opinion that atrophy is a more reliable than weakness is inopposite as the Guides require this grade modification for atrophy or weakness, not just atrophy. For these reasons, the Arbitrator gives only partial weight to this factor.

As to the second factor, the nature of the employment, Petitioner worked for Respondent in a rather physical job for his entire adult life. However, Petitioner took a planned retirement prior to completing his medical treatment. Evidence was presented at trial that Petitioner had been planning his retirement since before his date of accident. For this reason, the Arbitrator gives this factor some weight.

With regard to the third factor, age, Petitioner was 54 years old on the date of his accident. Petitioner has retired, but will likely live for a number of years with the effects of his injuries. As such, the Arbitrator places some weight on this factor.

With regard to the fourth factor, future earning capacity, Petitioner has retired and planned to do so prior to the date of accident. Post-retirement Petitioner has been hired by two companies to do work of a journeyman

lineman nature, ceasing work for both companies as winter approached as he does not like working in cold weather. His physical condition did not prevent his being employed by those companies. No evidence was introduced indicating his salary with those companies. No direct evidence concerning future earning capacity was introduced. The Arbitrator gives weight to this factor.

Finally, with regard to the fifth factor, evidence of disability as corroborated by the treatment records, Dr. Greatting testified that Petitioner's numbness was markedly improved following his surgeries and that he had a good result from them. Petitioner was advised by Dr. Greatting on February 9, 2015 that he should return if he had any problems and Petitioner testified that he had not returned as of the date of arbitration. (PX 7 pp.26, 51) Petitioner also testified that he did not feel his hands were nearly as strong as he used to be, that his elbows worked "just fine," but that he had occasional pain in both elbows.

Petitioner testified that he continues to have reduced strength in his arms. During the in-hearing demonstrations of his job duties, there were several tasks he had significant difficulty with that he testified he used to be able to do. Petitioner testified he has trouble grasping and lifting objects. Petitioner further testified that he has decreased strength in his arms and occasionally gets pain in his elbows. However, Petitioner has also had injuries to his shoulders. Petitioner's trouble lifting things and loss of strength could, in part, be due to his shoulder conditions.

Taking the evidence and the five factors into consideration, the Arbitrator concludes that Petitioner has sustained a 10% loss of the right hand and 10% loss of the left hand due to his bilateral carpal tunnel syndrome. Respondent is ordered to pay Petitioner $721.66 per week for a period of 10.9 weeks, representing 10% loss of the right hand and $721.66 per week for an additional period of 10.9 weeks, representing 10% loss of the left hand.

The Arbitrator further concludes that Petitioner has sustained a 5% loss of the left arm based on his left-sided cubital tunnel syndrome and a 5% loss of the right arm based on his right-sided cubital tunnel syndrome. Respondent is ordered to pay Petitioner $721.66 per week for an additional period of 12.65 weeks, representing 5% loss of the left arm and an additional $721.66 per week for an additional period of 12.65 weeks, representing 5% loss of the right arm.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Morrison,
Petitioner,

vs. NO: 14 WC 31081

Keystone Steel & Wire,
Respondent.

17IWCC0353

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disabiliity, 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 December 4, 2015 is hereby affirmed and adopted.

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

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

17IWCC0353

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:

JUN 12 2017

o-06/07/17
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORRISON, DAVID
Employee/Petitioner

Case# **14WC031081**

KEYSTONE STEEL & WIRE
Employer/Respondent

17IWCC0353

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

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

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

0192 CUSACK GI;FILLAN &O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

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

DAVID MORRISON
Employee/Petitioner

v.

KEYSTONE STEEL & WIRE
Employer/Respondent

Case # 14 WC 31081

Consolidated cases: _____

17IWCC0353

An *Application for Adjustment 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 **Peoria**, on **October 22, 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 _____

17IWCC0353

FINDINGS

On **July 14, 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 **$64,710.88**; the average weekly wage was **$1,244.44**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $ for TTD, $ for TPD, $ for maintenance, and **$11,375.00** for other benefits, for a total credit of **$11,375.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $828.79/week for 36 5/7 weeks, commencing October 9, 2014 through June 22, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay the outstanding medical bills as listed in Petitioner's Exhibit No. 25, pursuant to the medical fee schedule, 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 permanent partial disability benefits of $735.37/week for 125 weeks, because the injuries sustained caused the 25% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

D. Dylan McCarty

Signature of Arbitrator

DEC 4 - 2015

11/24/15
Date

David Morrison v. Keystone Steel & Wire
14 WC 31081

STATEMENT OF FACTS:

Petitioner, David Morrison, testified that he resides in Hanna City, Illinois, and has been employed by Respondent, Keystone Steel & Wire, since 1994. Since that time, Petitioner has had various jobs within the company and is currently an "ARC" stocker, a job which he began in 2006. He stated that he has reviewed the job description provided as Respondent's Exhibit No. 9 and found it to be generally accurate. As a regular part of his job, the Petitioner had to assist in unloading pieces of fuel used to operate the furnaces at the facility. One fuel is referred to in the vernacular as "coke" and it is of a consistency much like coal. The other fuel element is silicone-magnesium and it is generally smaller in size than coke, but is equally as hard.

Petitioner's testimony was that the fuel would generally go through a grate, depicted in Respondent's Exhibit 10. Most of the fuel would fit through the grate, but the larger pieces would not fit through the holes in said grate. When this would occur, Petitioner would take a pry bar and mash the fuel material so that it would eventually go down the holes. He demonstrated this process at arbitration, and indicated that he would push or drive the pieces of fuel using both of his arms. On July 14, 2014, Petitioner was using a pry bar to mash down "coke" so it would fit between the holes in the grate. On that day, while hitting on the material with the pry bar, Petitioner felt pain go down both arms. He didn't think much of it at the time and continued with his job duties. When the pain did not resolve, Petitioner stated that he reported the pain to his foreman, Jake VanCampen on July 21, 2014. Petitioner acknowledged that he filled out an accident report, which was admitted as Petitioner's Exhibit No. 2. In the report, the Petitioner alleges that his injury was caused by using various tools, including a pry bar, shovels and brooms. He also described his injuries as going down both arms, both wrists and fingers.

On July 22, 2014, he saw the company doctor, Dr. Pena. Petitioner related to Dr. Pena that he thought he might have carpal tunnel, as he had known of other workers with similar symptoms, and that the pain would not go away. Dr. Pena's notes indicate that the Petitioner said that pushing materials down a pit with a pry bar was among the various activities that provoked his symptoms. (PX 4) The notes also contain references to the Petitioner's prior herniated disc at C5-6, which had occurred in 2010. The petitioner was quoted as saying that he dealt with the pain, left it as it was and worked ever since. According to the doctor, the Petitioner denied having any neck pain at the time of his visit. The doctor's examination revealed positive Phalen and Tinel's tests in both elbows and wrists. His assessment was possible cubital and carpal tunnel syndromes, but the doctor noted that the symptoms came on too suddenly for those conditions. He also said "There is a potential for this being related to his previous degenerative cervical spine issues." (Id)

At that time, Dr. Pena referred Petitioner for an EMG test with Dr. Russo, conducted on July 29. The Petitioner reported that he had pain in his arms for about two weeks which he related to work activities including shoveling, sweeping and using a pry bar. The testing was reported as negative. (Id) After receiving the negative results of the EMG test, Dr. Pena's partner, Dr. Braun told the Petitioner to see his primary care physician for his problems, stating that they were apparently non-occupational.

Petitioner then contacted the office of Dr. Dinh, the neurosurgeon who had treated him previously for his cervical spine condition, and an MRI was ordered. He also went to see Dr. Doering, his family doctor, on

August 8. He reported bilateral arm paresthesias/weakness, and his system review mentioned that he had no residual effects from a recent stoke. The doctor's plan was to wait for the results of the MRI. (PX 6)

The Petitioner was next seen for treatment by Dr. Dinh's nurse, Diana France, on August 25. She noted that the MRI, done on August 21, showed multilevel degenerative disc disease of the cervical spine, worst at C5-6, where a disc protrusion with moderate canal stenosis and bilateral neural foraminal stenosis were found. The Petitioner said that he had pain and numbness down both arms which began on July 16. He also reported having some neck pain since 2010, which he had learned to live with. Her diagnosis included C6 radiculopathy. She discussed the case with Dr. Dinh, and the Petitioner was referred for an epidural steroid injection, which was performed on September 15, 2014. (PX 8, 9) Petitioner then went back to Dr. Doering on October 8, complaining of pain radiating from his neck down both arms with numbness and tingling. He was referred to Dr. Mulconrey, an orthopedic surgeon. (PX 6)

With regard to prior neck problems, Petitioner testified that he had neck pain back in 2010, and that he had treated with Dr. Dinh. He testified that a truck was backing up to his pit at work when he used a four by four post under one of the truck tires in effort to level the truck. When the truck moved, it spun the tire and the four by four flew out and hit him in the leg knocking him to the ground. He testified the neck pain felt like fire going through both of his arms. Thereafter, he had some injections and physical therapy. An MRI was performed on August 11, 2010, and it showed degeneration of the cervical spine and a moderate right lateral disc protrusion at C5-6. Dr. Dinh testified in an earlier arbitration concerning the 2010 accident that he had considered surgery after reviewing the MRI, but later decided against it when the Petitioner's symptoms resolved. Moreover, the pain gradually resolved and Petitioner was able to return to work full duty in April of 2011. (PX 26 at 12-13) Even though he had been released by Dr. Dinh, Dr. Pena required him to complete a work hardening program before he could actually work. Petitioner stated that he has not seen a physician for his neck since he was returned to work in April 2011 until the time of this accident.

Evidence was also admitted showing the Petitioner treating for neck and left shoulder pain in 2002. An MRI done at that time showed degenerative disc disease in the cervical spine and a small disc protrusion at C5-6, slightly centered to the right. The records, contained as exhibits in the deposition of Dr. Wehner, show the Petitioner treating into 2003, receiving some injections and possibly an ablation. (RX 8; Dep. Ex. 2 and 3) The Petitioner didn't recall much about that treatment other than acknowledging it.

Petitioner also had a history of longstanding stroke like symptoms which are referenced in the medical records and which were acknowledged by the Petitioner. Petitioner testified to having a stroke on July 22, 2014, wherein he was treated at the emergency room of UnityPoint Methodist Medical Center on July 23, 2014. He stated that at approximately 3:30 a.m. while getting ready for work, his entire right side went numb which lasted about 7 to 10 minutes. He then went to work and the same thing happened again around 5:00 – 5:30 a.m. He then completed his shift with no further incidents. That evening, at his wife's urging, he went to the emergency room. Petitioner testified that when he reported to Dr. Pena for the work injury on July 22, 2014, he did not mention the strokes because they were not related to work and he was afraid Pena would have taken him off work which he could not afford.

When Petitioner first saw Dr. Daniel Mulconrey on October 13, 2014, conservative measures were employed which consisted of an injection in the neck and physical therapy. After these measures were exhausted without avail, Dr. Mulconrey performed surgery in November 2014. Petitioner testified that he obtained some relief following the surgery; however, he stated that he was still having some pain at the end of January

2015. Dr. Mulconrey performed a second surgery in February 2015. Petitioner testified that after the second surgery he felt much better and was able to attend physical therapy and returned to work full duty on June 22, 2015.

Petitioner testified that he continues to have neck pain; however, he is able to live with the pain and able to function and work full duty.

At the request of Respondent, Scott Bardwell testified that he has worked with Petitioner for 20 plus years and has been his supervisor for the past 10 years. Mr. Bardwell agreed with the Petitioner's testimony that the job description offered as Respondent's Exhibit No. 9 is not entirely accurate. Mr. Bardwell also admitted that he took the photograph offered as Respondent's Exhibit No. 10. He agreed that the Petitioner would have to manually push the two fuels through the grate on a regular basis. He said that the coke was like charcoal; the silc more like a rock. He said that a worker would use a shovel, hoe or pry bar to push the fuel, and that it was usually done for about fifteen minutes at the end of each load being delivered. He said that between six and ten trucks dump loads during each work shift, and that another worker besides the Petitioner would work on the delivery.

On cross examination, Mr. Bardwell testified that he also took a two minute video with his phone of Petitioner actually in the process of using a pry bar to break up the fuel. Mr. Bardwell testified that he forwarded the video to the phone of Keystone's workers' compensation representative, Rusty Hewitt. He additionally admitted that Rusty Hewitt was sitting in the room across the hall from the hearing room. Mr. Bardwell admitted that the video would show the exact procedure with the pry bar that the Petitioner was doing when he was injured. Even knowing that, Respondent did not offer the video in evidence. Mr. Bardwell testified that the force to break the coke was minimal; although he did not produce the video which he admitted would show the exact mechanism of injury.

Finally, Mr. Bardwell testified that he had a conversation in his office with the Petitioner on July 22. He said the Petitioner told him he thought he had carpal tunnel, and that he was being sent for tests. He further said that the Petitioner did not discuss his work duties with him at that time.

Petitioner's treating physician, Dr. Daniel Mulconrey, a board certified orthopedic surgeon, testified by way of evidence deposition. Dr. Mulconrey first saw Petitioner on October 13, 2014 at the request of Petitioner's primary care physician, Dr. Doering. At that time, Petitioner gave Dr. Mulconrey a history of using a pry bar in July 2014 and having radiating pain into his arms and hands. At that time, Dr. Mulconrey recommended physical therapy. When Petitioner failed to obtain any pain relief from physical therapy, Dr. Mulconrey recommended surgery. On November 21, 2014, Dr. Mulconrey performed an anterior cervical decompression and fusion at C5-C6. Dr. Mulconrey testified that Petitioner did well after that surgery; however, by February 2015 he was having increased pain and pain radiating down his right arm. Due to the increased pain, a CT was ordered which showed Petitioner was fusing but had increasing degeneration at the level above. Dr. Mulconrey then recommended extending the fusion to the C4-5 segment. That was done on February 19, 2015. Following the second surgery, Petitioner was eager to return to work. He had been off work since October 2014. Petitioner's pain had improved and the radiating pain down the right arm had completely resolved. After a course of physical therapy, Dr. Mulconrey released the Petitioner to return to work on June 22, 2015. (Petitioner's Exhibit No. 1, page 13.) Although Petitioner wanted to go back to work earlier, because of the heavy nature of his job, Dr. Mulconrey didn't return him until June 22, 2015. (Petitioner's Exhibit No. 1, page 17). With regard to prognosis, Petitioner was still under Dr. Mulconrey's care and using a

bone stimulator. Dr. Mulconrey hoped he would achieve a fusion within approximately 6 months to a year and not require any future medical care.

When asked specifically about causation, Dr. Mulconrey stated as follows:

> "A : Based on the patient's history that he provided me, he reported the arm symptoms and he neck pain that he reported on October 13, 2014, was related to an incident at work using a pry bar in July 2014."

(Petitioner's Exhibit No. 1, page 18)

Respondent's Section 12 examining physician, Dr. Julie Wehner, also testified by way of evidence deposition. Although there was a fair amount of testimony regarding alcohol during cross examination of Petitioner, the Respondent's own IME physician states:

> "A: No. I don't believe alcohol caused any problem in his neck."

(Respondent's Exhibit No. 8, page 35)

Moreover, smoking was brought up as an issue; however, Dr. Wehner agreed that she can't say beyond a reasonable degree of medical certainty that it had anything to do with causation in this case. (Respondent's Exhibit No. 8, page 38).

With regard to the stroke, Dr. Wehner admits that his symptoms appeared to be right-sided. (Respondent's Exhibit No. 8, page 47-48). She did admit, when talking about the stroke, that the emergency room records only reveal that Petitioner was complaining of a stroke affecting his right side. Dr. Wehner agrees that when the Petitioner reports stroke problems to the emergency room, he is only reporting right-sided symptoms which is contra to what he reported to Dr. Pena on July 22, 2014, when Petitioner first saw him for the instant accident and he told Pena that the pain was going down both arms.

With regard to the prior neck treatment in 2010, Dr. Wehner admitted that although it is not in her report, Dr. Dinh had released the Petitioner to full work after physical therapy. She then admits that Dr. Pena released him to return to work only after a functional capacity evaluation required by Dr. Pena. (Respondent's Exhibit No. 8, page 54). Dr. Wehner also admitted that after the 2010 incident, she did not review any medical records that would stand for the proposition that the Petitioner saw any doctor or had any cervical problems until July 2014. In further commenting on the reason that Dr. Dinh released the Petitioner back to work in 2010, the doctor speculated by stating:

> "...My understanding is that his job is not that physical, so I would assume he was able to return to work."

(Respondent's Exhibit No. 8, page 55),

Dr. Wehner testified that the Petitioner's condition of ill being which was treated by Dr. Mulconrey was not causally related to any work activity on July 14, 2014, or any repetitive work activity performed by the Petitioner for the Respondent. She cited three reasons for her opinion. First of all, she noted that the Petitioner gave no history of a specific accident in his accident report. Secondly, she said that there was no

indication that the Petitioner experienced any neck pain around said date, and felt that his arm symptoms were related to the stroke he had around July 21. Finally, she said that the neck pain he did complain of at the time of Dr. Mulconrey's first surgery was due to his condition seen in 2010, and the 2014 MRI did not show any changes in said condition. (RX 8 at 28-29)

FINDINGS:

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

The Petitioner testified that his job required him to use both arms to break up hard pieces of fuel and force them through a metal grate. He used a pry bar and other tools to perform his job. He said he did this on a daily basis, and had done so since beginning his job in 2006. Respondent's witness, Mr. Bardwell, agreed that this activity was part of the Petitioner's regular job, though he said that it was not done as frequently as the Petitioner had indicated. He did, however, say that the Petitioner used his various tools to push fuel through the grate for about fifteen minutes per load, and that there were six to ten loads delivered each shift. He said that the process was not strenuous. He said that the process required more of a loosening of the fuel and pushing, as opposed to pounding. His testimony on that issue is not credible. First of all, he said that some pieces of fuel did not fit through the grate on its own. He also said that some of the fuel was as hard as charcoal and the rest as hard as a rock. It is had to imaging how such fuel could be loosened through the grate without using some force. More importantly, the Respondent failed to offer into evidence the video which showed the petitioner performing the work in question. Certainly this allows the Arbitrator to assume that the video would have favored the Petitioner's claim.

Respondent argues that the Petitioner did not have an accident because he did not report a specific event, as alleged, to anyone, including all of his doctor's and plant personnel. The fact is that the accident, while occurring on July 14, did not involve a one time event. It instead involved the Petitioner performing a strenuous activity using his arms over the course of his work day. He even said that he could not identify a specific piece of coke that he hit producing his symptoms. If he had tried to testify as such, his testimony would have lacked credibility.

Also, while the Petitioner may not have discussed his work duties with Mr. Bardwell on July 22, he did with his foreman on the preceding day, including it on his written accident report. Similarly, he told Dr. Pena on the 22nd that he cleaned material from the truck on the pit six times a shift and that using the pry bar was one of the things which provoked his arm symptoms. He also told Dr. Russo he had problems using the pry bar.

Respondent also contends that the Petitioner's failure to report his accident the day it happened indicates that it did not occur. While the Petitioner acknowledged that the rule require him to report it immediately, it was perfectly understandable that he would not given the circumstances. He had prior neck problems and treatment. He certainly could have thought the arm pain he was having might be a temporary problem, and it was understandable that he tried to work through it. Waiting a week was certainly reasonable.

Finally, there is the stroke or strokes he suffered on or about July 20, 21 or 22. The Arbitrator believes the strokes are "red herrings" concerning any of the contested issues in this case. First of all, the records from the

hospital indicate his stroke paresthesia involved only the right side. His symptoms reported and attributed to his work accident involved both arms. If, in fact, his stroke symptoms began on say July 20, before he reported his work injury, there is no evidence that his symptoms were like those he reported to his employer. Secondly, it is clear that he had stroke like events for many years prior to 2014. He knew what they were like, and he told his treaters at the hospital that each event produced symptoms of numbness for about fifteen minutes. He only went to the hospital because his wife persuaded him to go, and his symptoms upon admission were that of a headache. (RX 8, Dep. X 6)

The Arbitrator finds that the Petitioner has proven an accident arising out of his employment on July 14, 2014.

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

It was Petitioner's uncontradicted testimony that on July 21, 2014, he informed his foreman, Jake VanCampen, that on July 14, 2014, he experienced pain in his arms. His accident report identifies the specific work tools which he believed were causing his injuries. He has proven notice as required by the Act.

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

It is clear from the evidence that the Petitioner was in poor health prior to July 14, 2014. He was an alcoholic. He smoked excessively. He had a history of prior strokes or TIA's and on is own, decided to stop his Coumadin against his doctor's orders. He had a history of degeneration of the cervical spine which went back at least twelve years, and in 2010 had radiographic evidence of a disc herniation or protrusion at the same level which Dr. Mulconrey performed fusion surgery in late 2014.

None of that evidence, however, defeats his claim that his accident was causally related to his current condition of ill being. It has long been the law in Illinois that an employer takes his employees as it finds them. A pre-existing condition does not prevent recovery under the Act so long as that condition is aggravated or accelerated by the Petitioner's employment. In the case of Tower Automotive v. IWCC, a forklift driver forced to turn his head from side to side was awarded compensation based upon the principles stated above. In Tower, the petitioner had at least as much degeneration in the cervical spine as Mr. Morrison, and the gap between the claimed accident and relevant symptoms was much longer than a week. See 407 Ill. App. 3d 427 (2011)

Dr. Mulconrey testified to causation based mainly on the Petitioner's testimony that his arm symptoms developed after using the pry bar at work and the fact that he consistently told that to his treating and examining doctors prior to his involvement in the case. Even though the evidence showed the Petitioner with some degree of preexisting neck pain, the post accident radicular arm pain represented a change in his condition. (PX 1 at 24)

Respondent argues that the fact that there may not have been any changes on the post accident MRI from the one taken in 2010 means that there can be no aggravation. Nothing in our Act places such a requirement of proof on the Petitioner. Evidence based medicine has not been added to our Act. The change in the Petitioner's symptoms, which he proved by his consistent histories to his doctors, is enough to prove his claim.

Dr. Mulconrey's opinions are more persuasive than those of Dr. Wehner. As stated above, she gave three reasons for her opinions. While she said the Petitioner did not report a specific accident, she acknowledged that he attributed his problems to his work using the pry bars and other tools. (RX 8 at 29) As stated in the decision under accident, there is no requirement that the Petitioner identify the specific offending piece of fuel. She also put a lot of weight on the fact that the Petitioner did not have immediate neck symptoms. The Arbitrator finds this also not persuasive. Even Dr. Pena, at this first office visit, suggested the Petitioner's symptoms might be related to his cervical spine even though he wasn't having any neck pain. Finally, she said the neck pain which Dr. Mulconrey treated surgically was old. Dr. Mulconrey didn't do surgery because of only the Petitioner's neck. He did surgery to relieve his radiating bilateral arm pains which were not present prior to July 14, 2014.

The fact that Mr. Morrison returned to work full duty in April of 2011, and continued to work full duty at a heavy labor position until October 2014 is persuasive that his symptoms from 2010 had improved. I do not believe that he could have performed his job for over 3 years without incident if his symptoms had not improved. Additionally, the testimony and the fact that the video was not produced leads me to believe that Petitioner's job is more physical than Mr. Bardwell's testimony reflected. Petitioner, as well as Dr. Mulconrey, testified that Petitioner received pain relief from his surgeries; however, he continues to have occasional neck pain. Moreover, I find that Petitioner's symptoms from the strokes he suffered were different than the instant injury. The stroke was purely right-sided and the Petitioner was unable to move his right side for a few minutes. The instant case involved pain going down both of Petitioner's arms. Based on the above, I hereby find that Petitioner's current condition of ill-being is causally related to his accidental injury of July 14, 2014.

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

I hereby find that the medical services provided to Petitioner as listed in Petitioner's Exhibit No. 25 to be reasonable and necessary. I hereby order Respondent to pay the outstanding balances as listed in Petitioner's Exhibit No. 25 directly to the providers pursuant to the medical fee schedule. Additionally, Respondent shall hold Petitioner harmless with regard to payments made by his health insurance.

K: What temporary benefits are in dispute?

Based upon the evidence submitted as well as the credible testimony of Petitioner and Dr. Mulconrey, I find that Petitioner was taken off work on October 9, 2014 by his primary care physician. He was then off under the direction of Dr. Mulconrey until he was medically returned to work on June 22, 2015. I hereby find that Respondent shall pay Petitioner TTD benefits in the amount of $828.79 for a period of 36 5/7 weeks.

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

Using Section 8.1 (b) as a guide, the Arbitrator notes that no AMA rating was offered by either party. The Petitioner's job as material handler is fairly light in nature, though it does require him to lift up to 60 pounds, according to the job description. He was 50 years old when he was injured, and he has a full release with no showing of any expected future loss of earnings. He now has a two level cervical fusion, and both he and his treating doctor indicate that he has had a good surgical result. Based on those factors, Petitioner is awarded 25 % Person as a Whole under Section 8 (d) (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

Matthew Johnson,
Petitioner,

vs.

NO: 15 WC 03548

Shawnee Correctional Center,
Respondent,

17IWCC0339

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 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: JUN 1 - 2017
o051117
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JOHNSON, MATTHEW
Employee/Petitioner

Case# **15WC003548**

SHAWNEE CORRECTIONAL CENTERR
Employer/Respondent

17IWCC0339

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

JUL 28 2016

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

17IWCC0339

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

Matthew Johnson
Employee/Petitioner

v.

Shawnee Correctional Center
Employer/Respondent

Case # **15** WC **3548**

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 **07/17/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0339

FINDINGS

On **12/10/2014**, 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 **$56,329.00**; the average weekly wage was **$1,083.25**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

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

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 permanent partial disability benefits of $649.95/week for 25 weeks, because the injuries sustained caused 5% loss of use of the man as a whole pursuant to 8(d)2 of the Act.

Respondent shall pay reasonable and necessary medical services of $6,347.58, as set forth in PX1, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Michael K. Nowak, Arbitrator

6/23/16
Date

ICArbDec p. 2

JUL 28 2016

FINDINGS OF FACT

Petitioner is a 42-year-old correctional officer at Shawnee Correctional Center. The Parties stipulated that Petitioner sustained accidental injuries arising out of and in the course of his employment as a Correctional Officer on December 10, 2014, when he was punched in the temple area of his head by a combative inmate. Petitioner developed a severe headache within 30 minutes of the accident. Petitioner testified that prior to this accident he had never suffered any sort of trauma to his head.

On the date of accident Petitioner presented to the emergency room of Heartland Regional Medical Center with complaints of head pain due to being assaulted while on duty. Petitioner reported being hit in the left temple and reported scratches on his right arm. Petitioner reported headache and abrasions. Petitioner denied loss of consciousness. Petitioner underwent a CT of the head/brain which was unremarkable. Petitioner was discharged from the emergency room with a diagnosis of head injury. He was discharged with instructions for concussion and brain injury care

On December 15, 2014, Petitioner presented to Graham Family Medicine and was seen by Dr. Graham. Petitioner reported a history of the accident. Petitioner told Dr. Graham that he was diagnosed with a concussion at the emergency room. He still complained of intermittent headaches the past few days, described as "throbbing" behind/across the eyes. The headaches were somewhat relieved by ibuprofen. The only other symptom Petitioner noticed was forgetfulness. Petitioner was assessed with a concussion without loss of consciousness. Petitioner was given recommendations to avoid caffeine, cigarette smoke, and heavy exertion. A graduated exercise program, rest and stress reduction were also recommended. Petitioner was to remain off work until re-evaluated.

On December 22, 2014, Petitioner returned to Dr. Graham for his post-concussive symptoms. Petitioner continued to have intermittent headaches. Petitioner described his headaches as being in the frontal area, behind the eyes, and "throbbing". Petitioner had been taking 800 mg of Ibuprofen, which seemed to "dull it out within an hour or 2". Petitioner also had persistent intermittent episodes of short term memory loss. Petitioner described no other neurologic symptoms. Petitioner was again assessed with a concussion without loss of consciousness. He was kept off work for another week to see if his symptoms improved. Evaluation by a neurologist and an MRI were recommended.

On December 29, 2014, Petitioner returned to Dr. Graham. Petitioner reported that since the incident he had intermittent, but persistent headaches and short term memory loss, however, today he was stating that he is significantly better. Petitioner only had very mild headaches since he was seen last week. He has not had any memory loss. Petitioner claimed he was doing great and wanted to go back to work. The doctor noted Petitioner seemed to be doing well. Petitioner was advised to ease back into work on a half day or part time basis, but Petitioner claimed he felt good and was ready to go back to work full time without restrictions. Petitioner was allowed to return to work without restrictions on December 30, 2014, but was advised to stop work immediately if his symptoms worsened again.

On January 13, 2015, Petitioner presented to Dr. David Raskas at Orthpedic Sports Medicine & Spine Care Institute. Petitioner reported that since the accident he had persistent headaches. He complained of pain which felt like it was behind his eyes bilaterally. He did not have any sensitivity to light. He had been taking

Tylenol and Ibuprofen for his headaches. He was noted to be able to do activities of daily living. Physical examination revealed his pupils were equal and reactive to light bilaterally. He was able to track without difficulty. Dr. Raskas reviewed the CT scan of Petitioner's head which did not reveal any bleeding or abnormality. Petitioner was assessed with post-concussion syndrome based on symptoms. Dr. Raskas believed Petitioner should follow up with a neurologist regarding his persistent headaches.

On January 21, 2015, Dr. Raskas referred Petitioner to Dr. Chaudhry for continued care. Petitioner was to call with any questions or concerns. Petitioner testified that he did not see Dr. Chaudhry or any doctor after Dr. Raskas for his headaches.

Petitioner testified that he experiences headaches behind his eyes. He reported headaches when reading or watching television. He takes Tylenol or Ibuprofen for the headaches. He estimated he takes Tylenol or Ibuprofen once or twice a week.

CONCLUSIONS

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

The entirety of the evidence in the record indicates, without contradiction, that Petitioner's on-going symptoms are directly related the injuries he sustained in the undisputed work accident of December 10, 2014. Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the accident.

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

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

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither Party submitted an AMA rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to serve as a Correctional Officer. The Arbitrator gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of his injury. Because of the increased length of time for which Petitioner must live and work with his disability, the Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner sustained a concussion and developed post-concussion syndrome. Petitioner continues to suffer from significant, throbbing headaches, blurred vision, and loss of sleep due to his injury. Petitioner had no such problems prior to his undisputed accident. Petitioner's complaints are corroborated by his medical records. The Arbitrator therefore gives *greater* weight to this factor.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 5% loss of his body as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Pitts,
Petitioner,
vs. NO: 08WC 53683

Kehe Food Distributors,
Respondent.

17IWCC0355

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, notice, temporary total disability, and permanent partial disabilty, 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 1, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUN 14 2017
MJB/bm
o-6/6/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PITTS, JAMES
Employee/Petitioner

Case# **08WC053683**

KEHE FOOD DISTRIBUTORS
Employer/Respondent

17IWCC0355

On 3/1/2016, 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 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0347 MARSZALEK AND MARSZALEK
STEVEN A GLOBIS
120 W MADISON ST SUITE 801
CHICAGO, IL 60602

0445 RODDY LAW LTD
PAUL W SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

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

JAMES PITTS
Employee/Petitioner

v.

KEHE FOOD DISTRIBUTORS
Employer/Respondent

Case # **08** WC **53683**

Consolidated cases: _____

17IWCC0355

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Village of New Lenox**, on **1/8/16**. 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 **2/15/08**, 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 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 **$37,323.00**; the average weekly wage was **$717.75**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of $.

Respondent is entitled to a credit of **$49,809.63** under Section 8(j) of the Act.

ORDER

The Arbitrator finds that Petitioner failed to prove that he sustained an accident, which arose out of and in the course of the employment.

The Arbitrator concludes that Petitioner is denied benefits pursuant to the Illinois Workers' Compensation Act based upon the fact that Petitioner failed to prove that he sustained an accident, which arose out of and in the course of the employment. All benefits are hereby denied. All other issues are moot.

Signature of Arbitrator

1/25/16
Date

MAR 1 - 2016

MEMORANDUM OF DECISION OF ARBITRATOR

STATEMENT OF FACTS

James Pitts, was an employee of Kehe Food Distributors since 1999. Kehe Food is in the business of food distribution. In December of 2006 the Petitioner began working for building maintenance at Kehe Food Distributors. As a maintenance person, the Petitioner would maintain the building, which would include but not be limited to replacing ballasts, fix grates, plow snow, build structures. This job would require lifting of steel grates, I-beams, tools, etc.

On February 15, 2008 the Petitioner was working as a maintenance person at Kehe Food. The Petitioner testified that on that date he was going to a trailer where spare parts were held. The Petitioner testified that while going to the trailer to procure spare parts, he slipped and fell on snow and ice. The Petitioner's testimony was that he gave notice to Bob Grodon, Petitioner's manager. The Petitioner testified that he provided notice at the end of February of 2008. The Petitioner however never testified that in fact he informed Mr. Grodon at that time of a specific accident at the work place. The Petitioner told Mr. Grodon that he fell outside on ice. He informed his manager that he was going to the chiropractor. The Petitioner testified that he never completed any accident reports whatsoever. At the time of this discussion with Mr. Grodon the Petitioner did inform him allegedly of an issue with respect to his back but never specifically referred to an event at the work place.

The Petitioner initially sought treatment at Advantage Chiropractic on March 3, 2008. On April 2, 2008 the Petitioner went to Edward Hospital emergency room. On April 6, 2008 the Petitioner went for additional treatment at Adventist Bolingbrook Hospital. While being treated at Adventist Bolingbrook Hospital the Petitioner had sharp pain in his left leg and he was taken off work. Adventist Bolingbrook ultimately referred the Petitioner to Rezin Orthopedics and received care and treatment at this facility from April 8, 2008 to April 29, 2008. While being treated at Rezin Orthopedics, the Petitioner underwent an MRI, received medications and underwent physical therapy. He gave a history of falling on ice, but no mention of this fall occurring at work is contained in these medical records.

On or about April 26, 2008 the Petitioner began treating at Advantage Physicians and came under the care of Dr. Hendrix. While treating with Dr. Hendrix the Petitioner had pain down his legs. An EMG was performed and the Petitioner underwent an injection and also underwent additional physical therapy from April 28, 2008 to June 4, 2008. Ultimately the Petitioner was referred to Dr. Sean Salehi. He again gave a history of falling on ice, and again no history of the fall occurring at work is recorded.

The Petitioner testified that he began seeking treatment from Dr. Salehi on or about May 22, 2008. While Petitioner was treating with Dr. Salehi, he testified he could not work and was in total pain in the low back at the belt line. Dr. Salehi ultimately recommended surgery. The Petitioner underwent surgery and following surgery had physical therapy at Advance Physical Therapy. The Petitioner did undergo work conditioning, which concluded on September 23, 2008. Dr. Sean Salehi released the Petitioner to return to full duties on September 25, 2008. He gave Dr. Salehi a history of falling on ice at work. This is the first mention of a work related accident that the Arbitrator could find in the medical records.

The Petitioner testified that presently, he has issues with his right leg. The Petitioner characterized his right leg as feeling like a log. Petitioner testified that his right leg gets numb. He also testified that his right foot gets numb. The Petitioner testified that Petitioner's right leg problems started since the injury. The Petitioner also testified that occasionally he has swelling in the right leg. The Petitioner further described his symptoms as pain in the bottom right portion of the leg into the calf. The Petitioner further testified that at times it feels like

his leg is going to give way and it is often difficult sleeping. The Petitioner did testify that it feels much better at work however he is forced to sleep on his left side due to the issues with his right side.

The Petitioner did testify that he had no proper injuries to his back or legs. Presently the Petitioner is not taking any medications and he has not seen a doctor for his back since he was released by Dr. Salehi in September of 2008.

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

The Petitioner has alleged that he suffered an accident at the work place. The Petitioner has testified that he slipped and fell and injured his back at work. Following this accident, the Petitioner did seek chiropractic treatment at Advantage Chiropractic. The Petitioner was treated by Dr. Gareth Trichardt. Petitioner saw Dr. Trichardt on March 3, 2008. His history was that he slipped on ice. The Petitioner sought care from this chiropractic physician.

On April 2, 2008 the Petitioner reported to the Edward Hospital emergency room complaining of low back pain. The history that was provided at this facility was that Petitioner slipped on ice. The records also state the Petitioner suffered this accident 2 months ago.

The Petitioner then sought treatment at Bolingbrook Immediate Care on April 6, 2008. The Petitioner testified that he fell on slippery ice. Bolingbrook Immediate Care referred the Petitioner to Dr. Rezin and on April 8th Petitioner saw Dr. Rezin and provided a history of slipping and falling on ice a week ago. Dr. Rezin treated the Petitioner and ultimately the Petitioner was provided physical therapy and once again at Advance Physicians, as well as, Petitioner's physical therapy facility, the Petitioner provided a history that Petitioner slipped on ice.

The physical therapy records are replete with handwritten physical therapy initial evaluation documents wherein Petitioner described the accident, which was "slip/fell on ice (twisting)". There is no mention of a work related slip and fall whatsoever. (Petitioner's Exhibit #6)

Based upon Petitioner's own testimony, as well as, the numerous medical records, the Arbitrator finds that the Petitioner has not met his burden of proving by a preponderance of the evidence that he sustained an accident arising out of and in the course of his employment with Respondent on February 15, 2008. The Arbitrator notes that numerous histories were given to various medical providers in the two months after the alleged accident, but that there is no evidence of a work related accident recorded in the medical records until over 2 months following the alleged accident date. Petitioner testified he told his manager he slipped and fell but his own testimony was silent as to it happening at work. Based upon this finding, all benefits are denied, and the Arbitrator finds that all other 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

Jerome P. Vyborny,

Petitioner,

vs.

NO. 11WC 26755

Kroger Limited Partnership I,

Respondent.

17IWCC0359

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 5, 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.

17IWCC0359

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: JUN 14 2017
SJM/sj
o-5/25/2017
44

Stephen J. Mathis

David L. Gore

Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VYBORNY, JEROME P
Employee/Petitioner

Case# **11WC026755**

13WC012244

KROGER LIMITED PARTNERSHIP I
Employer/Respondent

17IWCC0359

On 10/5/2015, 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 0.10% 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:

0529 GREG TUITE & ASSOC
119 N CHURCH ST
PO BOX 59
ROCKFORD, IL 61101

0210 GANAN & SHAPIRO PC
BENJAMIN SCHROEDER
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0359

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

Jerome P. Vyborny
Employee/Petitioner

v.

Kroger Limited Partnership I
Employer/Respondent

Case # 11 WC 26755

Consolidated cases: 13 WC 12244

An *Application for Adjustment 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 **Rockford and Woodstock**, on **July 15, 2015 and August 6, 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 **September 30, 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 in part*** 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 **61** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 20 5/7 weeks, commencing January 13, 2011 through June 6, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $363.00 to Carlson Orthopedic Clinic and $246.00 to Dr. Disanti, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $253.00/week for 25.625 weeks, because the injuries sustained caused the 12.5% loss of the Left Leg, as provided in Section 8(e)12 of the Act.

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

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

Signature of Arbitrator

October 5, 2015
Date

OCT 5 - 2015

Statement of Facts

This matter was heard in conjunction with consolidated case 13 WC 12244. That matter will be addressed in a separate decision.

Petitioner Jerome Viborny testified that on September 30, 2010 he was employed by Respondent Kroger as a meat clerk. He had been working for Respondent for approximately a year and a half. Previously, he had worked in construction as a general contractor. The physical demands of his construction job included heavy lifting. He owned J. P. Viborny Construction. Petitioner testified the last construction work he did was in 2006. Between 2006 and 2009, he was supported by his wife and sister. His wife is a realtor, property manager. Petitioner denied doing carpentry work in December, 2010.

As a meat clerk for Respondent, he did a lot of stocking items that came off pallets. He put away boxes. He testified that the boxes weighed from 40 to 80 pounds. He also did grinding of hamburger, packaging and some cutting of meat. Petitioner testified that Petitioner's Exhibit 3 was an accurate job description. Petitioner testified that he worked between 40 and 55 hours per week. He was hourly and paid minimum wage. He testified he very seldom worked less than 36 hours.

Petitioner testified he had a prior injury to his left leg in 1969 when he had a surgery for a cartilage removed. He played football for the University of Illinois from 1968 through 1970. He testified he had no other medical treatment for his left knee from 1969 until September 30, 2010. He was able to work. He was still agile and mobile. He testified that his left leg was getting more bowed than the other knee.

On September 30, 2010, he was pulling a stocking cart and his left foot got caught underneath and it threw him down and wrenched his left knee. He testified he noticed his knee was irritated, sore. Petitioner testified that the store manager Chris Sprecker saw the incident or saw him on the floor. He kept working over the next couple of weeks. He noticed his left knee was irritated, a lot of pain. Two and a half weeks after, he went to the manager and told him he could not work anymore; his left knee was too sore. He filled out the accident report and was sent to Physicians Immediate Care.

The records of Physicians Immediate Care were admitted as Petitioner's Exhibit 5. Petitioner was seen initially on October 21, 2010. He provided a history of the accident and noted his symptoms have progressively worsened. He advised the doctor of his prior 1969 cartilage repair. He denied pain prior to the fall. The examination noted pain over the medial side of the knee. Petitioner walked with a limp. X-rays noted severe degenerative joint disease. The assessment was left knee pain, associated to a fall. The doctor notes there is the possibility that he has inflammation as a result of the fall but the degenerative portion was probably aggravated as a result of the fall; medication will probably calm the symptoms down, but he would be probable for joint replacement. Petitioner was prescribed Biofreeze and Meloxicam. He was released to work with restrictions on kneeling, squatting, jumping, running, and ladders (PX 5).

Petitioner returned on October 28, 2010 and reported significant improvement. The examination noted that the knee was deformed, associated with the chronic changes. Gait was normal. Petitioner was advised to continue applying Biofreeze and to take Meloxicam. He was released to full duty and discharged from care at MMI and no residual disability (PX 5).

Petitioner testified that as he continued to work, he noticed a blister on his right second toe. When he was putting product out into the cases, he notice irritation and saw that it was a blister at the end of the day. He testified he was wearing steel toe work boots. He bought them at Red Wing. They were fairly new. He testified he always wore them at work. The shoes were not provided, paid for or reimbursed by Respondent. Petitioner testified that he was not given a dress code for shoes other than to wear something appropriate. Petitioner testified he went on his own to Physicians Immediate Care for his toe on November 13, 2010. Petitioner testified he does not remember advising Physicians Immediate Care that the right second toe issue was not work-related.

After the blister developed, his job duties changed to include cleaning the meat department. Petitioner testified his feet became saturated with the water and chemicals used. Because his shoes were not waterproof, he bought rubber boots. Petitioner testified he told the store manager assistant Chris that when he was doing the cleaning the second or third time that his toe would burst in his boot and he could not keep doing it.

The records reflect Petitioner returned to Physicians Immediate Care on November 11, 2010 with complaints of redness, swelling and oozing in his right foot. The record states the date of onset was July 10, 2010. The cause lists an injury from wearing steel toe boots. The injury is not listed as work related (PX 5). Petitioner testified that the record stating the onset of his toe issue was July 10 is a mistake. He does not remember telling them that the condition was not work related. Petitioner admitted he made direct payment for the visits to Physicians Immediate Care for his right toe. Petitioner was prescribed Doxycycline and Bactrim. He continued treatment through December 6, 2010. On November 15, 2010, Petitioner noted working long hours on his feet caused swelling. He complained of swelling and oozing of the second toe. X-rays note degenerative joint disease of the great toe. On November 27, 2010, Petitioner also complained of swelling in the left leg (PX 5).

Petitioner testified he continued to work. He was noticing a lot of pain in both his toe and his knee. On December 6, 2010, Physicians Immediate Care recommended he go to the emergency room. He went to OSF St. Anthony. He was told to see his family doctor. Petitioner testified he saw Dr. Disanti on December 9, 2010. Dr. Disanti admitted him to OSF Hospital. He brought in Dr. Pyun. Dr. Pyun performed surgery to remove the second toe on December 13, 2010.

Petitioner testified that, when they came to show him how to be more mobile, he was in extreme pain in his left knee. Petitioner had x-rays taken of the left knee on December 10, 2010 which showed no soft tissue swelling and an impression of degenerative osteoarthritis. An MRI on December 16, 2010 showed a large left knee joint effusion along with a complete ACL and probable PCL tears (PX 6). He saw Dr. Carlson for a consultation on December 17, 2010 for left knee pain and swelling. The history was of the fall with injury two months ago. Transferring all his weight to the left leg worsened his symptoms. Dr. Carlson noted the infection must be addressed before treatment to the knee (PX 9). Petitioner testified that he followed up with Dr. Disanti and Dr. Pyun for his toe. He was released by Dr. Pyun to regular work for his toe on February 7, 2011 (PX 7).

Petitioner returned to Dr. Carlson for his left knee on January 13, 2011. Dr. Carlson's history included the work injury which he dates as October 19, 2010 and notes that when Petitioner put more pressure on his left side because of the infected right toe, it began to hurt worse. Dr. Carlson recommended arthroscopic surgery to repair the ACL. Petitioner testified he was told that he was unable to work. The record states Petitioner can resume everyday activities immediately with a knee immobilizer. The January 24, 2011 Work Release form takes Petitioner completely off work (PX 6).

Petitioner was seen for a Section 12 examination at Respondent's request by Dr. Weiss on March 2, 2011. Dr. Weiss testified by evidence deposition on July 29, 2015 (RX 2). Dr. Weiss opined that it was very unlikely Petitioner would have been able to continue working for three weeks after the initial work accident of September 30, 2011 if he had sustained an ACL tear as a result of the work incident. He also noted that there would have been more significant findings at the first office visit. Based on Dr. Weiss' experience, he noted that an ACL tear would have been painful enough to require immediate treatment and would have limited Petitioner's ability to walk, bend or kneel, all of which Petitioner did for three weeks.

Dr. Weiss opined that Petitioner's knee complaints and need for treatment as of March 2, 2011 were due to a normal progression of his underlying condition. Surgery would be appropriate but unrelated to the work accident. Dr. Weiss opined that Petitioner would not have been disabled from work because of the work injury. He would have reached MMI at the time the December 16, 2010 MRI confirmed his ongoing complaints were related to an underlying condition and not the work injury in question. Dr. Weiss opined Petitioner had suffered a left knee sprain in relation to the September 30, 2010 work accident. Medical care through October 28, 2010 was reasonable and necessary. He also opined that Petitioner developed a cyst secondary to his work-related injury, which was currently asymptomatic, but if it did become symptomatic then removal would be appropriate.

Petitioner testified that Workers Compensation rejected treatment. Dr. Carlson still recommended surgery and kept Petitioner off work. Petitioner tried to get his surgery approved through his union insurance. He did not get it approved. Dr. Carlson never did surgery. Dr. Carlson saw Petitioner on April 6, 2011. The left knee mass had gradually increased in size. He aspirated the bursa. On May 12, 2011 Dr. Carlson again aspirated the bursa. He states the cause of the swelling is the fall, but the pathology is yet unknown. Dr. Carlson provided off work notes through June 6, 2011 (PX 6).

Petitioner had no treatment for his left knee from June 6, 2011 until he saw Dr. Glasgow on May 30, 2012. He testified that everyone turned down coverage. Petitioner testified that he saw Dr. Steven Glasgow on May 30, 2012 at his attorney's recommendation. Dr. Glasgow recommended a left knee replacement surgery.

Petitioner testified he fell at home in June, 2012 and injured his right knee. He was still off work for the left knee at the time. Petitioner testified that he feels he fell because of the left knee. Dr. Carlson's records note an initial visit on July 18, 2012 with a history of a fall on June 7, 2011. No further details were provided (PX 6). He testified he did not injure the left knee in the fall. He returned to Dr. Carlson for the right knee and had an arthroscopy of the right knee on September 21, 2012. Petitioner testified he treated for the right knee through November, 2012.

Petitioner returned to Dr. Glasgow for the left knee on September 28, 2012. Petitioner had the total knee replacement on November 20, 2012. He testified he had physical therapy. He was discharged from therapy on February 7, 2013. They recommended a home exercise program. On March 25, 2013, Dr. Glasgow released Petitioner to return to work in a supervisory capacity with no lifting greater than 25 pounds and no kneeling, squatting or running. On June 24, 2013, Dr. Glasgow released Petitioner to full duty work effective July 1, 2013. Dr. Glasgow stated he was at maximum medical improvement. Petitioner last saw Dr. Glasgow for follow on November 25, 2013. Dr. Glasgow's record states that Petitioner has no complaints. Physical examination found no effusion, complete extension and flexion to 125 degrees. Petitioner was told to follow up every two years. He has seen no other doctors for treatment since that time. He has had no other injuries to his left knee since September 30, 2010.

Dr. Glasgow testified by evidence deposition on March 1, 2013 (PX 2). He opined that the work related injury exacerbated Petitioner's preexisting condition and has changed the status of his knee forever, changing it from a knee that had significant degenerative change that required no treatment to a knee that has significant degenerative change requiring total knee replacement. He testified that Petitioner had preexisting arthritic change, and an ACL deficient knee and perhaps a PCL tear that was completely unrelated to his work injury. After the work incident, he started to have a symptomatic knee.

Petitioner was examined by Dr. Jeffrey Coe on February 26, 2014 at his attorney's request. Dr. Coe testified by evidence deposition on November 25, 2014 (PX 11). Dr. Coe opined that Petitioner's September 30, 2010 work accident aggravated a pre-existing, post-traumatic and degenerative condition in the left knee, causing his previously asymptomatic left knee to be acute and chronically painful. He testified that Petitioner had a chronic left knee problem. He had a chronic absence of the medial meniscus and likely a chronic tear of the ACL. Dr. Coe does not believe that it was acutely torn in the September 30, 2010 accident. He believes that the accident caused bleeding inside the left knee. He opined that the treatment to the left knee was reasonable and related to the work accident of September 30, 2010.

Dr. Weiss provided a supplemental report dated April 28, 2015. He reviewed updated treatment records for Petitioner after Dr. Weiss' initial examination (RX 2, Ex 4). Dr. Weiss' stated that the total knee replacement was due to the pre-existing degenerative joint disease which is common in individuals who have undergone prior open arthrotomies and meniscectomies. He opined that the total knee replacement was due to normal progression and the arthrotomy and meniscectomy when Petitioner was in his early 20s. He did opine that the injections Petitioner underwent were related to the work accident as they were relation to and for the hematoma/cyst.

Dr. Aaron Bare prepared a record review report at Respondent's request on May 14, 2015 (RX 3). Dr. Bare opined that the work injury caused the temporary aggravation of a pre-existing problem. After four weeks the injury had essentially reached maximum medical improvement. Further treatment was based on a pre-existing problem. Although he did agree with the need for a total knee replacement, Dr. Bare opined that it was not related to a work injury that was a pivot and twist injury and not a high velocity trauma. The need for the total knee replacement was based upon chronic, lingering, and severe degenerative osteoarthritis. The left knee issue was related to his previous injury in the 1960s where Petitioner had a partial meniscectomy with cartilage damage and a deficient ACL.

Petitioner testified that he did not go back to Kroger. Petitioner testified that he was not contacted in regards to a new position with Schnucks. He never contacted them. Respondent had been bought out by Schnucks and he was not in the system anymore.

Mr. David Thomas testified that at the time of the alleged work accident, Mr. Thomas was the Retail Operations Manager for the Central Division of Kroger. Mr. Thomas' current position is safety manager and special assignments. His duties as safety manager include implementing and running Respondent's safety program. This includes working with stores when they have incidents and to help work with the cause of the incident to prevent future incidents. Mr. Thomas testified that the location of the alleged work accident was bought by Schnucks Company in August, 2011, with a takeover happening in September, 2011. Mr. Thomas was the lead person regarding the transition. He worked with the Schnucks representative and store managers to talk with each associate (employee) regarding a new position being available. Mr. Thomas

testified if employees were not at the workplace, they were contacted by telephone. Mr. Thomas testified that this news of the Schnucks takeover was in both print media and on TV. Mr. Thomas testified that any documentation would have been transferred to Schnucks during the takeover.

Petitioner found a supervisory job with M. L. Farm Systems. His title is superintendant. He travels all over the country for this job. He usually drives. He supervises a crew erecting the structure. He has no weights to deal with other than moving a board once in a while. Petitioner testified that he is not as mobile as he was. He is not as secure. He notices a callus on his right big toe because it turns in where the second toe was amputated. He works 10-12 hour days and by the end of the day his knee is tired and his feet are sore. Petitioner testified he does not run any more. He had limits on many household chores such as cleaning his eaves and using his snow blower. Petitioner does not utilize a walker or cane.

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 September 30, 2010 when he was pulling a stocking cart and his left foot got caught underneath and it threw him down and wrenched his left knee. Petitioner testified he had a prior injury to his left leg in 1969 when he had a surgery for a cartilage removed. Medical testimony also includes statements that he tore his ACL at that time. Petitioner testified he had no medical treatment for his left knee from 1969 until after September 30, 2010. He was able to work. He was still agile and mobile. He testified that his left leg was getting more bowed than the other knee.

After the September 30, 2010 accident, he had initial treatment at Physicians Immediate Care on October 21 and October 28, 2010. The October 21, 2010 assessment was left knee pain, associated to a fall. The doctor notes there is the possibility that he has inflammation as a result of the fall but the degenerative portion was probably aggravated as a result of the fall; medication will probably calm the symptoms down. Petitioner returned on October 28, 2010 and reported significant improvement. The examination noted that the knee was deformed associated with the chronic changes. Gait was normal. Petitioner was advised to continue applying Biofreeze and to take Meloxicam. He was released to full duty and discharged from care at MMI and no residual disability.

Petitioner began treatment for the right second toe condition, which is the subject of the consolidated case 13 WC 12244 heard in conjunction with this matter, on November 11, 2010. Petitioner testified that, when they came to show him how to be more mobile, he was in extreme pain in his left knee. Petitioner had x-rays taken of the left knee on December 10, 2010 which showed no soft tissue swelling and an impression of degenerative osteoarthritis. An MRI on December 16, 2010 showed a large left knee joint effusion along with a complete ACL and probable PCL tears. He saw Dr. Carlson for a consultation on December 17, 2010 for left knee pain and swelling. Petitioner returned to Dr. Carlson for his left knee on January 13, 2011. Dr. Carlson's history included the work injury which he dates as October 19, 2010 and notes that when Petitioner put more pressure on his left side because of the infected right toe, it began to hurt worse. Dr. Carlson recommended arthroscopic surgery to repair the ACL.

Respondent presented the reports and testimony of Dr. Weiss. Dr. Weiss opined that Petitioner's knee complaints and need for treatment as of March 2, 2011 were due to a normal progression of his underlying

condition. Surgery would be appropriate but unrelated to the work accident. Dr. Weiss opined Petitioner had suffered a left knee sprain in relation to the September 30, 2010 work accident. Medical care through October 28, 2010 was reasonable and necessary. He also opined that Petitioner developed a cyst secondary to his work-related injury, which was currently asymptomatic, but if it did become symptomatic then removal would be appropriate.

Dr. Carlson never did surgery. Dr. Carlson saw Petitioner on April 6, 2011. The left knee mass had gradually increased in size. He aspirated the bursa. On May 12, 2011 Dr. Carlson again aspirated the bursa. He states the cause of the swelling is the fall, but the pathology is yet unknown.

Petitioner had no treatment for his left knee from June 6, 2011 until he saw Dr. Glasgow at his attorney's request on May 30, 2012. Dr. Glasgow recommended knee replacement surgery to the left knee. Petitioner had the total knee replacement on November 20, 2012. Dr. Glasgow opined that the work related injury exacerbated Petitioner's preexisting conditions and has changed the status of his knee forever, changing it from a knee that had significant degenerative change that required no treatment to a knee that has significant degenerative change requiring total knee replacement. He testified that Petitioner had preexisting arthritic change, and an ACL deficient knee and perhaps a PCL tear that was completely unrelated to his work injury.

Dr. Coe opined that Petitioner's September 30, 2010 work accident aggravated a pre-existing, post-traumatic and degenerative condition in the left knee, causing his previously asymptomatic left knee to be acute and chronically painful. He testified that Petitioner had a chronic left knee problem. He had a chronic absence of the medial meniscus and likely a chronic tear of the ACL. Dr. Coe does not believe that it was acutely torn in the September 30, 2010 accident. He believes that the accident caused bleeding inside the left knee.

Dr. Weiss provided a supplemental report dated April 28, 2015. Dr. Weiss' stated that the total knee replacement was due to the pre-existing degenerative joint. He opined that the total knee replacement was due to normal progression and the arthrotomy and meniscectomy when Petitioner was in his early 20s. He did opine that the injections Petitioner did undergo were related to the work accident as they were related to and for the hematoma/cyst.

Dr. Bare opined that the work injury caused the temporary aggravation of a pre-existing problem. Further treatment was based on a pre-existing problem. Although he did agree with the need for a total knee replacement, Dr. Bare opined that it was not related to a work injury. The need for the total knee replacement was based upon chronic, lingering, and severe degenerative osteoarthritis. The left knee issue was related to his previous injury in the 1960s where Petitioner had a partial meniscectomy with cartilage damage and a deficient ACL.

The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. Gross v. Illinois Workers' Compensation Comm'n, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Id. Expert opinions must be supported by facts and are only as valid as the facts underlying them. In re Joseph S., 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts.

In weighing the expert opinions, the Arbitrator includes his evaluation of the Petitioner's credibility after observing his testimony and noting the discrepancies between his testimony and the complaints contained in the initial medical records and his ability to continue his work activities in a heavy job following the injury and after his release by Physicians Immediate Care until his admission to the hospital for his infected toe. The Arbitrator notes that the opinions of Dr. Glasgow and Dr. Coe are founded on Petitioner's history of continuing and increasing pain which is contradicted by the initial medical records. They each testify that they have assumed that those records are either based upon the incompetence of the examining physician's assistant or are simply wrong. The Arbitrator also notes that neither of these experts saw Petitioner until over a year after last treatment by Dr. Carlson, a period in which he sought no medical treatment. The Arbitrator also considers that Dr. Carlson never recommended the total knee replacement in 2011, but rather discussed an ACL repair. The consensus of all the experts is that the ACL tear or deficiency was not caused by the September 30, 2010 accident but was a result of the earlier 1969 injury and prior surgery.

After a review of the testimony, medical records, reports and deposition testimony, the Arbitrator finds the opinions of Dr. Weiss and Dr. Bare more persuasive that, as a result of the accidental injuries sustained on September 30, 2010, Petitioner suffered a temporary aggravation of his preexisting degenerative left knee condition, a left knee sprain and a cyst secondary to his work-related injury. The Arbitrator finds the treatment by Physicians Immediate Care and Dr. Carlson in diagnosing and aspirating the bursa are causally related to the accident.

Based upon the record as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the evidence that he suffered a temporary aggravation of his preexisting arthritic condition in the left knee, a left knee sprain and a cyst secondary to his work-related injury. The treatment by Physicians Immediate Care and Dr. Carlson in diagnosing and aspirating the bursa are causally related to the accident. The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that any treatment for the left knee after June 6, 2011, including the treatment by Dr. Glasgow for the knee replacement, was causally connected to the accidental injuries sustained on September 30, 2010.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, the Petitioner is entitled to reasonable and necessary medical while under the care of Dr. Carlson for aspiration of the bursa. Petitioner was under active care beginning on January 13, 2011 through May 12, 2011 for his left knee. Petitioner's Exhibit 1A includes unpaid balances for bills allegedly incurred as a result of the treatment to the left knee. Based upon the Arbitrator's finding with respect to Causal Connection, the following bills would be reasonable, necessary and causally related to the injury sustained on September 30, 2010:

Carlson Orthopedic Clinic: $363.00
Dr. Disanti: $246.00

Based upon the record as a whole, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $363.00 to Carlson Orthopedic and $246.00 to Dr. Disanti, as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Causal Connection, the Petitioner is entitled to temporary compensation while under the care of Dr. Carlson for aspiration of the bursa. Petitioner was under active care beginning on January 13, 2011 for his left knee. Dr. Carlson disabled Petitioner in anticipation of possible surgery to repair the torn ACL in his left knee. However, Petitioner did undergo aspiration of the bursa on April 6, 2011 and May 12, 2011, which treatment Dr. Weiss found reasonable, necessary and causally related to the September 30, 2010 accident sustained. Petitioner received off work slips through June 6, 2011. Dr. Carlson's records include a note that Petitioner requested a further off work slip on June 7, 2011, but questioned if they could do it since no surgery was scheduled. No such further off work slip was included in the records.

Based upon the record as a whole, and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he was temporarily totally disabled from January 13, 2011 through June 6, 2011, a period of 20 5/7 weeks.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

The Petitioner's date of accident on September 30, 2010 is before the effective date of Section 8.1b of the Act and therefore the factors listed therein are not applicable to the present case.

Petitioner suffered an undisputed accident when he fell over the stocking cart suffering a twisting injury to his left knee. Initial medical records confirmed the significant preexisting arthritic condition of the left knee. Petitioner complained of progressively worsening symptoms. He had a limp. The assessment was left knee pain, associated to a fall. The doctor notes there is the possibility that he has inflammation as a result of the fall but the degenerative portion was probably aggravated as a result of the fall; medication will probably calm the symptoms down. Petitioner was prescribed Biofreeze and Meloxicam. He was released to work with restrictions on kneeling, Squatting, jumping, running, and ladders. Petitioner returned on October 28, 2010 and reported significant improvement. Petitioner was advised to continue applying Biofreeze and to take Meloxicam.

Petitioner, while returned to full duty, testified to worsening complaints and swelling. An MRI on December 16, 2010 showed a large left knee joint effusion along with a complete ACL and probable PCL tears. He saw Dr. Carlson for a consultation on December 17, 2010 for left knee pain and swelling. Petitioner returned to Dr. Carlson for his left knee on January 13, 2011. The January 24, 2011 Work Release form takes Petitioner off work. Dr. Carlson never did surgery to repair the ACL. On April 6, 2011, the left knee mass had gradually increased in size. Dr. Carlson aspirated the bursa. On May 12, 2011 Dr. Carlson again aspirated the bursa. He states the cause of the swelling is the fall, but the pathology is yet unknown. Dr. Carlson provided off work notes through June 6, 2011.

Based upon the record as a whole, including the Petitioner's testimony, the medical records and expert reports and depositions, and in accordance with the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that, as a result of the accidental injuries sustained on September 30, 2010, Petitioner has suffered a loss of the left leg to the extent of 12.5%.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Daniels,
Petitioner,
vs.

NO: 12WC 7160

Southwest Airlines,
Respondent.

17IWCC0354

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 28, 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 $16,075.00. 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.

JUN 14 2017

DATED:
MJB/bm
o-6/6/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DANIELS, MICHELLE
Employee/Petitioner

Case# **12WC007160**

SOUTHWEST AIRLINES
Employer/Respondent

17IWCC0354

On 7/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
JOSEPH HIGGINS
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

MICHELLE DANIELS
Employee/Petitioner

v.

SOUTHWEST AIRLINES
Employer/Respondent

Case # 12 WC 7160

17IWCC0354

An *Application for Adjustment 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 **JANUARY 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 **12/09/2011**, 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 $**57,200.00**; the average weekly wage was $**1,100.00**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**3,172.39** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,172.39**.

Respondent is entitled to all credit for all medical expenses paid under §8(j) of the Act.

ORDER

Respondent shall pay all reasonable and necessary medical services. Respondent shall be given a credit pursuant to §8(j) for all reasonable and necessary medical services paid against reasonable and necessary medical expenses owed to Petitioner and Respondent shall hold Petitioner harmless from any and all claims or liabilities that may be made against Petitioner by reason of Petitioner having received such payments only to the extent of the credit.

Respondent shall pay Petitioner temporary total disability benefits of **$733.33 per week** for a total of **12 & 3/7** weeks, commencing **December 10, 2011** through **December 21, 2011 (1 & 4/7 weeks)** and commencing **February 13, 2012** through **April 30, 2012 (10 & 6/7 weeks)**, as provided in §8(a) of the Act. Respondent shall be given a credit pursuant to §8(j) of $3,172.39 against temporary total disability benefits owed to Petitioner and Respondent shall hold the Petitioner harmless from any and all claims or liabilities that may be made against Petitioner by reason of Petitioner having received such payments only to the extent of the credit.

Respondent shall pay Petitioner the sum of **$660.00 per week** for a further period of **15.2** weeks, as provided in §8(e)9 of the Act, because the injuries sustained caused **8%** loss of use of the left hand.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day

before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 26, 2016
Date

ICArbDec p. 2

JUL 28 2016

17IWCC0354

INTRODUCTION

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

The parties have stipulated that Respondent is entitled to credit of $3,172.39.

Petitioner was the only witness at trial.

STATEMENT OF FACTS

On December 9, 2011, Petitioner Michelle Daniels was working as a flight attendant for Respondent Southwest Airlines. As a flight attendant, she testified that she had to be able to lift up to 50 pounds, open and close cabin doors, lift bags in and out of overhead bins, and that while they used to use carts for drink service, they were now using serving trays that held up to 14 eight-ounce drinks. Petitioner testified that she would hold the tray with one hand and serve the drink with the other. Periodically, she would switch off arms to hold the tray.

Prior to working on December 9, 2011, Petitioner had never experienced anything unusual about her left hand or arm, had never had any medical treatment for her left hand or arm, and was working full duty as a flight attendant performing the duties described above. Petitioner did previously have right carpal tunnel release surgery in 2006 (PX 5).

Petitioner testified that on December 9, 2011, she worked flight 2623, which was a three-leg fight: from Chicago to Jackson, MS, from Jackson, MS to Houston, TX; and from Houston, TX to Los Angeles, CA. During the three-leg flight, Petitioner performed the normal duties of a flight attendant. Petitioner carried and passed trays of drinks, consisting of as many as 6 or 8 drinks each, requiring Petitioner to carry and grip the trays in her left hand in a flexed position. On each of the three legs, Petitioner performed at least 2 drink services. Petitioner opened and closed the airplane cabin doors on each of the three legs, requiring Petitioner to push and pull at least 50 lbs. each time the door was opened or closed.

Petitioner testified that while working flight 2623 on December 9, 2011, she began to experience pain and tingling in her left hand and arm. She first noticed the pain and tingling while performing her various duties. These complaints increased with activity like carrying drink trays and opening and closing cabin doors. By the end of

Flight 2623 in Los Angeles, petitioner was noticing that her left hand and wrist was painful and that the tingling in her left hand was constant.

Upon landing in Los Angeles on December 9, Petitioner immediately sought medical treatment for her left hand at Concentra Urgent Care. Petitioner went there because she knew that Concentra was the clinic where work-related injuries were to be reported. Petitioner complained of "tingling & numbness of fingers". Patient Discharge Instructions (PX #1) noted a diagnosis of a left hand strain. Petitioner was instructed to follow work restrictions: no heavy lifting more than 5 lbs. with left hand, no pushing or pulling more than 10 lbs. with left hand, and no repetitive work with left hand for one week.

Petitioner did not work on December 10, 2011, but flew back to her home in Oklahoma.

Upon arriving home in Oklahoma, Petitioner sought medical care for her left hand at McBride Orthopedic Hospital [McBride] in Oklahoma City (PX #5) on December 10, 2011. Petitioner complained of onset of left hand pain and numbness 24 hours before admission, at 4:00 p.m. Petitioner gave a history of her left hand going numb and swelling on December 9, 2011 when she "was working with a tray on the job." Physical examination of the left hand revealed a positive Tinel's sign and reduced strength over the median nerve. Clinical impression was left carpal tunnel syndrome. Petitioner was given a left wrist splint and a Medrol Dosepak.

On December 13, 2011, Petitioner submitted an incident report [apparently online] to Respondent (PX #3). Petitioner reported that while working as a flight attendant on Flight 2623, from MDW-HOU she noticed that her hand started to tingle and go numb. From HOU-LAX she reported trouble holding anything in her left hand. Petitioner reported shooting pain along with the numbness and tingling.

Petitioner testified that on December 13, 2011, she saw Dr. Bradley Margo of Orthopedic and Arthritis Center/McBride Clinic Oklahoma City (PX #5). She testified that in the history she provided to Dr. Margo that she did tell him about her use of trays when her complaints began. Dr. Margo's typed report of December 13, 2011 (PX #5, pp 8-9) showed Petitioner's chief complaint to be left hand numbness in the three radial fingers. There is no reported history of a work-related incident in the typed report. Dr. Bradley's signed note on Pg. 17 of PX #5 noted Petitioner's history of right carpal tunnel release in 2006. The handwritten note also documented Petitioner's report that the injury occurred on the job on December 9, 2011. Petitioner's history of "while working my hand and fingers went numb with pain" was also noted. Petitioner disclosed a history of breast cancer but denied diabetes.

On examination Dr. Margo found a positive Tinel's sign and a mildly positive Phalen's sign. There was decreased sensation over the three radial fingers. Dr. Margo diagnosed left carpal tunnel syndrome. While conservative measures such as medication, bracing, and injections were discussed, Petitioner was interested in going

directly with a left carpal tunnel release (PX #5). He also kept her off work for at least 2 weeks, but maybe for as long as 8-10 weeks.

On December 15, 2011, Respondent's workers' compensation third-party administrator sent Petitioner a letter that referred to: date of injury as "12/09/2011"; and "this on-the-job injury" (PX #4).

Petitioner testified that after she saw Dr. Margo and surgery was recommended that she was directed by Respondent to be seen at Concentra Medical Center, Oklahoma City. She saw Dr. Larry Ressler on December 21, 2011 at Concentra (PX #2 & RX #1). Dr. Ressler noted Petitioner's report that her complaints began from holding trays during work.

Petitioner gave a history of a sudden office onset of left hand numbness while working as a flight attendant on December 9, 2011. She further reported that she had been diagnosed with carpal tunnel syndrome and in fact was scheduled for surgery on the day at this visit. Petitioner expressed her opinion that her carpal tunnel syndrome was work-related because as a flight attendant she moves people's bags to overhead bins, moves a refreshment cart in the airplane, and uses a tray to serve passengers. She denied having any prior complaints with her left hand or wrist.

Dr. Ressler noted Petitioner's complaints of decreased sensation over the entire hand. Percussion and pressure over the carpal tunnel caused increased complaints of pain. Phalen's maneuver resulted in no change in symptoms. He found no increased paraesthesias. Dr. Ressler also noted that Petitioner gave little to no effort with grip testing. A visual inspection of the hands noted a left thenar atrophy.

Dr. Ressler's opinion was a non-occupational carpal tunnel syndrome. He stated that Petitioner's work activities would not be considered repetitive or consistent with activities that would be likely to cause a repetitive stress injury such as carpal tunnel syndrome. In addition, he noted that thenar atrophy would be consistent with long standing pathology of the median nerve and would not consistent with Petitioner's history of sudden onset of all symptoms on December 9, 2011.

It was Dr. Ressler's opinion that the condition was not work related was based on a prevailing factor standard. He recommended Petitioner should consult her primary physician for the non-work related condition, and that she could return to regular work.

Petitioner testified that she returned to work and continued to follow up Dr. Margo at McBride. On December 27, 2011, Dr. Margo injected Petitioner's left wrist with Kenalog and Lidocaine to relieve continuing complaints. He recommended continued use of the left wrist splint and anti-inflammatory medication.

On February 10, 2012, Petitioner followed up with Dr. Margo, complaining that her symptoms had returned. Dr. Margo noted that conservative measures had failed. Despite lack of nerve conduction velocity studies, Dr. Margo noted that Petitioner clinically had carpal tunnel syndrome. Surgical risks were discussed and Petitioner decided to undergo surgical carpal tunnel release.

Dr. Margo performed left carpal tunnel release on Petitioner at McBride on February 22, 2012 (PX #5, p 37). Dr. Margo noted a slight hemorrhagic appearance of the median nerve along with mild adhesions. The post-operative diagnosis was left carpal tunnel syndrome.

Petitioner continued with post-operative follow up with Dr. Margo. On March 2, 2012 Petitioner still had numbness but had full function of her fingers. On March 16, 2012, Dr. Margo noted obvious weakness in the left hand and tingling in the fingers. On March 30, 2012, Petitioner still had tingling in her left middle and ring fingers. Dr. Margo recommended hand therapy. The initial physical therapy evaluation took place at McBride on April 3, 2012. Petitioner received physical therapy through April 26, 2012.

On April 30, 2012, Dr. Margo released Petitioner from treatment. Petitioner testified that she felt like her strength had improved but Dr. Margo noted that tingling in the left hand was still an issue for the Petitioner. Petitioner was released to return to work full duty with no restrictions on April 30, 2012 (PX #5, p 87).

Petitioner testified that she still has some occasional tingling in her left hand but is pain free.

Petitioner placed into evidence medical bills and receipts for medical treatment from McBride Orthopedic Hospital Clinic (PX #5, beginning at pg. 89 & PX #6); Concentra Urgent Care-California, date of service 12/09/2011 (PX #7); Central Anesthesia Associates, date of service 02/22/2012 (PX #8); and Walgreens receipts dated 02/10/2012 & 03/02/2012 (PX #9). These bills and receipts show payments made by Respondent pursuant to §8(j) of the Act as stipulated by the parties and balances due after those payments were made.

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 proved she sustained accidental injuries that arose out of and in the course of her employment with Respondent on December 9, 2011.

Petitioner testified credibly that she did not have complaints or an injury to her left wrist before December 9, 2011. She testified that her job as a flight attendant required her to push/pull airplane cabin doors and be able to lift up to 50 pounds. She also had to assist passengers in lifting and stowing their luggage in overhead compartments. Petitioner noticed a sudden onset of pain and tingling in her left hand, wrist, and arm without a discreet trauma while working as a flight attendant on December 9, 2011.

Petitioner's treating orthopedist, Dr. Margo, noted the onset of Petitioner's symptoms was on December 9. He diagnosed carpal tunnel syndrome. Dr. Ressler also diagnosed carpal tunnel syndrome but noted evidence of a chronic condition rather than acute. Even if Petitioner had a pre-existing condition it was asymptomatic until she engaged in activities arising out of and in the course of her employment by Respondent. Petitioner's injury manifested itself on December 9, 2011. The Arbitrator finds that evidence of established that the repetitive nature of Petitioner's work activities was the cause of the onset of Petitioner's symptoms and complaints.

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

The Arbitrator concludes that Petitioner's condition of ill-being, namely left hand strain/sprain and left hand carpal tunnel syndrome, is causally connected to the accidental injuries of December 9, 2011. Petitioner proved by circumstantial evidence, through a chain of events demonstrating a previous condition of good health, an incident or activity relate to work, and a subsequent injury resulting in disability, that her left hand and wrist injury were causally related to her work activities.

Petitioner credibly testified that prior to December 9, 2011 she did not experience anything unusual about her left hand or wrist. There was no evidence contradicting this. Further, Petitioner had been working full duty as a flight attendant for years before December 9, 2011 without recorded complaints about her left hand or wrist.

Following the onset of her symptoms Petitioner sought medical care. She consistently reported to her healthcare providers that her complaints arose while she was working flights on December 9, 2011.

The Arbitrator notes that Dr. Ressler applied a "prevailing factor" analysis, which is not the evidentiary foundation for proving causation in Illinois. An injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro v. Illinois Industrial Com'n*, 207 Ill.2d 193 (2005). Dr. Ressler's opinion is not based on an applicable basis of analysis under Illinois law and is, therefore, not persuasive.

The Arbitrator finds Dr. Ressler's opinion regarding lack of causation as not persuasive for other reasons. Dr. Ressler's qualifications, other than a medical doctor, are unknown. During his examination he did find thenar atrophy, which he attributed to a long-standing pathology of the median nerve. What detracts from Dr. Ressler's persuasiveness is, despite his diagnosis of carpal tunnel syndrome and Petitioner's history of consulting and orthopedic surgeon, he referred Petitioner back to her primary physician for further care. The Arbitrator does not understand why Dr. Ressler did not refer Petitioner back to her treating orthopedist. Furthermore, he did not recommend continuation of physical therapy or continued use of the wrist splint or continued use of prescribed anti-inflammatory medications. This care plan does not make sense in light of the diagnosis and all other factors.

As important, Dr. Ressler does not explain how Petitioner became symptomatic on December 9, 2011 when she had credibly testified she was asymptomatic before that work day. At no time did Dr. Ressler suggest that Petitioner was an inaccurate or unreliable historian. It was not enough for Dr. Ressler to find no causal connection. It was incumbent on him to explain the how and why of the onset of Petitioner's symptoms.

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

Based on the conclusions stated above, relating to accidental injuries and causal connection, the Arbitrator finds that the medical services and treatment Petitioner received from Concentra, McBride Orthopedic Hospital, and Dr. Margo, including the left carpal tunnel release surgery on February 22, 2012 and the post-operative care, were necessary and reasonably required to cure or relieve the effects of the accidental injuries sustained by Petitioner on December 9, 2011.

Pursuant to the fee schedule as provided in §8.2(e) of the Act, Respondent shall pay to Petitioner any "applicable deductibles, co-payments, or co-insurance" for which Petitioner remains liable, as indicated in PX #6, PX #7, & PX #8.

K: What temporary benefits are in dispute? TTD

Based on the conclusions stated above, relating to accidental injuries and causal connection, the Arbitrator finds that Petitioner prove she was temporarily and totally disabled: from December 10, 2011, when she was restricted from working by Concentra in Los Angles, through December 21, 2011, when she was released to return to work by Concentra in Oklahoma City, or 1 & 4/7 weeks; and from February 13, 2012, when she was taken off work by Dr. Margo, through April 30, 2012, when she was released to return to work by Dr. Margo, or 10 & 6/7 weeks, totaling 12 & 3/7 weeks.

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

The date of accidental injuries in this case is after June 28, 2011; therefore, the provisions of §8(e)9 of the Act relating to repetitive trauma carpal tunnel injuries applies here.

The date of the accidental injury in this matter is after September 1, 2011; therefore, permanent partial disability is evaluated in accord with pursuant to §8.1(b) of the Act:

(i) An AMA impairment rating was not introduced in evidence. The Arbitrator gives no weight to this factor.

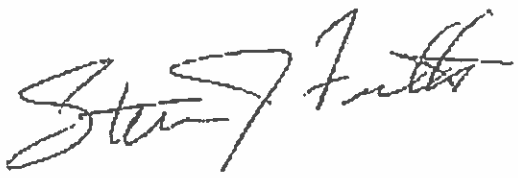
(ii) Petitioner was employed by Respondent as a flight attendant and returned to work for Respondent as a flight attendant. As a flight attendant petitioner had to be able to lift up to 50 pounds, open and close cabin doors, lift bags in and out of overhead bins, and that while they used carts for drink service, they now use serving trays that held up to 14 eight-ounce drinks. Petitioner testified that Petitioner returned to her job full-duty job with no restrictions. Petitioner continues working for the Respondent in that capacity. Petitioner credibly testified about the job duties of a flight attendant. The Arbitrator gives great weight to this factor.

(iii) Petitioner was 53 years old at the time of his accident. She had a statistical life expectancy of 27 years and a statistical worklife expectancy of 11 years. In light of Petitioner's current complaints the Arbitrator concludes that the nature of this injury resulted in a *de minimis* effect on Petitioner's work life. The Arbitrator gives little weight to this factor.

(iv) There was no evidence that Petitioner's injury affected her earning capacity. Petitioner continues working for Respondent. The Arbitrator gives no weight to this factor.

(v) The evidence clearly established that Petitioner sustained an accidental injury to her left hand and wrist, ultimately diagnosed as carpal tunnel syndrome. Circumstantial evidence proved the carpal tunnel syndrome was caused by repetitive activity which manifested on December 9, 2011. The nature and extent of Petitioner's injury required surgical intervention in the form of carpal tunnel release. Upon discharge by Dr. Margo Petitioner felt like her strength had improved but that she still had tingling in her left hand. Petitioner has returned to her regular job duties with minimal continuing complaints. The Arbitrator gives great weight to this factor.

Based on the evidence and applying the five factors of §8.1(b)b, the Arbitrator finds that Petitioner sustained a 8% loss of use of her left hand as provided in §8(e)9 of the Act (8% of 190 weeks or 15.2 weeks).



July 26, 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

David Mills,

Petitioner,

vs. NO: 12WC 12238

Park District of Oak Park,

Respondent.

17IWCC0356

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 and 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 31, 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.

17IWCC0356

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: JUN 14 2017
MJB/bm
o-6/6/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

MILLS, DAVID
Employee/Petitioner

Case# **12WC012238**

PARK DISTRICT OF OAK PARK
Employer/Respondent

17IWCC0356

On 8/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
KISA STHANKIYA
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Mills
Employee/Petitioner

v.

Park District of Oak Park
Employer/Respondent

Case # **12 WC 12238**

Consolidated cases: **N/A**

17IWCC0356

An *Application for Adjustment 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 **7/19/2016**. 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 present condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 _____

17IWCC0356

FINDINGS

On the date of accident, **9/29/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,450.32**; the average weekly wage was **$758.66**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **0** dependent children.

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

At the hearing, Petitioner claimed only one period of temporary total disability, namely 7/21/15 through 7/19/16. The parties agreed Respondent paid no temporary total disability benefits during this period. They further agreed that Respondent paid certain temporary total disability benefits prior to this period but that Respondent was not claiming credit for such payments. T. 6.

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

ORDER

- Respondent shall pay Petitioner temporary total disability benefits in the amount of **$505.77**/week for **52** weeks, for the period of **7/21/2015 through 7/19/2016**. This is the only period of temporary total disability Petitioner claimed at the hearing. The parties agree Respondent paid and Petitioner received certain temporary total disability benefits prior to July 21, 2015.
- Respondent shall pay Petitioner the further sum of **$165.00** for necessary medical services as provided in Section 8(a) of the Act for payment of the medical bill of Dr. Preston Wolin, Center for Athletic Medicine. The medical bill is awarded subject to payment pursuant to Section 8(a) and the Medical Fee Schedule.
- Respondent shall authorize and provide payment for prospective care, including the repeat MRI, pain physician consultation and blocks and right knee arthroscopy/repair, recommended by Petitioner's treating physician, Dr. Preston Wolin.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Molly C Mason

Signature of Arbitrator

August 31, 2016
Date

AUG 31 2016

ICArbDec19(b)

David Mills v. Park District of Oak Park
12 WC 12238

Summary of Disputed Issues

The parties agree Petitioner sustained an accident while working for Respondent on September 29, 2011. Arb Exh 1. Petitioner, a park maintenance employee, alleges he stepped in a hole in one of his assigned parks on that date and injured his right knee. The disputed issues include causal connection, temporary total disability from July 21, 2015 through the hearing of July 19, 2016, medical expenses (a $165.00 bill from Dr. Wolin) and prospective care, with Petitioner seeking an award of saphenous nerve blocks, a repeat right knee MRI and right knee surgery.

Arbitrator's Findings of Fact

Petitioner testified he had worked for Respondent for four years as of his September 29, 2011 accident. T. 13. He worked in the grounds division, performing various tasks at several parks. He testified he performed certain tasks each morning, namely walking a park's perimeter while picking up garbage, cleaning out the comfort stations and water fountains and dragging/emptying large garbage containers. Other tasks, such as snow blowing, salt spreading, carrying large bags of grass seed and branch trimming, were seasonal in nature. He performed additional tasks, such as lifting/transferring bags of concrete in order to make memorial plaques, about four or five times per month. Still other tasks, including climbing ladders to hang holiday lights, might be required only once a year. T. 33-44.

Petitioner testified he spent about four to six hours per workday walking. T. 16. Otherwise, his job involved the following physical activities: driving from park to park, lifting various items, climbing ladders, bending to pick up garbage, squatting while performing maintenance and twisting while sliding and dragging garbage cans out to trucks. T. 16-17.

Petitioner testified the heaviest item he had to lift was a snow plow that weighed about 225 pounds. He did not have to lift this item daily. On a daily basis, the heaviest items he lifted and carried were 100-pound bags of cement and grass seed. T. 14-15.

Petitioner testified his workday was 8 ½ hours long. He was allotted 30 minutes for lunch as well as two 15-minute breaks. T. 17.

Petitioner testified he did not notice anything about his right knee before his September 29, 2011 accident. He denied injuring his right knee or undergoing any right knee treatment prior to the accident. T. 18.

Petitioner testified his accident occurred while he was "blowing out sprinkler heads" at Lindberg Park. As he was performing this activity, he stepped in a hole that was about 12 inches deep and 8 or 9 inches wide and "wrenched" his right knee. When he stepped in the

hole, his right knee buckled and popped. He experienced an immediate onset of pain and swelling in the knee. T. 20.

Petitioner testified he initially sought care at Work Plus on September 29, 2011. T. 20. The Work Plus records reflect that Petitioner saw Dr. Claudia Weddaburne on that date. The doctor noted a complaint of 7/10 right knee pain. She indicated Petitioner reported twisting the knee when he stepped in a hole while checking irrigation heads. She also indicated Petitioner denied any previous right knee injury. On right knee examination, she noted mild soft tissue swelling and moderate tenderness at the head of the fibula. She described Petitioner's gait as mildly antalgic. She obtained right knee X-rays, which showed no gross fracture or dislocation. She provided Petitioner with a hinged knee support and prescribed Norco and Naproxen. She directed Petitioner to return on October 3rd. She released Petitioner to light duty with usage of the brace at work, no bending or stooping and minimal walking and standing. PX 1.

On October 5, 2011, Petitioner returned to Work Plus and saw Dr. Mehrpuyan, who recorded the following interval history:

> "R knee sprain on 9/29/11 after stepping in a hole & twisting. Yesterday while walking down stairs at home fell again twisting R knee [secondary to] severe pain. States pain is getting worse. Has been off work since the day of injury. On Norco & Naproxen for pain."

The doctor prescribed a right knee MRI, elevation of the leg, ice applications and medication. He released Petitioner to light duty with no lifting over 10 pounds, no squatting or kneeling, no over the shoulder work, no machine operation, limited bending, stooping and twisting and minimal standing and walking. PX 1, p. 11. T. 20.

Petitioner underwent the MRI on October 7, 2011. T. 21. The radiologist interpreted the MRI as showing an interstitial tear of the anterior cruciate and no other obvious abnormalities. PX 2.

On October 11, 2011, a physician at Work Plus noted the anterior cruciate ligament tear, took Petitioner off work and recommended an orthopedic consultation. T. 21. PX 1, p. 12.

On October 31, 2011, Petitioner saw Dr. Desai, an orthopedic surgeon affiliated with Little Company of Mary Hospital. Under cross-examination, Petitioner testified he chose Dr. Desai because he had seen him in the past for treatment of a back condition. T. 50.

In his note of October 31, 2011, Dr. Desai recorded a consistent history of the September 29, 2011 work accident and noted that Petitioner described his right knee as giving out occasionally while going down stairs. He also noted that Petitioner complained of pain "mainly along the lateral aspect of his right knee." On right knee examination, he noted no

effusion, a slightly limited range of motion, minimal medial and lateral joint tenderness, minimal tenderness to palpation over the medial and lateral collateral ligaments, no evidence of instability and negative pivot shift, Apley's and McMurray's testing.

Dr. Desai interpreted the MRI as showing a slight signal change within the anterior cruciate ligament fibers, along with some swelling, but "no obvious discontinuity of the ACL fibers." He diagnosed an interstitial/partial tear of the right anterior cruciate ligament. He advised Petitioner there was no indication for any functional instability to the anterior cruciate ligament based on either his examination or the MRI. He administered an injection and prescribed physical therapy and an over-the-counter knee brace as needed. He directed Petitioner to stay off work and return to him in six weeks. PX 3, pp. 2-4.

Petitioner underwent an initial physical therapy evaluation at ATI on November 9, 2011. T. 21.

In a progress note dated December 7, 2011, Petitioner's therapist noted an increased range of right knee motion but persistent complaints of right knee pain and difficulty with stairs. He indicated it might be beneficial to review Respondent's job description, noting that the Dictionary of Occupational Titles classified Petitioner's job as a heavy physical demand level occupation. In a subsequent progress note, dated February 23, 2012, a different therapist indicated Petitioner had missed two weeks of therapy due to illness and was still demonstrating an abnormal gait as well as strength and range of motion deficits. She indicated Petitioner might benefit from a transition to work conditioning. On March 9, 2012, the therapist noted that Petitioner's subjective pain remained high at 5-7/10 and that Petitioner was scheduled to begin work conditioning on March 12th.

Petitioner began participating in work conditioning on March 12, 2012. In reports dated March 20 and 27, 2012, therapist David Noble, MS indicated Petitioner entered the work conditioning program at a light to medium physical demand level, was putting forth good effort and was experiencing low back as well as right knee pain. Noble further indicated that, according to the Dictionary of Occupational Titles, Petitioner's job fell into the medium physical demand level category. On April 10, 2012, Noble indicated that Petitioner was now performing at a medium physical demand level but was still experiencing right knee pain. In this report, Noble stated that Petitioner's job fell into the heavy physical demand level category. On April 16, 2012, Noble described Petitioner as having fallen at home with resulting pain, swelling and ecchymosis to the patellar and lateral knee area. He described Petitioner as functioning at a light to medium physical demand level. PX 4.

Under cross-examination, Petitioner described his April 2012 home fall as follows: "I was going down the stairs and my knee buckled on me and I tumbled down." He further testified he experienced bruising and swelling of his knee after this fall. His pain level was 8/10 after the fall. He self-treated by applying ice and taking aspirin. T. 51-52.

At Respondent's request, Petitioner saw Dr. Bach for purposes of a Section 12 examination on April 16, 2012. T. 22. The doctor's report concerning that examination is not in evidence except to the extent that a summary of the report appears in Dr. Neal's Section 12 examination report of May 29, 2015. According to Dr. Neal, Dr. Bach noted that Petitioner complained of a "sense of buckling" and described most of Petitioner's pain as "generally in a peripatellar area, both medially and laterally." Dr. Neal indicated that Dr. Bach documented "very specific point tenderness over the distal pole of the patella" along with "tenderness at the distal pole," "discomfort referred to the retropatellar tendon" and a range of motion limited by pain. Dr. Neal indicated that Dr. Bach reviewed the MRI, diagnosed "post-traumatic patellar tendinitis with a hypertrophic fat pad." He also indicated that Dr. Bach "assigned a causal relationship" and found the need for an arthroscopy. RX 1, at 4.

Petitioner testified he saw Dr. Wolin, a physician of his own choice, on April 17, 2012. T. 22. In his note of that date, Dr. Wolin recorded a history of the work accident and subsequent care. He also noted that Petitioner reported his knee "recently gave out from under him at home and he landed on the anterior aspect of his knee and he is now having bruising.'

On initial right knee examination, Dr. Wolin noted tenderness to palpation of the patellofemoral area and medial femoral condyle. He also noted right knee flexion of 0/0/120 versus 0/0/130 in the left knee. He described Petitioner's gait as "straight knee without use of assistive device." He indicated that he reviewed the MRI. While he agreed with the report of an intact anterior cruciate ligament, he added the following comment: "this is an open MRI and is not diagnostic for chondral pathology."

Dr. Wolin assessed Petitioner as having "intra-articular pathology including possible chondral injury and/or symptomatic plica." He injected the right knee with Lidocaine and recommended surgery including "possible chondroplasty versus microfracture." He recommended that Petitioner remain off work. PX 5, pp. 1-3.

Petitioner testified that Respondent terminated him on May 1, 2012. T. 30.

On June 7, 2012, Dr. Wolin operated on Petitioner's right knee at Weiss Memorial Hospital. T. 23. In his operative report, he indicated he performed an arthroscopic resection of medial plica. He described the articular cartilage, both menisci and the anterior cruciate ligament as normal. PX 6.

On June 11, 2012, Petitioner underwent an initial physical therapy evaluation at ATI. Jennifer Burbage, PT [hereafter "Burbage"], conducted this evaluation. Petitioner attended several therapy sessions thereafter. PX 4.

On June 20, 2012, Dr. Wolin's assistant removed Petitioner's sutures. He described Petitioner as "taking Norco on the days of PT and currently off work." He prescribed Naproxen. He directed Petitioner to stay off work, continue therapy and follow up in one month. PX 5, p. 4.

On July 17, 2012, Burbage discharged Petitioner from therapy "due to non-compliance," noting that Petitioner had failed to attend scheduled sessions or correspond with ATI.

Petitioner testified he stopped attending physical therapy in July 2012 after learning that his mother had terminal cancer and was expected to live only another two weeks. T. 53-54.

On August 17, 2012, Dr. Wolin's assistant noted that Petitioner complained of clicking and weakness in his right knee. He also noted that Petitioner had "not been compliant with PT and his HEP due to some social issues over the last two weeks." He informed Petitioner he was "developing some anterior knee pain due to quad weakness esp eccentric strength." He recommended that Petitioner stay off work, participate in therapy and a home exercise program and return in one month. PX 5, pp. 5-6.

On August 22, 2012, Petitioner resumed therapy at ATI. On that date, Burbage noted that Petitioner had missed five weeks of therapy due to a death in his family. Petitioner continued attending therapy on a regular basis thereafter, with the therapists noting persistent complaints of significant right knee pain.

On September 25, 2012, Dr. Wolin described Petitioner as reporting that his pain and swelling were "much improved following the surgery." The doctor described Petitioner's gait as non-antalgic. He recommended that Petitioner remain off work, undergo a functional capacity evaluation at the Center for Athletic Medicine and then follow up. PX 5, pp. 7-8.

On September 27, 2012, Burbage noted that Dr. Wolin was recommending Petitioner undergo a functional capacity evaluation and continue therapy until the evaluation could be scheduled. On October 25, 2012, Burbage recommended that Petitioner be discharged from therapy "due to plateau."

At Respondent's request, Dr. Bach re-examined Petitioner on October 29, 2012. T. 23. The doctor's report of that date is not in evidence, except to the extent that a summary of the report appears in Dr. Neal's reports of May 29, 2015 and May 5, 2016. (RX 2, 3). Dr. Neal described Dr. Bach as noting "fairly exquisite localized pain over the anterior aspect of the knee" that was "quite similar to" the pain noted at the previous examination. He also described Dr. Bach as noting "exquisite tenderness over the distal pole of the patella" and "palpable crepitation . . . consistent with patellar tendinitis." He described Dr. Bach as reaching the same diagnosis as at the original examination, i.e., "post-traumatic patellar tendinitis and hypertrophic fat pad." He stated that Dr. Bach found Petitioner capable of sedentary work. He also described Dr. Bach as opining that Petitioner "most likely will require additional surgery." RX 2, pp. 5-6.

Petitioner underwent a functional capacity evaluation at ATI on December 3, 2012. T. 24. The evaluator, Tom Werner ATC/L, rated the evaluation as valid. He found Petitioner to be

functioning at a light to medium physical demand level. He concluded that Petitioner could perform the following activities on only a "minimally occasional" basis: crouching, kneeling, crawling and squatting. He indicated he reviewed a specific job description provided by Respondent, which indicated Petitioner was required to handle up to 100 pounds of material or equipment and to perform occasional kneeling and crawling. He opined that Petitioner's capabilities appeared to fall below his job requirements, noting that Petitioner "did not demonstrate the ability to lift up to 100 pounds or kneel and crawl on an occasional basis." PX 4.

Petitioner returned to Dr. Wolin on December 21, 2012. On that date, the doctor reviewed the functional capacity evaluation and Dr. Bach's report. He noted that Dr. Bach recommended patellar tendon strapping, Voltaren gel and an intra-articular steroid injection. He indicated that a physical therapist performed patellar tendon taping in his office and that this relieved about 10 to 20% of Petitioner's pain.

Dr. Wolin addressed causation and treatment needs as follows:

> "I told [Petitioner] that I am unclear as to the etiology of his pain. The previous MRI did not show any pathology in the patellar tendon and therefore it was not explored. It was felt that the response to pre-operative intra-articular injection and the findings at the time of surgery pointed to the medial plica as the pain generator. Unfortunately, resection of the plica has not resulted in pain relief. At the present time, given the exam, it appears that there may be more involved than just the patellar tendon. Given the limited response to the taping, I am uncertain as to whether he would benefit from topical anti-inflammatories and/or a patellar strap. I believe that an MRI is indicated to evaluate the current status of his knee, including the patellar tendon."

Dr. Wolin also indicated Petitioner could work within the limitation of the functional capacity evaluation. Wolin Dep Exh 2.

Petitioner underwent the recommended repeat right knee MRI on January 22, 2013. T. 24. The interpreting radiologist noted focal partial-thickness degeneration of the articular cartilage of the lateral tibial plateau beneath the posterior horn of the lateral meniscus and attenuation of the body of the medial meniscus which, in his estimation, might reflect the prior partial meniscectomy. PX 8.

Petitioner returned to Dr. Wolin on February 5, 2013. The doctor reviewed the repeat MRI and indicated he agreed with the radiologist's assessment. He injected Petitioner's right knee with Lidocaine. He noted that the injection resulted in significant pain relief but that

Petitioner still had "persistent pain and tenderness about the distal one-half of the patellar tendon." He injected that area with Lidocaine but noted the injection did not result in pain relief. He stated that the results of the injection "would point to an intra-articular source of pain rather than the patellar tendon." He indicated the "possibilities include a subtle chondral injury not seen at the original surgery or on the 2 MRIs, scarring, etc." He recommended that Petitioner see Dr. Hefferon if he was no better within a week. He described work status as unchanged. Wolin Dep Exh 2.

Petitioner testified he never saw Dr. Hefferon because the doctor would not accept workers' compensation patients. T. 24. He subsequently saw Dr. Hutchinson at Dr. Wolin's referral. T. 24-25.

Dr. Hutchinson's note of March 18, 2013 sets forth a consistent history of the work accident and subsequent treatment. The doctor noted that Petitioner reported having less instability, but persistent pain, in his right knee following the June 7, 2012 surgery. He described the location of the pain as "along the patellar tendon, as well as along the medial and lateral joint lines." He indicated Petitioner was now complaining of "constant pain 5-6/10 that is burning in nature and located just distal to the patella both medial and lateral, as well as along the patellar tendon." He indicated Petitioner denied any numbness or tingling and also denied any other recent traumas. He described Petitioner's past medical history as significant only for back pain in 2010 that was treated via therapy.

Dr. Hutchinson described Petitioner as a "bit of a quiet talker" and seemingly "hesitant with new doctors" but alert and oriented and "nontoxic in appearance." On right knee examination, he noted no swelling or skin color change, good mobility of the patella, with slight hypermobility, tenderness to palpation medially at the distal patella, negative patellar grind and apprehension testing, tenderness to palpation along the joint line both medially and laterally and negative Lachman, posterior drawer, varus/valgus stress and McMurray's testing.

Dr. Hutchinson indicated that "due to the distribution of the pain and burning, there is worry about injury to the prepatellar branch of the saphenous nerve." He indicated an EMG might be helpful. He also indicated that Petitioner's pain might be coming from his back, given his prior history of back pain. He stated he was unable to make complete recommendations because he lacked Dr. Bach's reports and the MRI images. He recommended that Petitioner provide these items to him "before having a follow-up appointment." PX 9.

No subsequent note from Dr. Hutchinson is in evidence.

Petitioner testified that, on May 15, 2013, he was cleaning his personal firearm, which he later described as a 38 caliber handgun, when the gun fell to the floor and went off. T. 25. Petitioner testified that a round hit him in the left ankle. T. 25. He denied injuring his right knee in this incident. He is not claiming any benefits from Respondent in connection with the left ankle injury. T. 25.

Records in RX 5 reflect that paramedics transported Petitioner to Munster Community Hospital. Petitioner complained of pain and numbness in his left foot. He provided a history of his .38 caliber pistol accidentally discharging when his hand slipped while he was closing the gun's barrel. Dr. Harris operated on Petitioner's left ankle on May 19, 2013. The doctor performed an open reduction and internal fixation of a Grade II open distal tibia and fibia fracture. He removed a bullet fragment and inserted a plate and locking screws. Petitioner followed up with Dr. Harris on several occasions following the surgery, with the doctor consistently describing him as "doing exceptionally well." On June 4, 2013, the doctor removed 21 staples, placed Petitioner in a CAM walker boot and recommended he avoid weight bearing for another four weeks. On July 9, 2013, the doctor told Petitioner to begin bearing weight as tolerated in the boot and wean off of his crutches. He indicated that the sensation in the plantar aspect of the left foot had "nearly completely returned" and that Petitioner was experiencing only some mild persistent numbness in his left fourth and fifth toes. On August 8, 2013, he noted that "a lot of the small nerve sensations" were continuing to improve. He directed Petitioner to return in six to eight weeks for repeat X-rays and discharge from care. No subsequent note is in evidence.

Petitioner testified his right knee condition deteriorated a little between the incident of May 15, 2013 and June 4, 2013. T. 26. He returned to Dr. Wolin on June 4, 2013, with the doctor noting the intervening injury and a complaint of anterior knee pain. The doctor described Petitioner as wearing a CAM walker on his left leg and ambulating with two crutches. He also noted that Petitioner "was supposed to gather past records" and return to Dr. Hutchinson but had not done so. He indicated that the etiology of Petitioner's knee pain "remains unclear" but appeared to be intra-articular. He did not believe Petitioner had a neuroma. He recommended formal therapy for eccentric quadriceps strength but noted Petitioner could not participate in therapy at that time due to his left ankle condition. He instructed Petitioner to call his office to schedule therapy once he was discharged from left ankle care. He described Petitioner's work status as "unchanged." PX 5, at 13-14.

On August 23, 2013, Dr. Wolin issued a note addressed "to whom it may concern" indicating that Petitioner was being treated for a right knee injury and that his current work restrictions were "per the FCE on 12/3/12." PX 5, p. 15.

Petitioner underwent additional physical therapy at ATI between August 21 and September 12, 2013. On October 1, 2013, Dr. Wolin recommended a 3T MRI scan, to be performed by Dr. Bresler, who he identified as "the head of musculoskeletal imaging at the University of Illinois." Dr. Bresler performed this study on November 19, 2013. He noted that Petitioner had difficulty remaining still during the study. He described the results as unremarkable. Specifically, he found "no convincing evidence of chondromalacia patella, despite limitations related to persistent patient motion artifact." PX 9, p. 5. PX 10.

Petitioner returned to Dr. Wolin on December 3, 2013. On that date, the doctor noted both persistent anterior knee pain and pain "posterior medially, which is increasing." He indicated Petitioner reported experiencing only three days of relief following the February

injection. On examination, he noted tenderness in the infrapatellar, medial femoral condyle and posterior medial areas of the knee. He reviewed the MRI, noting "no frank chondral pathology," and injected his knee and injected the posteomedial area of the knee. He indicated that, following the injection, Petitioner reported significant relief posteromedially "but no relief anteriorly."

Petitioner saw Dr. Tonino on January 27, 2014. T. 28. The doctor's note of that date sets forth a history of the work accident and subsequent care. The doctor noted a complaint of anteromedial right knee pain with "no giving way or locking." He described the 2013 right knee MRI as showing no significant pathology. He obtained right knee X-rays, which showed a small effusion and no acute osseous abnormality. On examination, he noted tenderness over the medial joint line, some medial parapatellar discomfort, stable ligaments and a negative McMurray's sign. He addressed treatment needs as follows:

> "Despite a normal MRI, without improvement after three injections, I think an arthroscopic re-evaluation would be indicated for him, possible patellofemoral arthrofibrosis and evaluation of his medial meniscus with appropriate treatment, depending on what is found. I do not think further conservative treatment will be of any benefit for him."

PX 11.

On April 21, 2014, Petitioner saw Dr. Frank, a neurologist. The doctor recorded a history of the work accident and noted a complaint of 7-8/10 pain in the anterior and medial portions of the right knee. He also noted a history of the left ankle gunshot wound and complaints of "constant numbness/tingling in the left foot and weakness in the left ankle." On examination, he noted 4/5 left ankle dorsiflexion strength, normal sensation except in the left S1 and L4 distribution and normal reflexes in both lower extremities. He performed EMG/NCV studies and described the results as negative. He found no electrodiagnostic evidence of a lumbar radiculopathy, lumbosacral plexopathy or peripheral neuropathy. PX 12-13.

Petitioner returned to Dr. Wolin on May 16, 2014. Petitioner testified that the doctor recommended saphenous nerve blocks on that date. T. 28.

In his May 16, 2014 note, Dr. Wolin indicated Petitioner was still experiencing pain and popping in his right knee, particularly when getting up from a prolonged seated position. On examination, the doctor noted tenderness on the anteromedial aspect of the knee, in the region of the saphenous nerve, with no frank Tinel's or skin changes. The doctor recommended a saphenous nerve block and Nortryptiline. Wolin Dep Exh 2.

At the next visit, on September 23, 2014, Dr. Wolin noted that Petitioner was essentially the same and had not undergone the recommended block. On examination, he noted pain to

varus stress. He again recommended a saphenous nerve block, to be followed by a sympathetic block if the saphenous block did not provide relief. Wolin Dep Exh 2.

At Respondent's request, Petitioner saw a different Section 12 examiner, Dr. Neal, on May 18, 2015. T. 28. In his report of May 29, 2015 (RX 2), Dr. Neal indicated he reviewed Dr. Bach's Section 12 reports along with various treatment records and the 2011 MRI films in connection with his examination. He also indicated that Petitioner complained of constant right knee pain, from morning till night, that had caused him to lose his job and that prevented him from being able to walk his pit bulls and drive a stick shift vehicle. He further stated that Petitioner complained of pain in his kneecap as well as the anteromedial joint line.

On examination, Dr. Neal noted that Petitioner was not wearing any brace or using any walking aid and seemed to have a slight limp while walking. He also noted equal alignment and range of motion in both legs. He detected no right knee swelling, ecchymoses or effusion. He described Petitioner as complaining of tibial tubercule pain until he was distracted. He noted anteromedial and anterolateral joint line pain and stability to varus/valgus stress testing.

Dr. Neal obtained knee X-rays, which he described as normal.

Dr. Neal diagnosed "non-physiological, non-organic, unexplainable right knee pain of unknown etiology" and a "history of reported insensate left foot and ankle with subjective instability requiring bracing or high-top shoe gear usage following left ankle gunshot wound with open reduction internal fixation." He acknowledged he did not examine Petitioner's left ankle or review any records relating to the left ankle. He indicated he was unable to state that the treatment to date had been inappropriate. He recommended against any additional care but went on to concur with an outpatient knee arthroscopy, which he described as "the ultimate imaging modality to definitively determine" whether Petitioner has an intra-articular condition. He did not agree with the need for a "lumbar nerve block" or saphenous nerve block. He went on to state that Petitioner is at maximum medical improvement and is able to perform full duty, at least insofar as his right knee is concerned. RX 2.

On August 31, 2015, Dr. Wolin issued a narrative report summarizing his treatment and diagnosis-related opinions. He described Petitioner's current diagnosis as "post-traumatic knee pain, status post medial plica excision, rule out complex regional pain syndrome versus saphenous neuropathy." He described Petitioner as consistently voicing complaints of anterior knee pain, throughout his treatment, and more recently complaining of posterior knee pain as well. He identified a "key issue," i.e., "whether or not there is a component of neuropathic pain." He recommended both a saphenous nerve block and a sympathetic nerve block to rule out a saphenous nerve problem and/or complex regional pain syndrome. He indicated he was still relying on the functional capacity evaluation in setting Petitioner's restrictions. He noted that Dr. Neal underwent fellowship training in hand surgery rather than sports medicine and set forth various reasons as to why he disagreed with Dr. Neal's opinions. Wolin Dep Exh 3. PX 14.

Petitioner testified he last saw Dr. Wolin on November 3, 2015. In his note of that date, the doctor described Petitioner as "essentially unchanged" and continuing to complain of anterior right knee pain as well as popping and clicking in the anterior aspect of the knee. He noted that Petitioner had not undergone the previously recommended nerve block apparently because Respondent's examiner disagreed with that recommendation.

On right knee examination, Dr. Wolin noted tenderness in the medial femoral condyle, medial parapatellar area, proximal patellar tendon and medial metaphysis. On bilateral knee range of motion testing, he noted 120 degrees of flexion in the right knee versus 130 in the left. He also noted a positive apprehension sign on the right and "increased rubor about the region of the saphenous nerve." He indicated that Petitioner experienced significant relief after his therapist performed a medial patellar taping. He diagnosed two problems: "what appears to be patellar instability" and "a variant of complex regional pain syndrome." He again recommended a saphenous nerve block, a new MRI and a repeat arthroscopy, including ligament reconstruction if appropriate. He commented that Petitioner's patellar instability "fits with the initial injury as well as the findings on examination." He stated that patellar instability "can be a very subtle diagnosis and can be present even in the presence of a normal MRI." He took Petitioner off work. Wolin Dep Exh 2.

Dr. Wolin testified by way of evidence deposition on November 11, 2015. Dr. Wolin testified he obtained board certification in orthopedic surgery in 1986. He was re-certified in 1997 and 2007. PX 15 at 6. He obtained board certification in sports medicine in 2007. PX 15 at 6. He is currently affiliated with Weiss Memorial and St. Joseph Hospitals. PX 15 at 7. He is the chief of sports medicine at Weiss Medicine. In this capacity, he oversees the sports medicine education of orthopedic residents and students. In 2011, he obtained certification from the American Board of Independent Medical Examiners. PX 15 at 8. He is the chairman of the workers' compensation task force for the Illinois Medical Society. PX 15 at 9.

Dr. Wolin testified he has been the director of the Center for Athletic Medicine for 24 years. In this capacity, he sees about 100 patients and performs about 8 orthopedic surgeries per week. PX 15 at 11. About 40% of these surgeries involve the knee. PX 15 at 11.

Dr. Wolin testified he does not independently recall Petitioner. PX 15 at 12. He first examined Petitioner on April 17, 2012. On that date, Petitioner provided a history of the work accident and also indicated his knee had recently given out on him at home. PX 15 at 13.

Dr. Wolin testified he reviewed Petitioner's right knee MRI scan on April 17, 2012. He believed the anterior cruciate ligament was grossly intact. PX 15 at 14. After reviewing the MRI and examining Petitioner, he suspected a possible condyle injury, or medial plica. A medial plica is a piece of scar tissue that can catch within the knee. It is usually post-traumatic. PX 15 at 14. He recommended an arthroscopy, which he performed on June 7, 2012. The surgery confirmed his suspicion of a medial plica. PX 15 at 15. Petitioner underwent therapy and a functional capacity evaluation postoperatively. The evaluation, performed on December 3, 2012, was valid. It showed that Petitioner could balance and climb stairs occasionally, could

bend and stoop and could crawl, crouch, knee and squat minimally. PX 15 at 16. On January 22, 2013, Petitioner underwent a repeat MRI, which showed some loss of cartilage on the lateral tibial plateau. He injected the area of the patellar tendon on February 5, 2013 but this did not seem to help. At his recommendation, Petitioner saw Dr. Hutchinson, a full professor at the University of Illinois, for a second opinion on March 18, 2013. Dr. Hutchinson noted a complaint of burning pain on the medial, or inside, aspect of the knee and tenderness along the patellar tendon and mediolateral joint lines. He recommended an EMG, which proved to be negative. PX 15 at 19-20. Petitioner underwent yet another MRI on November 19, 2013. This study was not optimal because Petitioner was moving while the MRI was being performed. It showed some other pathology, which, in retrospect, is a "variant of patellar instability." PX 15 at 21. At his recommendation, Petitioner saw Dr. Tonino, a professor at Loyola, on January 27, 2014. Dr. Tonino concluded Petitioner should have another arthroscopy. Dr. Tonino's examination findings were consistent with his own. PX 15 at 22.

Dr. Wolin testified he last saw Petitioner on November 3, 2015. When he examined Petitioner on that date, he noted tenderness over the medial femoral condyle, the patellar tendon and the medial metaphyseal, or shin, region of the knee. Petitioner also had 10 degrees less motion and flexion in his right knee compared with his left and a patellar apprehension sign, suggesting patellar instability. PX 15 at 23-24. Petitioner also exhibited increased redness in the region of the saphenous nerve. This nerve produces sensation to the inside portion of the shin. It is a branch of the nerves that go from the back down the leg. PX 15 at 26. He concluded Petitioner had two problems: patellar instability and a variant of complex regional pain syndrome. PX 15 at 24. He recommended a new MRI and an arthroscopy, with ligament reconstruction and correction of kneecap displacement if appropriate. PX 15 at 24.

Dr. Wolin testified that Petitioner's subjective complaints have been consistent with the objective findings throughout his course of care. To him, that means Petitioner "has a real problem." Petitioner is "not making things up." PX 15 at 26-27.

Dr. Wolin opined that Petitioner has three diagnoses: patellar instability, complex regional pain syndrome and patellar tendinopathy. Petitioner's burning pain and skin color changes are consistent with complex regional pain syndrome. PX 15 at 28-29.

Dr. Wolin opined that Petitioner's diagnoses are related to his work accident. When Petitioner stepped in a hole, he twisted his knee and felt a pop. When he twisted his knee, his kneecap came out of place. The kneecap "went back in place but the fact that it happened once is enough to cause recurrent instability." PX 15 at 30.

Dr. Wolin characterized Petitioner's treatment as reasonable and necessary. In his view, Petitioner requires a repeat MRI to check the patellar tendon and a right knee arthroscopy, with ligament reconstruction and exploration of the patellar tendon if appropriate. Due to Petitioner's complex regional pain syndrome, which could cause surgical complications, he is also recommending a saphenous or equivalent nerve block. The block involves injecting numbing medicine around the area of the saphenous nerve. Its purpose would be diagnostic. If

it provided pain relief, that would be indicative of pain control during surgery. The recommendation of the block is related to the complex regional pain syndrome which, in turn, is related to the knee condition. PX 15 at 32-34.

Dr. Wolin testified he considered the opinions of Drs. Hutchinson, Tonino and Bach in making his treatment recommendations. He believes Petitioner cannot resume his former job because that job requires bending, stooping, squatting, kneeling and climbing ladders. Petitioner cannot perform those activities right now. PX 15 at 35.

Dr. Wolin opined that Petitioner's right knee condition has worsened since the functional capacity evaluation. PX 15 at 35.

Dr. Wolin testified he is familiar with Dr. Neal "only by name." He has reviewed Dr. Neal's report, which sets forth a diagnosis of "non-physiologic and non-organic subjective right knee pain which is unexplainable and of unknown etiology." He "absolutely" disagrees with this diagnosis. Petitioner had a documented injury and has had persistent knee problems. Four fellowship-trained orthopedic surgeons believe he has a real problem. He is "flabbergasted" by Dr. Neal's diagnosis. PX 15 at 36. On page 20 of his report, Dr. Neal stated he is not recommending more care but that a "different question" existed as to whether there was additional care that he would not personally recommend but that other physicians might feel was appropriate. PX 15 at 37.

Dr. Wolin testified he agrees with Dr. Neal's physical examination of Petitioner. PX 15 at 38.

Dr. Wolin opined that Petitioner has not reached maximum medical improvement. PX 15 at 38. There is an "anatomic basis" for Petitioner's pain. PX 15 at 38.

Under cross-examination, Dr. Wolin testified he devotes 20% of his time to medical-legal work, including examinations and record reviews. He does not know how Petitioner came to be referred to him. PX 15 at 39. His initial report reflects Petitioner smokes a pack per day. Smoking can inhibit healing. He does not know whether Petitioner quit smoking before his surgery. At the first visit, he noted a possible condyle injury. This kind of injury can cause catching, locking and falling. He noted no effusion or crepitus. When he operated on Petitioner, he noted no patellar abnormalities. PX 15 at 41. On August 17, 2012, he noted Petitioner had not complied with therapy or home exercise secondary to social issues. PX 15 at 41-42. Petitioner had missed eight to twelve sessions at that point. Compliance with post-operative therapy is important in order to rehabilitate the muscles around the knee. PX 15 at 43. Petitioner underwent the functional capacity evaluation at his office. In December 2012, following this evaluation, he released Petitioner to work per the evaluation. That release would still be in place as of the current time. PX 15 at 45. The repeat MRI performed in January 2013 showed no patellar tendon pathology. The radiologist noted no other findings to account for Petitioner's pain. PX 15 at 46. Petitioner did not obtain relief from the patellar tendon injection he administered on February 5, 2013. Petitioner's patellar tendon pain was probably

"referred" from inside the knee. PX 15 at 46-47. When he injected Petitioner's knee, he did not examine Petitioner for patellar instability. PX 15 at 47. He originally referred Petitioner to Dr. Hefferon but it turned out Dr. Hefferon does not see workers' compensation patients. He then recommended that Petitioner see Dr. Hutchinson. PX 15 at 48. Dr. Hutchinson asked Petitioner to bring in additional records but it is not clear whether Petitioner ever did this. PX 15 at 48-49. He next saw Petitioner in June 2013, after a gap in treatment that stemmed from Petitioner's left ankle injury. He does not know what kind of left ankle surgery Petitioner underwent. PX 15 at 49. He recommended therapy but Petitioner could not start this therapy until he concluded his left ankle care. PX 15 at 49-50. He next saw Petitioner in October 2013, at which point he recommended a 3T scan and a regular MRI. The 3T scan produces a clearer image. PX 15 at 50-51. The MRI was unremarkable but Petitioner moved during the study. PX 15 at 51. Petitioner told him he did not want to take pain medication because such medication had not helped in the past and he wanted to avoid any complications from taking it. PX 15 at 52. On February 18, 2014, he planned to refer Petitioner to Dr. Chang for evaluation of possible complex regional pain syndrome but Petitioner never saw Dr. Chang. He also recommended an EMG, which Dr. Hutchinson had recommended a year earlier. PX 15 at 53. He believes a pain management specialist should determine whether it would be better to administer a saphenous nerve block or a sympathetic nerve block. Some people believe it is preferable to perform a lumbar sympathetic nerve block in the presence of complex regional pain syndrome. PX 15 at 54, 57. The redness he noted on November 3, 2015 was apparently a new finding. PX 15 at 55. On November 3, 2015, he recommended that Petitioner be off work altogether. PX 15 at 55. He is an orthopedic surgeon, not a pain physician. To him, Petitioner's burning pain and redness are indicative of neuropathically-generated pain. PX 15 at 58. He drafted a report at the request of Petitioner's attorney. He charges $1,300 per hour for records review but does not know exactly how much he charged for the report. PX 15 at 59.

On redirect, Dr. Wolin testified he conducts examinations for both claimants and insurers. Petitioner's smoking does not have an impact on his causation-related opinions. PX 15 at 60. Petitioner's diagnoses have changed somewhat throughout his course of care. PX 15 at 60. Some of the treatment was directed at ruling out certain diagnoses. PX 15 at 60. Patellar tendon pain can stem from any pathology inside the knee joint or from direct pathology of the tendon itself. PX 15 at 61. Petitioner's failure to comply with therapy does not have any impact on his causation opinions or on Petitioner's diagnosis. PX 15 at 61. The diagnosis of patellar instability had not been made as of February 5, 2013 but that does not necessarily mean Petitioner had no such instability on that date. It means he (Dr. Wolin) "wasn't smart enough to make the diagnosis by then." PX 15 at 62. Petitioner's left ankle injury has no impact on the treatment recommendations for the right knee. PX 15 at 62-63. Nor does it impact his opinions concerning causation and diagnosis. PX 15 at 63. He would have referred Petitioner to Dr. Chang for the injections. He wants to leave it up to an anesthesiologist to determine what kind of block to administer. PX 15 at 63. The redness means Petitioner's condition is probably evolving. Petitioner's condition could be getting worse. PX 15 at 64. Any type of injury can cause complex regional pain syndrome. The syndrome can worsen over time, "especially if the underlying pathology is not taken care of." PX 15 at 64. In Petitioner's case, the underlying pathology is the patellar instability. PX 15 at

65. Petitioner's difficulty with sitting, standing and walking prompts him to conclude Petitioner should be off work. PX 15 at 65. There are different names for the kind of neuropathic pain Petitioner is experiencing. PX 15 at 66-67.

Under re-cross, Dr. Wolin acknowledged he has not tested Petitioner's ability to sit, stand or walk. He cannot specifically pinpoint when Petitioner's complex regional pain syndrome began. PX 15 at 67.

On further redirect, Dr. Wolin testified it is not necessary to formally test Petitioner's physical capabilities. At this point in his career, he "pretty much" knows who can work and who cannot. PX 15 at 68.

Under additional re-cross, Dr. Wolin testified he does not disagree with the statement he made in his August 2015 report, i.e., that the only objective determination of [Petitioner's] ability to work is a functional capacity evaluation. PX 15 at 68.

On further redirect, Dr. Wolin testified that a functional capacity evaluation could make things worse if Petitioner has complex regional pain syndrome. He cannot in good conscience recommend a measure that might exacerbate Petitioner's condition. PX 15 at 69.

Under additional re-cross, Dr. Wolin testified that, at this point, a functional capacity evaluation is not needed. He thinks he is pretty objective but again acknowledged he has not formally tested Petitioner's capabilities. PX 15 at 70.

On further redirect, Dr. Wolin testified he has observed Petitioner. He has been an orthopedic surgeon for 30 years and can tell whether a patient appears to have complex regional pain syndrome by looking at the patient's behavior, facial expression and skin. A patient with this syndrome cannot get to work, sit at a desk and "pick up and go." PX 15 at 71.

Dr. Neal testified by way of evidence deposition on May 10, 2016. RX 1.

Dr. Neal testified he is board certified in orthopedic surgery. He underwent fellowship training in hand surgery but has a general orthopedic practice. RX 1 at 5. He currently performs about 50 to 100 surgeries annually. He performs both knee arthroscopies and knee replacement surgery. He operates on ankles if necessary. RX 1 at 6. He conducts about six Section 12 examinations per week. RX 1 at 7. He is a sole practitioner so all the income generated by such examinations goes to him. RX 1 at 8. He is on staff at Northwest Community and Alexian Brothers Medical Centers. RX 1 at 8.

Dr. Neal testified he examined Petitioner on May 18, 2015 and issued a report concerning that examination on May 29, 2015. RX 1 at 9. He reviewed various records in connection with the examination. He is familiar with the duties of a maintenance employee. In his opinion, Petitioner's job fell into the light to medium physical demand category. RX 1 at 11. Petitioner complained to him of constant right knee pain that was at its worst in the morning.

Petitioner did not mention anything about numbness, tingling or paresthesias. Nor did Petitioner complain of low back or radicular pain. RX 1 at 17. Petitioner completed a pain- and activity-related questionnaire at the end of the examination. Some of the responses Petitioner gave were inconsistent with his verbal complaint of constant, disabling right knee pain. RX 1 at 19. Petitioner told him about his left ankle gunshot wound and surgery. He concluded that the plantar area of Petitioner's left foot is insensate and that Petitioner will need a brace or high-top shoe for the rest of his life. RX 1 at 20. Petitioner did not explain why he was in Indiana when he was shot. Petitioner did not state he was working when he was shot. RX 1 at 21.

Dr. Neal testified that Petitioner complained to him of pain in the tibial tubercle, or bony prominence where the patellar tendon inserts. However, when he distracted Petitioner, by asking him about his dogs, it no longer appeared that the tibial tubercle was painful. RX 1 at 23-24. Petitioner's patellofemoral joint was "definitely less painful than either the tibial tubercle or the medial joint line area." RX 1 at 25. He noted no temperature asymmetry, no color asymmetry and no hair loss from the right knee. RX 1 at 25-26.

Dr. Neal testified he reviewed the 2011 right knee MRI films and saw no abnormalities. He obtained knee X-rays in his office and they were normal. RX 1 at 27.

Dr. Neal testified that, with respect to Petitioner's right knee, he diagnosed "non-physiological, non-organic, unexplainable pain of unknown etiology." RX 1 at 28. He also diagnosed a reported insensate left foot and ankle. RX 1 at 28.

Dr. Neal opined that Petitioner's right knee condition as of his examination was not related to the work accident. In his view, the work accident caused a knee strain and brought about the need for an arthroscopy and plica resection. RX 1 at 29. He believes it would not be appropriate to target an exact date on which Petitioner reached maximum medical improvement for this condition but "probably one can extrapolate" that Petitioner reached maximum medical improvement between February 5 and June 4, 2013. Petitioner did not see Dr. Wolin during this period. RX 1 at 29. Based on the valid functional capacity evaluation performed in December 2012, Petitioner could have resumed his former job. RX 1 at 30.

Dr. Neal testified he has no explanation for the right knee complaints Petitioner voiced at the May 2015 examination. As of that examination, Petitioner exhibited no right knee instability or range of motion deficits. RX 1 at 31. From an objective standpoint, Petitioner's X-rays and EMG were normal and the three MRIs he had over time "did not reveal any significant intra-articular pathology." RX 1 at 32.

Dr. Neal believed there was "an element of symptom magnification [Petitioner] put forth when describing his symptoms." RX 1 at 32. It is not plausible that Petitioner is unable to walk a dog or take the garbage out. It is also not plausible that Petitioner's pain is significant enough to prompt him to make dramatic statements such as he has pain from morning until night, despite taking no pain medication. RX 1 at 33. As for Petitioner's complaint that he can no longer drive a stick shift vehicle, it is more plausible that this complaint stems from his left

ankle injury. RX 1 at 34. If Petitioner did have an extra-articular soft tissue contusion around the tibial tubercle, due to the work accident, that would have healed over time. RX 1 at 35. If Petitioner really had a soft tissue abnormality, you would expect some MRI abnormalities. RX 1 at 36. The treatment through his May 2015 examination was reasonable and necessary but not all of that treatment related back to the work accident. RX 1 at 36. The need for the arthroscopy stemmed from the accident. The treatment that took place after June 4, 2013 did not relate back to the accident. RX 1 at 38. As of his examination, Petitioner did not require any more care. RX 1 at 38. Petitioner's pain at that point was non-physiologic and unexplainable. RX 1 at 39. He acknowledges, however, that "others might feel differently" about this and "there are occasions where the most definitive diagnostic procedure available is an actual surgery to visualize the intra-articular structures." RX 1 at 39, 41. At some point, there has to be an end of the diagnostic procedure. RX 1 at 40. He also does not recommend any nerve blocks. Neither Petitioner's symptoms nor his records support neurologic processes for which such blocks would be appropriate. RX 1 at 41. If Petitioner truly cannot work, it is "much more likely" that this is due to his contralateral ankle condition. He does not believe Petitioner has "any significant patellofemoral condition" in his knee. RX 1 at 42. If such a condition existed, it "presumably" would have been visualized at the time of the June 2012 arthroscopy. RX 1 at 42.

Dr. Neal testified he has reviewed Dr. Wolin's deposition. Dr. Wolin advanced the theory that Petitioner has three conditions, including complex regional pain syndrome. Dr. Neal testified he has treated patients who have this syndrome. The syndrome "is not well understood." It is "a difficult condition to both understand and treat." RX 1 at 45. He did not find any CRPS pathology when he examined Petitioner. Moreover, Dr. Wolin did not suspect this diagnosis until years after the injury. In most cases, CRPS symptoms manifest "much sooner" than six months after a trauma. As for the other possible diagnoses, Petitioner had no signs of a patellar subluxation or dislocation on initial presentation. The MRI that was performed eight days after the accident showed no effusion or patellofemoral joint abnormalities. RX 1 at 47-48. Dr. Bach did not diagnose patellofemoral instability at either his first or second examination. RX 1 at 49. Dr. Bach did initially diagnose post-traumatic patellar tendonitis but that is a different condition from patellofemoral instability. RX 1 at 49-50. On April 18, 2012, Dr. Wolin documented a recent knee trauma, raising the possibility of an "additional trauma that could explain patellofemoral instability." RX 1 at 52. In his operative report, Dr. Wolin documented only medial pathology. RX 1 at 53. A saphenous nerve block is a "reasonable modality" to rule out a neuroma and can be done in a doctor's office, via an injection. RX 1 at 57. Some of Petitioner's records reference medial pain while others reference lateral pain. RX 1 at 58. Dr. Wolin's deposition testimony did not prompt him to change his opinion that Petitioner is at maximum medical improvement with respect to his knee and can perform full duty, at least insofar as the knee is concerned. RX 1 at 59.

Under cross-examination, Dr. Neal acknowledged he saw Petitioner only once. RX 1 at 60. He currently sees about 60 patients per week. He is a general orthopedic surgeon. The knee is probably the most common joint he operates on. RX 1 at 61, 63. He underwent fellowship training but not in sports medicine. RX 1 at 62. He does not hold any teaching

positions. RX 1 at 62. About 20 to 25% of the surgeries he performs involve the knee. RX 1 at 63. He performs about two IMEs and/or impairment ratings per day. The "vast majority" of the IME/rating referrals he receives come from respondents but he will perform examinations and ratings for claimants. RX 1 at 64. His typical IME fee is $1,000. RX 1 at 64. He charges $750/hour for deposition time, not including his preparation time. RX 1 at 65. Less than 20% of his IMEs involve the knee. RX 1 at 66. He does not rely on a staff member to obtain a history from an examinee. He takes the history himself. He makes handwritten notes but does not retain them. He reads the cover letters he receives but does not give them much thought. He conducts his own review of the records. RX 1 at 71. He has not reviewed Dr. Tonino's records. He met Dr. Tonino once, very briefly. He has never met Dr. Wolin or Dr. Hutchinson. RX 1 at 72. His direct intervention with Petitioner lasted 60 to 90 minutes. RX 1 at 75. Knee pain can wax and wane. To him, it is not plausible that Petitioner cannot walk his two dogs. He is unable to say that a person who has concerns about knee buckling would never have difficulty walking two 60-pound pit bulls. RX 1 at 80. Nor can he say that a person with knee problems would never have difficulty driving. RX 1 at 81. However, in Petitioner's case, he believes any difficulty with driving likely stems from the insensate left foot condition. RX 1 at 81. He did not review the operative report concerning the left ankle. Nor did he review any of Dr. Webb's records. RX 1 at 82. He watched Petitioner walk but did not specifically examine Petitioner's left ankle. RX 1 at 83. He observed a slight limp and did not state whether Petitioner was favoring his right knee. He found no crepitus on knee examination but other doctors have noted this. RX 1 at 84. There can be good reasons for one physician to refer a patient to another physician for a second opinion. RX 1 at 85. An arthroscopy is a minimally invasive procedure that allows a surgeon to visualize the intra-articular joint and soft tissue anatomy. An arthroscopy can be performed for both diagnostic and treatment purposes. RX 1 at 87. It is "always possible" that Dr. Wolin missed something when he performed the plica removal. RX 1 at 88. An X-ray does not directly show soft tissue. An MRI may show soft tissue. RX 1 at 90. It is highly unlikely that an actual, symptomatic intra-articular abnormality would not show up on an MRI. RX 1 at 91. He reviewed the films of only Petitioner's initial MRI. RX 1 at 92. A saphenous nerve injury resulting from an arthoscopy would typically produce a localized abnormality, i.e., a localized Tinel's. Petitioner never had an abnormal Tinel's finding. RX 1 at 94-95. After Petitioner saw Dr. Hutchinson, Dr. Wolin stated that Petitioner did not appear to have a neuroma. RX 1 at 95. It is possible, however, that Dr. Wolin has since reconsidered. RX 1 at 96. Some neuromas resolve on their own. Or you can try medical management or a diagnostic local block. RX 1 at 97. Petitioner reached maximum medical improvement sometime between February 5, 2013 and June 4, 2013. Petitioner did not see Dr. Wolin during that time and the time frame was adequate for recovery from the medial plica resection. RX 1 at 99. None of the records he reviewed documented any pre-accident right knee condition. RX 1 at 101. He did not review the functional capacity evaluation or a formal job description from Respondent. He did obtain a job description from Petitioner and he believed what Petitioner told him. RX 1 at 105. Petitioner told him he had to lift up to 100 pounds and the evaluator concluded he did not demonstrate the ability to do this. RX 1 at 106. He has not reviewed any accident report or inspected the area where the accident occurred. RX 1 at 107. Petitioner demonstrated the mechanism of injury to him. Petitioner demonstrated a valgus stress rather than a rotational twisting injury. RX 1 at 108. Hypothetically, the kind of valgus stress injury

Petitioner demonstrated could cause patellar instability. If a person has symptomatic patellar instability, he would demonstrate persistent effusion, or swelling. RX 1 at 114-115. However, he cannot say that effusion is present in every case involving patellar instability. RX 1 at 115. A person who has patellar instability experiences lateral movement of the patella and possibly pain about the kneecap. The person might also experience popping and cracking. RX 1 at 118. It is possible for a person to have a medial plica problem and patellar instability at the same time. A medial plica resection would not be expected to bring about a significant change in patellofemoral symptoms. RX 1 at 120. A fall could explain the patellar instability that Dr. Wolin has diagnosed. RX 1 at 127. Dr. Wolin noted that Petitioner attributed his fall at home to his knee giving out. RX 1 at 128. CRPS can be caused by trauma and can develop following surgery. RX 1 at 130.

On redirect, Dr. Neal acknowledged that Dr. Wolin recommended an arthroscopy at his deposition but he extrapolates from the records that Dr. Wolin "does not seem enthusiastic about surgery." RX 1 at 131.

Under re-cross, Dr. Neal testified he "detects that [Dr. Wolin] does not want to proceed with arthroscopy." It was only at his deposition that he stated he was recommending an arthroscopy. RX 1 at 135. It appears Dr. Wolin is "very unenthusiastic." RX 1 at 136.

Petitioner testified he is currently unemployed. Dr. Wolin has not released him to full duty. T. 30.

Petitioner denied reinjuring his right knee at any time after the accident of September 29, 2011. T. 30. He experiences constant pain, buckling, popping and clicking in the right knee. The painful area of his knee is just below the kneecap on the left inner side and right outer side. He does not currently take any pain medication because he does not want to become a pill popper. T. 31.

Petitioner testified he owns two pit bulls. Each of the dogs weighs about 65 pounds. Before the accident, he was able to walk these dogs on a regular basis. Now he simply lets them out into his backyard. Walking them causes too much pain. T. 31-32.

Under cross-examination, Petitioner clarified he had to remove the snow plow from his work truck and put the plow into storage only once a year, at the end of winter. T. 33-34. He had to lift 100-pound bags of concrete four or five times per month in order to create memorial plaques, which are placed on trees in parks. T. 35. He would make as many as ten to fifteen plaques at one time. T. 36. He would lift the bag from a pallet to a table, pour the contents into a wheelbarrow and create a mixture in order to fabricate the plaques. Some of his routine maintenance tasks included wiping down playground equipment, raking leaves and sweeping. T. 37. His ladder usage was limited. He would climb a ladder once in the fall to clean gutters and again in December to hang Christmas lights. T. 38-39. He carried bags of grass seed during the spring, summer and fall, but not on a daily basis. He would re-seed bald patches in fields and other park areas.

Petitioner testified that other employees worked in the grounds division but he only occasionally worked with a partner. T. 39-40. He spent a lot of time working alone. T. 40. In the summer, Respondent hired seasonal part-time workers but they primarily picked up trash. Nevertheless, he still had to pick up trash in the summer. He drove Respondent's garbage truck one week per month. On each day of that week, he had to pull 50-gallon trash cans to the curb and empty the contents into the truck. Not all of Respondent's grounds employee could operate the truck because a CDL was required. T. 43.

Petitioner testified that, when he saw Dr. Neal in May 2015, he was honest about his job requirements and pain complaints. T. 44.

Petitioner testified that the surgery Dr. Wolin performed in June 2012 did not result in improvement. His right knee still buckled. He had pain below his right kneecap before the surgery. If his records reflect his complaints varied, in terms of the location of his pain, he would disagree with the records. His knee swells occasionally, when he walks or stands for too long. The knee gets red and blotchy when it swells. He has experienced no difference, temperature-wise, between his right and left knees. It seems to him that he has less hair on his right knee than his left but his right knee was shaved in preparation for the surgery and the hair is still growing back. When his right knee swells, it seems a little bigger than his left.

Petitioner acknowledged he saw Dr. Wolin at the recommendation of his attorney. T. 50.

Petitioner acknowledged telling Dr. Wolin in April 2012 that he had fallen at home a week earlier. His right knee buckled when he was on stairs at home, causing him to fall onto the knee. His right knee became swollen after this incident. He self-treated by applying ice to the knee and taking aspirin. He experienced 8/10 pain in the knee after the home fall.

Petitioner denied taking any pain medication, whether prescription or over the counter, for his right knee in 2013, 2014, 2015 or 2016. He did take Norco in 2013 but that was in connection with his gunshot wound.

Petitioner acknowledged that, after his June 2012 right knee surgery, Dr. Wolin recommended he attend therapy two to three times per week. He was supposed to start therapy in July 2012. He did start therapy at that time but stopped after only two weeks. It was "after [he] was done burying [his] mother" that he resumed therapy. He did not resume therapy until October 2013. Dr. Wolin recommended a functional capacity evaluation in late 2012. He does not know why the doctor recommended this evaluation. He does not recall being rated as putting forth invalid effort. He believes he put forth his best effort during the evaluation.

Petitioner testified his left ankle injury occurred at a shooting range in Lansing, Illinois. He was cleaning his gun after firing it when the gun discharged. T. 57-58. He underwent

treatment at a hospital in Indiana, Munster Community Hospital, because this is the hospital that the paramedics brought him to. He typically goes to a shooting range a couple of times per year, with each visit lasting 30 to 45 minutes. He sits when he shoots at the range. He continues to go to the shooting range. T. 58.

Petitioner testified he last saw Dr. Harris for his left ankle on August 8, 2013. T. 59. On that date, the doctor recommended he come back in six to eight weeks but he did not go back. On August 8, 2013, he asked the doctor whether he required any restrictions relative to the left ankle and the doctor said no. T. 60.

Petitioner testified he used crutches for about four weeks after his left ankle injury. While using the crutches, he relied on his right leg for weight bearing. In late June or early July 2013, he stopped using the crutches and transitioned to a walking boot. While wearing the boot, he continued to rely on his right leg for weight bearing. If his 2014 EMG report shows he complained of left foot weakness, he would not disagree with the report. T. 62. He no longer experiences any left foot weakness.

Petitioner acknowledged that, between June and October 2013, there was a break in his care with Dr. Wolin. He cancelled appointments with Dr. Wolin during this interval.

Petitioner recalled Dr. Hutchinson recommending right knee surgery in March 2013. If, however, the doctor's records show he recommended a nerve block, he would not disagree with the records. Dr. Wolin did not disagree with the nerve block recommendation. Dr. Wolin referred him to Dr. Tonino. Dr. Wolin recommended both nerve blocks and surgery. He is not sure whether Dr. Wolin's records are consistent with those of Drs. Hutchinson and Tonino. T. 68. He went to the second opinion appointments because he was told to. At his last two visits with Dr. Wolin, the doctor was consistent about recommending both the blocks and the surgery.

Petitioner testified he has not attempted to perform light duty anywhere since July 2015. T. 71. He has not looked for work within the restrictions recommended by the functional capacity evaluator. T. 71.

On redirect, Petitioner testified that an empty garbage can weighs 20 to 25 pounds. A full can weighs over 100 pounds. He performed lifting and carrying every day when working for Respondent. He would have assistance with his work for about 10 to 15 days each summer but he continued to perform lifting and carrying on his own on these days. He never sat when performing his job at the parks. T. 74-75.

Petitioner testified he has never reviewed his medical records. He has no control over the content of those records. T. 76.

Petitioner testified he stopped attending physical therapy in 2012 when he learned his mother had been diagnosed with terminal cancer and had two weeks to live. He "went down" to spend time with his mother. T. 76-77.

Petitioner testified that Dr. Wolin injected his knee. He does not know whether Dr. Wolin recommended a second functional capacity evaluation. He owns long rifles and AR 15 weapons. Sitting while shooting helps him zero the scope. During the time he was restricted to crutches, following his left ankle injury, he moved as little as possible and obtained help from his grandfather and girlfriend. When he transitioned to the walking boot, his activities were still limited but he was able to get up in order to let his dogs out.

Under re-cross, Petitioner testified he was sitting and cleaning his gun when his gun discharged. After he stopped attending therapy in July 2012, he did not resume until October 2013.

Arbitrator's Credibility Assessment

Petitioner's testimony concerning his accident and work duties was detailed and credible. Petitioner's pain complaints were also credible.

The Arbitrator has no reason to question Petitioner's denial of pre-accident right knee problems. The records in evidence contain no mention of any such problems.

On direct examination, Petitioner denied injuring his right knee after the work accident. The treatment records, however, show that Petitioner fell at home on at least two occasions after the accident, due to his right knee buckling. The Arbitrator views these falls as stemming from the accident. Fermi National Accelerator v. Industrial Commission, 224 Ill.App.3d 899, 908 (2nd Dist. 1992). [See further below].

Respondent maintains Petitioner impaired his recovery by missing an inordinate amount of post-operative therapy. Under cross-examination, Petitioner testified he stopped attending therapy in mid-July 2012, due to his mother's terminal cancer diagnosis, and did not resume until 2013. In fact, the ATI records show that Petitioner actually resumed therapy on August 22, 2012. PX 4. The Arbitrator does not view the one-month gap in therapy as inordinate, given the underlying circumstances. It appears to the Arbitrator that Petitioner had to travel to get to his mother, based on his testimony that he "went down [to an unspecified location]" to spend time with her. T. 77.

Respondent's second examiner, Dr. Neal, noted symptom magnification and indicated Petitioner "may even be frankly malingering for secondary gain." RX 2. None of Petitioner's treating physicians drew similar conclusions. It also appears, based on Dr. Neal's summaries, that Respondent's first examiner, Dr. Bach, did not note any inconsistencies.

Petitioner's functional capacity evaluation was valid. Respondent's examiner, Dr. Neal, testified he had no reason to doubt Petitioner's verbal account of his job duties.

Overall, the Arbitrator found Petitioner credible.

Arbitrator's Conclusions of Law

Did Petitioner establish a causal connection between his undisputed work accident of September 29, 2011 and his claimed current conditions of ill-being?

The Arbitrator finds that Petitioner established a causal connection between his undisputed work accident and his current conditions of ill-being. In so finding, the Arbitrator relies in part on the following: 1) Petitioner's credible denial of any pre-accident right knee problems; 2) Petitioner's detailed account of the work accident; 3) the consistent accounts of the work accident set forth in the treatment records; 4) the causation opinions rendered by Respondent's first examiner, Dr. Bach, as summarized by the second examiner, Dr. Neal; and 5) the causation opinions rendered by Dr. Wolin.

In addressing causation, the Arbitrator acknowledges that Petitioner experienced at least two post-accident falls at home. Petitioner testified these falls occurred due to accident-related right knee weakness and buckling. This testimony is consistent with the histories set forth in the treatment records. In reliance on Fermi National Accelerator Lab v. Industrial Commission, 224 Ill.App.3d 899, 908 (2nd Dist. 1992), the Arbitrator finds that Petitioner's falls at home were a natural consequence flowing from the original work accident. But for the knee instability resulting from the work accident, the falls would likely not have occurred.

The Arbitrator also acknowledges that Petitioner sustained a significant left ankle injury in 2013, with this injury requiring surgery and post-operative care, including crutch usage. Petitioner denied re-injuring his right knee at the time of his left ankle injury. This denial is also consistent with the left ankle records from Munster Community Hospital and Dr. Harris. RX 5. Those records do not reflect that Petitioner complained of injuring his right knee in the same incident. They also do not reflect that Petitioner complained of worsening of his right knee during the time he was non-weight-bearing as a result of the left ankle.

The Arbitrator further acknowledges that Petitioner's right knee condition has evolved since the work accident. Dr. Desai, his original orthopedic surgeon, believed he had an anterior cruciate ligament tear but this was not the case. Dr. Wolin performed a medial plica resection. At his deposition, Dr. Neal conceded that, during this resection, Dr. Wolin might not have looked for or noticed patellar pathology. He also conceded that a resection would do nothing to address an underlying patellar problem. Perhaps most significantly, he agreed that Respondent's first examiner, Dr. Bach, suspected a patellar problem. Dr. Neal attempted to attribute any such problem to a post-accident fall, rather than the accident itself, but, as noted previously, the Arbitrator views Petitioner's post-accident falls as stemming from the original work injury. More recently, Dr. Wolin opined that Petitioner may have more than one

condition, including possibly a variant of chronic regional pain syndrome, and that diagnostic blocks followed by a repeat arthroscopy are necessary. Dr. Neal saw no evidence of chronic regional pain syndrome on the one occasion he examined Petitioner but conceded that the syndrome is difficult to diagnose and can manifest following trauma or surgery. He did not refute Dr. Wolin's opinion that patellar instability is also a subtle condition. The Arbitrator does not view the uncertainty as to Petitioner's current diagnoses as a valid reason to deny benefits. The Supreme Court has held that where a disease is subject to only limited medical knowledge, the issue of causation can hardly permit an unqualified and unequivocal answer. Mechanical Univ. Joint v. Industrial Commission, 21 Ill.2d 535, 541-2 (1961). [See also Oberlander v. University of Chicago, 14 IWCC 1026, a case in which the Commission (Lamborn, Tyrrell and Brennan) upheld an award of benefits despite uncertainty as to the claimant's diagnoses.]

The Arbitrator elects to assign more weight to the causation-related opinions of the treating physicians and Respondent's first examiner, Dr. Bach, than to those of Respondent's second examiner, Dr. Neal. Dr. Neal saw Petitioner only once while Dr. Bach saw him twice, before and after surgery, and Dr. Wolin saw him on a number of occasions over a lengthy period of time. Dr. Neal conceded that, with respect to Petitioner's various MRIs, he reviewed only one set of actual images, namely the images from the initial 2011 scan. Otherwise, he relied solely on the MRI reports. Dr. Neal also conceded he holds no teaching positions and performs two Section 12 examinations and/or impairment ratings per day, the "vast majority" of which are requested by respondents. Dr. Neal based his recommendation against a lumbar sympathetic block on the inaccurate assumption that such blocks are intended to address spinal conditions. As Dr. Wolin explained, sympathetic blocks address complex regional pain syndrome. Overall, the Arbitrator views Dr. Wolin as more qualified, more objective and more persuasive than Dr. Neal.

Is Petitioner entitled to reasonable and necessary medical expenses? Is Petitioner entitled to prospective care?

Petitioner claims only one unpaid bill, namely a $165.00 bill from Dr. Wolin for the last office visit of November 3, 2015. PX 16. As noted above, the Arbitrator has elected to rely on Dr. Wolin, insofar as causation and treatment recommendations are concerned. The Arbitrator does not find persuasive Dr. Neal's testimony that Petitioner is at maximum medical improvement. At his deposition, Dr. Neal testified he would not recommend an arthroscopy but readily conceded that it would be reasonable for Petitioner to undergo this surgery. Dr. Neal also conceded that a saphenous nerve block could be done and that such a block is a simple procedure that can be performed in an office setting.

The Arbitrator, having considered the foregoing, awards Petitioner Dr. Wolin's November 3, 2015 office visit charge, subject to the fee schedule. The Arbitrator also awards Petitioner prospective care in the form of an evaluation by Dr. Chang or other pain physician of Dr. Wolin's selection, along with any saphenous nerve and/or sympathetic block recommended

by said physician, and a repeat right knee MRI and right knee arthroscopy and potential repair, as recommended by Drs. Tonino and Wolin.

Is Petitioner entitled to temporary total disability benefits?

At the hearing, the attorneys took pains to clarify Petitioner is seeking only one period of temporary total disability, namely July 21, 2015 through the hearing of July 19, 2016. Respondent claims no credit for this period. Arb Exh 1. T. 5-6.

The Arbitrator has previously found in Petitioner's favor on the issue of causation. The Arbitrator has also found that Petitioner is not at maximum medical improvement. The Arbitrator views Petitioner's causally related right knee condition as unstable. While the ability to perform limited work is a factor to consider in assessing the instability of a condition, it is not determinative. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010). While Dr. Wolin previously found Petitioner capable of restricted work, based on the 2012 functional capacity evaluation, he concurrently found Petitioner in need of treatment. As of November 3, 2015, he concluded that Petitioner should be off work, while still recommending the treatment. At his deposition, he explained why a repeat functional capacity evaluation could be harmful, in light of Petitioner's possible complex regional pain syndrome. The Arbitrator, having considered the foregoing along with Dr. Neal's concession that an arthroscopy would be a reasonable diagnostic procedure and Petitioner's credible testimony concerning his current complaints, awards temporary total disability benefits from July 21, 2015 through the hearing of July 19, 2016, a period of 52 weeks. Based on the stipulated average weekly wage, the Arbitrator awards these benefits at the rate of $505.77 per week.

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

Nakita Settles,

Petitioner,

vs.

NO. 12WC039123

17IWCC0357

Chicago Transit Authority,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2016 is hereby affirmed and adopted.

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.

JUN 14 2017

DATED:
SJM/sj
o-5/25/2017
44

Stephen J. Mathis

David L. Gore

Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SETTLES, NAKITA
Employee/Petitioner

Case# **12WC039123**

17IWCC0357

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 11/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2356 DONALD W FOHRMAN & ASSOC
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

0515 CHICAGO TRANSIT AUTHORITY
JEANNINE D SIMS
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

17IWCC0357

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

Nakita Settles
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # 12 WC 39123

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 21, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 6, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,923.76**; the average weekly wage was **$810.91**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **2** dependent children.

ORDER

Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries that arose out of and in the course of her employment, benefits pursuant to Section 8 of the Act are denied.

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

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

Deborah L. Simpson

Signature of Arbitrator

November 22, 2016
Date

ICArbDec p. 2

NOV 28 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nakita Settles,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 39123**
	)	
Chicago Transit Authority,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 6, 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 accident that is the subject matter of the dispute. They agree further that in the year preceding the injuries, the Petitioner earned $38,923.76, and that her average weekly wage was $810.91.

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) What is the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner, Nakita Settles, is a bus operator employed by Respondent. Petitioner testified she had worked as a bus operator for Respondent for approximately five years on the date of the alleged accident. Petitioner testified that her primary duty as a bus operator is to drive a bus and transport passengers on various designated routes.

Petitioner testified that October 6, 2012, she was driving along her usual route west on 63rd Street towards Midway Airport. Petitioner testified that her route ran on 63rd Street from Stony Island to Cicero. Petitioner testified that she was pulling up to a bus stop on 63rd and Wabash when the front right end of the bus came into contact with a missing piece of concrete in the street. Petitioner testified that she thought she hit a pothole and further described it as an indention in the road. Petitioner testified that when she drove over the pothole, the front right wheel of the bus dropped down and the front of the bus hit or scraped the concrete of the road. Petitioner testified that the pothole was "pretty deep." Petitioner testified that her bus was filled with passengers at the time of the alleged accident. Petitioner testified that she did not stop after hitting the pothole;

she did not examine the bus for damages and did not have any difficulty driving out of the pothole, instead, she continued driving along her designated route. Petitioner estimated that she drove approximately 20 minutes to the end of her route following the alleged accident. Petitioner testified that when the bus hit the pothole she felt it in her seat and back but said that what she felt was more of a vibration than pain.

Petitioner testified that when she arrived at the end of her route at Midway Airport, she put the bus in park to take a break. When she stood to exit the driver's seat of the bus she felt a pop in her back and instant pain. Petitioner described the pain as feeling like a screwdriver was being stuck into her back. Petitioner testified that she contacted Respondent's control center to report her injury and eventually was taken to the emergency room via ambulance.

Under cross-examination, Petitioner testified that despite her testimony that the front right side of the bus hit a pothole so deep that the front right side of the bus scraped against the road, she did not stop the bus to check for any damage to the bus. Petitioner testified that pursuant to her employment, she is required to contact Respondent's control center any time an incident occurs. Petitioner testified that she is required to contact the control center in the event there may be physical damage to the bus. Petitioner also testified that she is required to contact the control center in the event she or any passenger suffers any injury while on the bus. Petitioner admitted that she did not contact the control center until she arrived at the end of her route. Petitioner testified that she did not feel any pain in her back immediately after she encountered the pothole. Petitioner further testified that she did not feel any pain in her back until she stood up at the end of her route after putting the bus in park.

Respondent presented an "Employee's Report of Injury on Duty" form to the Petitioner. (RX 1). Petitioner identified the document and verified that she personally completed the form on the date of accident. In the description of the alleged accident on the form, Petitioner wrote that at 63rd and Prairie, the bus "came into contact with a missing slab of concrete in the ground." *Id.* Petitioner wrote that she continued in service "unknowing of any injury at that time." *Id.* Petitioner also wrote that once at Midway, she "turned to step out of [her] seat and felt a pop in [her] back followed by stabbing pain." *Id.* Respondent also gave the Petitioner a "Miscellaneous Incident Report" form to examine. (RX 2). Petitioner identified this document and verified that she personally completed the form on the date of accident. Petitioner wrote a description of the alleged accident almost identical to the description provided in the Report of Injury on Duty form. On the Incident Report form, Petitioner marked the location of the alleged incident as Midway and indicates the incident occurred in the driver's seat of the bus. *Id.* Petitioner also indicated that at the time of the alleged accident, no passengers were present. *Id.*

Prior Health Condition

Petitioner testified that she did experience some minor low back pain prior to the alleged work accident. Petitioner testified that prior to the alleged work accident she had not received any treatment for her low back for approximately one year. Petitioner testified that she saw her primary care physician and participated in one or two physical therapy sessions approximately a year before the alleged accident. Petitioner testified that she experienced no symptoms following that last visit with her primary care doctor.

During cross-examination, Petitioner admitted that she had suffered from serious low back pain off and on for years prior to the alleged work accident. Petitioner testified that she had suffered from back pain since at least 2009. Petitioner admitted that she was involved in a serious car accident in 2009 and suffered injuries including back pain and a lacerated liver. According to the Petitioner this accident was not related to her employment.

Respondent presented a Certification of Health Care Provider for Employee's Serious Health Condition (hereinafter referred to as the "Certification") dated February 23, 2010 to Petitioner to examine. (RX 6). Petitioner identified the document as an FMLA document completed at her request by Dr. Martin, Petitioner's primary care physician. Petitioner identified her own signature on the last page of the document. The document reveals that Petitioner was involved in a motor vehicle accident on November 18, 2009 and suffered a lacerated liver and a back injury. *Id.* Dr. Martin indicated that Petitioner suffered from recurring flare-ups that required her to miss work each month. *Id.* It also indicated that Petitioner was in physical therapy three times a week for several weeks. *Id.*

Respondent gave Petitioner a Certification dated February 17, 2011, to examine. (RX 7). Petitioner identified the document as FMLA paperwork completed by Dr. Martin at her request. Dr. Martin indicated the relevant underlying condition was a still unhealed back injury relating to the November 2009 motor vehicle accident. *Id.* Dr. Martin also indicated Petitioner still suffered right side pain as well as a result of the accident. *Id.* Petitioner was to complete additional physical therapy.

Medical Treatment after alleged accident

Petitioner was taken to Holy Cross ER via ambulance. (PX 3). Once there, she complained of back pain after hitting a pothole while driving. The doctor diagnosed Petitioner with a lumbar strain. *Id.* An x-ray of the lumbar spine revealed no acute pathology as well as normal sacroiliac and hip joints. *Id.*

Petitioner followed up with her primary care physician, Dr. Martin, on October 9, 2012. (PX 6). Petitioner told Dr. Martin she "[w]as driving her bus on Saturday when her bus went over a pothole. Started hurting a little while later. Felt a pop and feels burning..." *Id.* Dr. Martin diagnosed low back pain and placed Petitioner on restricted duty for two weeks. *Id.* Petitioner followed up at Concentra a few days later. She told the examining doctor, "I hit a pothole in the bus, as I turned to step out of my seat my back popped and began to burn and ache." (PX 4). Petitioner also told the doctor that she felt a popping sensation in her mid-back when she hit the pothole and then felt it again later on when she stepped down off the bus. *Id.* The doctor diagnosed thoracic and lumbar strains. *Id.* The doctor also prescribed physical therapy.

Petitioner continued to follow up with Dr. Martin, who also prescribed physical therapy. (PX 6). Petitioner began physical therapy on October 29, 2012. (PX 2). In the patient history section, the therapist noted, "[t]he patient reports a severe increase in her mid and low back pain on 10-6-12 while driving a bus when she hit a pothole." *Id.* Petitioner participated in a total of 13 sessions between October 29, 2012 and January 2, 2013. *Id.*

While in physical therapy, Petitioner continued to periodically follow up with Dr. Martin. A November 15, 2012 MRI of the lumbar spine was normal. (PX 6). In January 2013, Dr. Martin referred Petitioner to a chiropractor as Petitioner did not improve with physical therapy. *Id.*

Petitioner first saw Dr. Fiorini, a chiropractor, on February 8, 2013. (PX 5). In the patient history, Dr. Fiorini noted that Petitioner stated she had no history of prior injury, falls, etc. *Id.* Petitioner noted her 2009 motor vehicle accident on the patient questionnaire; however, she indicated she only suffered a lacerated liver. She gave no indication she also had suffered an injury to her low back. *Id.* The last chiropractic medical record in evidence is dated February 25, 2013. *Id.*

Petitioner followed up with Dr. Martin in mid-February 2013. Dr. Martin noted that Petitioner did not feel she was ready to return to work and still complained of back pain. (PX 6). On March 8, 2013, Dr. Martin again saw Petitioner and noted that Petitioner stated Dr. Fiorini released Petitioner to return to work for 4.5 hours each day to build strength. X-rays taken that day of both the thoracic and lumbar spine were both normal. *Id.* Petitioner returned to Dr. Martin on March 13, 2013, and complained of continued pain with movements. Although there are no chiropractor notes in evidence after February 25, 2013, Petitioner told Dr. Martin that Dr. Fiorini wanted Petitioner to stay off work and continue treatments. *Id.* Dr. Martin requested Dr. Fiorini fax a copy of his plan to her office and kept Petitioner off work for one last month.

Dr. Kesani examined Petitioner on May 8, 2013. *Id.* Petitioner complained of low back pain. He noted that Petitioner stated she had an appointment scheduled in early June with a pain management doctor. His examination revealed normal lumbar range of motion, normal strength, and normal sensation. His exam did reveal tenderness to palpation in the paravertebral muscles of the lower back. *Id.* Dr. Kesani diagnosed lumbar degeneration, a lumbar strain, and lumbosacral spondylosis without myelopathy. *Id.* He did not recommend any surgical intervention for Petitioner. He prescribed pain medication and physical therapy. Petitioner was to follow up in two months. There is no evidence that Petitioner completed the prescribed physical therapy, saw the pain management doctor, or followed up with Dr. Kesani.

Petitioner did not return to any of her treating physicians for almost an entire year. In fact, other than to address a few other health concerns not concerning her back, she only returned to her primary care doctor to receive updated FMLA paperwork. *Id.* She returned to Dr. Martin in March 2014 to obtain FMLA documents for her maternity leave. *Id.* She next saw Dr. Martin in May 2014 to obtain FMLA documents for her migraine headaches and rib/back pain. In September 2014 Petitioner returned to Dr. Martin for updated FMLA documents due to her complaints of migraines and fatigue. *Id.* In April 2015, Petitioner returned to Dr. Martin primarily to obtain FMLA paperwork for her migraines and back pain. *Id.* Petitioner returned to Dr. Martin in June 2015 for updated FMLA paperwork for her migraines. *Id.* During this visit, Dr. Martin also prescribed Ibuprofen for Petitioner's migraines. In December 2015 Petitioner again returned to Dr. Martin for FMLA paperwork relating to her chronic migraines. *Id.* In May 2016 Petitioner returned to Dr. Martin for FMLA paperwork relating to her migraines and low back pain. An exam of the lumbosacral spine was normal and there was no evidence of tenderness, deformity, or edema. Petitioner also had normal range of motion and normal strength. *Id.*

TTD, Work Status, and Current Complaints

Petitioner testified that Dr. Martin cleared her to return to work full duty on April 15, 2013. Petitioner testified that although her doctors had previously provided work restrictions, Respondent was unable to accommodate the restrictions and Petitioner remained off work from the date of accident until she had a full duty release from Dr. Martin. Petitioner testified that she did return to her normal job as a bus operator and continued in that position until her recent change in position.

Petitioner testified that she continues to experience low back pain and is unable to sit or stand for prolonged periods of time. Petitioner testified that she has only treated her back pain conservatively and chose to not pursue surgery. The Arbitrator notes there is no surgical recommendation in evidence. Petitioner testified that she continues to take pain medicine as needed, including prescription strength ibuprofen as prescribed by Dr. Martin. The Arbitrator notes that there are no medical records in evidence which support Petitioner's testimony that a doctor has currently prescribed any medication to her for any condition related to this alleged work accident. Petitioner testified that she continues to receive treatment from Dr. Martin for her back and Dr. Martin refills her pain medications. Petitioner testified that she is currently off work through

FMLA due to her ongoing symptoms relating to the alleged work accident. Petitioner testified she takes off once or twice a month under FMLA due to ongoing low back pain.

On cross-examination, Petitioner again testified that her ongoing absences from work under FMLA were related to the alleged work accident. Respondent presented Petitioner with a Certification dated September 23, 2014, to examine. (RX 3). Petitioner identified this as a document completed for one of her FMLA terms. Petitioner testified that Sedgwick is the administrator of CTA's short term disability claims. Petitioner testified that this type of Certification is completed by the treating physician and submitted to Sedgwick. Petitioner testified that her own signature was on the final page of the document. *Id.* Petitioner testified that the doctor's signature on page 5 looks like the signature of her primary care provider, Dr. Allison Martin. *Id.* Petitioner further testified that she did ask Dr. Martin to complete the document for her FMLA. Dr. Martin completed the form and indicated Petitioner suffers from migraine headaches that come and go as well as back and rib pain from a motor vehicle accident that also comes and goes. *Id.* Dr. Martin wrote that the health condition began in 2009 for the back pain and an indecipherable date for the migraine headaches. *Id.* Dr. Martin further indicated that Petitioner could suffer a reoccurrence of pain on any day of the week and is unable to work during these flare-ups. *Id.*

Respondent also gave Petitioner a Certification dated June 16, 2015, to examine. (RX 4). Petitioner testified that her own signature was on the last page of the document. Petitioner also testified that her primary care doctor, Dr. Martin, completed the Certification at Petitioner's request. A review of the document shows that Dr. Martin identified the relevant conditions as recurrent migraine headaches and rib/back pain from a motor vehicle accident. *Id.* Dr. Martin identified the commencement of Petitioner's back pain as 2009. *Id.*

Respondent then gave Petitioner a Certification dated May 18, 2016, to examine. (RX 5). Petitioner testified that Dr. Martin completed the document at Petitioner's request. Once again, Dr. Martin identified the underlying conditions as migraine headaches as well as rib/back pain from a motor vehicle accident. *Id.* Dr. Martin again identified the commencement of Petitioner's back pain as the year 2009. *Id.*

Medical Bills

Petitioner submitted bills that show outstanding balances into evidence. (PX 1). Petitioner submitted two billing statements from Dr. Fiorini showing an outstanding balance of $919.50 for services provided from 3/11/13 through 5/6/13. *Id.* The Arbitrator notes there are no corresponding medical records in evidence to support these billing statements. Petitioner submitted a bill from Holy Cross Hospital showing an outstanding balance of $1,273.00 for services rendered on the alleged date of accident. *Id.* Petitioner also submitted a billing statement from PTSIR showing an outstanding balance of $2,752.00 for services provided from 10/29/12 through 1/2/13. *Id.*

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 and whether Petitioner's current 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 Petitioner bears the burden of proving each element of her claim. An essential element is the issue of whether or not an accident occurred that arose out of and in the course of Petitioner's employment by Respondent. If Petitioner fails to prove any element of her claim, no benefits will be awarded.

The words "arising out of" and in the course of" are used conjunctively, and therefore both elements must be present at the time of the accidental injury in order to justify compensation. *Mazursky v. Indus. Comm'n.*, 364 Ill. 445, 448 (1936). In order for an injury to arise out of the employment, the risk of injury must be a risk particular to the work or a risk to which the employee is exposed to a greater degree than the general public by reason of his employment. See *Orsini v. Indus. Comm'n.*, 117 Ill.2d 39 (1987). An injury "arises out of" petitioner's employment when there is a causal connection between the employment and the injury; the origin or cause of the injury must be some risk connected with, or incidental to, the employment. *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill. 2d 542, 578 N.E. 2d 921, 161 Ill. Dec. 275 (1991). Injuries sustained on an employer's premises, or at a place where the employee might reasonably have been performing his duties, and while the employee is at work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill. 2d 52, 57, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989). 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. An injury is not compensable if it resulted from a risk personal to the employee rather than incidental to the employment. *Id.*

"For an injury to arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52 at 58, 133 Ill.Dec. 454 (1989). There are three types of risks which an employee might be exposed to, namely: 1) risks distinctly associated with the employment; 2) risks which are personal to the employee; 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, 247 Ill.Dec. 22, (2000).

The evidence presented a few varying stories regarding Petitioner's mechanism of injury on the date of the alleged accident. Petitioner testified that she was driving along her route and drove the right front tire of the bus into a large pothole that was so deep that the bus itself scraped the road. Petitioner testified that the bus was filled with passengers and none of the passengers reported any injury. Petitioner testified that she felt a "vibration" in her back immediately after the bus hit the pothole but continued to the end of her route. Petitioner testified that it was not until she stood up and turned to exit the driver's seat at the end of her route that she felt a pop in her back and felt instant pain. In some medical records, Petitioner indicates she felt pain while driving after hitting a pothole, in others she claims she felt the pain when she stood up at the end of the route.

Respondent presented two documents completed by Petitioner on the date of accident. (RX 1, RX2). In both documents, Petitioner essentially writes that she hit a large pothole while driving on her route. However, contrary to her testimony during the hearing, Petitioner does not indicate she felt anything immediately after hitting the pothole. Instead, Petitioner states that when she arrived at Midway Airport and turned to exit the driver's seat she felt a pop in her back followed by stabbing pain. There is absolutely no mention of Petitioner feeling anything out of the ordinary, such as even a vibration, when she hit the pothole. The Arbitrator also notes that Petitioner completed the documents and made all indications that her actual injury occurred at Midway Airport when she stood up to exit the driver's seat rather than when she hit the pothole. She identifies the location of the alleged accident as Midway terminal. (RX 2). Although she testified that the bus was full of passengers, on the documents completed on the date of the accident she indicates no passengers were on the bus when the alleged accident occurred. *Id.* On the diagram of the bus where Petitioner was directed to place an "x" on the exact point on the bus where the incident occurred, she indicated only her driver's seat. *Id.* Petitioner notably did not indicate the front wheel of the bus on the passenger side—where the bus allegedly encountered the pothole.

Petitioner testified that she is required to call into Respondent's control center whenever an incident of any type occurs. Petitioner did not call in when she hit the pothole. Petitioner also testified that she is required to inspect the bus for damage after an incident occurs. Petitioner despite her testimony that there was a hole in the road and the bus frame actually scraped against the road, she did not stop the bus and perform an inspection to see whether or not there was any damage to the bus. These facts indicate to the Arbitrator that the pothole encounter was less severe than Petitioner indicated and discredits her testimony that she felt a vibration or pain in her back after hitting the pothole.

After reviewing all the evidence, the Arbitrator finds that the Petitioner has failed to meet her burden of proving by a preponderance of the evidence that a compensable accident occurred. From Petitioner's own contemporaneous reports, her back was injured simply when she stood up and attempted to exit the driver's seat at the end of her route. That is when she felt a pop in her back and felt immediate stabbing pain. There is no credible evidence that the encounter with the pothole caused the injury Petitioner suffered when she stood to exit the bus. The Arbitrator notes that none of Petitioner's treating physicians have provided a causation opinion specifically linking the pothole encounter, that occurred at least 20 minutes prior to the acute back pain Petitioner felt during her attempt to stand up and exit the driver's seat, as a cause of the pop and acute back pain that Petitioner experienced when she stood up to exit the bus and take her break.

Once presented with the actual alleged accident—attempting to stand and exit the driver's seat—it becomes clear that no accident occurred that arose out of and in the course of Petitioner's employment. Petitioner has presented no evidence that her attempt to exit the driver's seat is a risk distinctly associated with her employment. There is no evidence that turning to exit a driver's seat is something so distinctly associated with her employment as a bus driver so as to make her injury arise out of her employment. People drive every day and must exit the driver's seat of all types of vehicles. Petitioner has presented no evidence that the manner in which she must exit the driver's seat on the bus varies so greatly from the usual manner in which people exit driver's seats in their vehicles that any injury associated with exiting the seat would arise to a compensable risk. Petitioner provided absolutely no information regarding the characteristics of the driver's seat in the bus, unique or otherwise. Driving and exiting driver's seat is a common experience, and absent any evidence to the contrary, the Arbitrator must consider the risk presented to Petitioner when she exits the driver's seat to be a neutral risk. Petitioner has presented no evidence that there was a defect that contributed in some way to her alleged work accident. Instead, the contemporaneous evidence reveals Petitioner felt a pop in her back as she turned to exit the driver's seat.

The Arbitrator notes that even if the Arbitrator were to find that a compensable accident occurred on the date of accident, there is no evidence other than Petitioner's testimony that supports a finding that her current condition of ill-being is connected to the alleged work accident. Petitioner had a history of ongoing and intermittent low back pain prior to the alleged work accident that required Petitioner to regularly miss work. There are no medical records supporting Petitioner's testimony that Dr. Martin continues to provide prescriptions and treatment relating to this alleged work accident. Instead, a review of the medical records reveals that the only current prescriptions prescribed by Dr. Martin relate to Petitioner's chronic and frequent migraine headaches. (PX 6 at 34-35). There is no evidence that the ongoing Ibuprofen prescription relates in any way to this alleged work accident. Likewise, Dr. Martin has continued to complete FMLA documents that related Petitioner's ongoing back pain solely to the 2009 motor vehicle accident.

The Petitioner has failed to prove a compensable accident or that her current condition of ill-being is causally related to a compensable accident therefore benefits pursuant to Section 8 of the Act are denied.

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

November 22, 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

Jerome P. Vyborny,

Petitioner,

vs.

NO. 13WC 12244

Kroger Limited Partnership I,

17IWCC0358

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 5, 2015 is hereby affirmed and adopted.

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: JUN 14 2017
SJM/sj
o-5/25/2017
44

Stephen J. Mathis

David L. Gore

Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VYBORNY, JEROME P
Employee/Petitioner

Case# **13WC012244**

11WC026755

KROGER LIMITED PARTNERSHIP I
Employer/Respondent

17IWCC0358

On 10/5/2015, 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 0.10% 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:

0529 GREG TUITE & ASSOC
119 N CHURCH ST
PO BOX 59
ROCKFORD, IL 61101

0210 GANAN & SHAPIRO PC
BENJAMIN SCHROEDER
210 W ILLINOIS ST
CHICAGO, IL 60654

17IWCC0358

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

Jerome P. Vyborny
Employee/Petitioner

v.

Kroger Limited Partnership I
Employer/Respondent

Case # 13 WC 12244

Consolidated cases: 11 WC 26775

An *Application for Adjustment 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 **Rockford and Woodstock**, on **July 15, 2015 and August 6, 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 **November 11, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$17,160.00**; the average weekly wage was **$330.00**.

On the date of accident, Petitioner was **61** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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

BECAUSE PETITIONER HAS FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT ON NOVEMBER 11, 2010, THE CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

October 5, 2015
Date

ICArbDec p. 2

OCT 5 - 2015

Statement of Facts

This matter was heard in conjunction with consolidated case 11 WC 26755 for an accident date of September 30, 2010. That matter is addressed in a separate decision.

Petitioner Jerome Viborny testified that on November 11, 2010 he was employed by Respondent Kroger as a meat clerk. He had been working for Respondent for approximately a year and a half. Previously, he had worked in construction as a general contractor. The physical demands of that construction job included heavy lifting. He owned J. P. Viborny Construction. Petitioner testified the last construction work he did was in 2006. Between 2006 and 2009, he was supported by his wife and sister. His wife is a realtor, property manager. Petitioner denied doing carpentry work in December, 2010.

As a meat clerk for Respondent, he did a lot of stocking items that came off pallets. He put away boxes. He testified that the boxes weighed from 40 to 80 pounds. He also did grinding of hamburger, packaging and some cutting of meat. Petitioner testified that Petitioner's Exhibit 3 was an accurate job description. Petitioner testified that he worked between 40 and 55 hours per week. He was hourly and paid minimum wage. He testified he very seldom worked less than 36 hours.

Petitioner testified he had a prior injury to his left leg in 1969 when he had a surgery for a cartilage removed. He testified he had no other medical treatment for his left knee from 1969 until September 30, 2010. On September 30, 2010, he was pulling a stocking cart and his left foot got caught underneath and it threw him down and wrenched his left knee. That accident is the subject of the consolidated case 11 WC 26755 heard in conjunction with this matter.

Petitioner testified that after the September 30, 2010 injury, as he continued to work, he noticed a blister on his right second toe. When he was putting product out into the cases, he notice irritation and saw that it was a blister at the end of the day. He testified he was wearing steel toe work boots. He bought them at Red Wing. They were fairly new. He testified that he always wore them at work. The shoes were not provided, paid for or reimbursed by Respondent. Petitioner testified that he was not given a dress code for shoes other than to wear something appropriate. Petitioner testified that he did not have any prior issues with his right second toe, and that the onset of his right second toe issues began on November 11, 2010 or a couple of days before.

After the blister developed, his job duties changed to include cleaning the meat department. Petitioner testified his feet became saturated with the water and chemicals used and because his shoes were not waterproof. He bought rubber boots. Petitioner testified he told the store manager assistant Chris that when he was doing the cleaning the second or third time that his toe would burst in his boot and he could not keep doing it.

Mr. David Thomas testified that at the time of the alleged work accident, he was the Retail Operations Manager for the Central Division of Kroger. The safety manager for the central division of Kroger would have reported directly to him. Mr. Thomas' current position is safety manager and special assignments. His duties as safety manager include implementing and running Respondent's safety program. Mr. Thomas testified to his knowledge of the alleged accident site. Mr. Thomas testified he visited the stores in the Rockford area 3-4 times each in 2010.

Mr. Thomas testified to the cleaning process of the meat department. The meat saw would need to be sanitized with scalding hot water and soap. The same temperature of water and soap would also be utilized for

cleaning the meat tenderizer and hopper grinder. Mr. Thomas testified that employees performing this job would need to wear a rubber apron, rubber boots and yellow latex gloves. Some would wear goggles. Due to the temperature of the water, the hose was insulated. Mr. Thomas testified that the protective clothing was provided by Respondent. He has never seen someone clean the meat department without utilizing this gear. He did not remember ever seeing Petitioner. He has never been in a store that did not have the provided gear. Petitioner testified that the rubber boots provided were too small for his size 14 feet because they were for the employee who regularly did the cleaning job. He testified that there was no rubber apron. The water used was hot, not scalding.

Mr. Thomas testified that he had never seen anyone wear steel-toed boots in any department for Respondent. On rebuttal, Petitioner testified that he was wearing a low cut below the ankle steel-toed shoe.
Mr. Thomas testified regarding a dress code that either businesslike or an athletic shoe could be worn by employees (RX 1). Mr. Thomas noted that this was important due to the concrete floors. The dress code, along with safety training, would have been provided to Petitioner and all employees during the hiring process, as employees were provided a packet of information.

Mr. Thomas testified that he did not receive notice from the store manager of a work accident taking place on November 11, 2010. After taking over the safety manager role in 2013, he received a report with open claims and recognized the last name of Petitioner.

Petitioner testified he went on his own to Physicians Immediate Care for his toe on November 13, 2010. Petitioner testified he does not remember advising Physicians Immediate Care that the right second toe issue was not work-related.

The records reflect Petitioner was seen at Physicians Immediate Care on November 11, 2010 with complaints of redness, swelling and oozing in his right foot. The record states the date of onset was July 10, 2010. The cause lists an injury from wearing steel toe boots. The injury is not listed as work related (PX 5). Petitioner testified that the record stating the onset of his toe issue was July 10 is a mistake. He does not remember telling them that the condition was not work related. Petitioner admitted he made direct payment for the visits to Physicians Immediate Care for his right toe. Petitioner was prescribed Doxycycline and Bactrim. He continued treatment through December 6, 2010. On November 15, 2010, Petitioner noted working long hours on his feet caused swelling. He complained of swelling and oozing of the second toe. X-rays note degenerative joint disease of the great toe. On November 27, 2010, Petitioner also complained of swelling in the left leg (PX 5).

Petitioner testified he continued to work. He was noticing a lot of pain in both his toe and his knee. On December 6, 2010, Physicians Immediate Care recommended he go to the emergency room. He went to OSF St. Anthony. He was told to see his family doctor. Petitioner testified he saw Dr. Disanti on December 9, 2010. Dr. Disanti admitted him to OSF Hospital. He brought in Dr. Pyun. Dr. Pyun performed surgery to remove the second toe on December 13, 2010.

Petitioner testified that, when they came to show him how to be more mobile, he was in extreme pain in his left knee. Petitioner had x-rays taken of the left knee on December 10, 2010 which showed no soft tissue swelling and an impression of degenerative osteoarthritis. An MRI on December 16, 2010 showed a large left knee joint effusion along with a complete ACL and probable PCL tears (PX 6). He saw Dr. Carlson for a consultation on December 17, 2010 for left knee pain and swelling. The history was of the fall with injury two months ago.

Transferring all his weight to the left leg worsened his symptoms. Dr. Carlson noted the infection must be addressed before treatment to the knee (PX 9). Petitioner testified that he followed up with Dr. Disanti and Dr. Pyun for his toe. He was released by Dr. Pyun to regular work for his toe on February 7, 2011 (PX 7).

Petitioner returned to Dr. Carlson for his left knee on January 13, 2011. Dr. Carlson's history included the work injury which he dates as October 19, 2010 and notes that when Petitioner put more pressure on his left side because of the infected right toe, it began to hurt worse. Dr. Carlson recommended arthroscopic surgery to repair the ACL. Petitioner testified he was told that he was unable to work. The record states Petitioner can resume everyday activities immediately with a knee immobilizer. The January 24, 2011 Work Release form takes Petitioner completely off work for his left knee condition (PX 6).

Petitioner underwent further treatment for his knees including arthroscopy of the right knee on September 21, 2012 by Dr. Carlson and a left knee replacement by Dr. Glasgow on November 20, 2012. The left knee treatment is more fully described in the decision in case 11 WC 26755. Petitioner was released to return to full duty following the left knee replacement by Dr. Glasgow on June 24, 2013.

Petitioner was evaluated by Dr. Coe at his attorney's request. Dr. Coe testified by evidence deposition on November 25, 2014. Dr. Coe testified that based upon the statements of the Petitioner, that there is a causal connection between his accident on November 11, 2010 and the amputation of the second toe.

Petitioner testified that he is not as mobile as he was. He is not as secure. He notices a callus on his right big toe because it turns in where the second toe was amputated. He works 10-12 hour days and by the end of the day his knee is tired and his feet are sore.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of the claimant's employment. To sustain his burden of proof of an accident arising out of and in the course of his employment, Petitioner must prove an accident that is traceable to a definite time, place and cause. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury.

Petitioner is seeking compensation based upon the development of a blister on his second toe of the right foot, which became infected and needed treatment beginning in November, 2010 ultimately resulting in the amputation of the second toe. The Arbitrator notes discrepancies between Petitioner's testimony and the medical records as to the onset and development of the condition. Petitioner testified that the blister began after his September, 2010 knee injury, but the records consistently record his history of onset as in July, 2010. The uncontested testimony of the Petitioner and Mr. Thomas is that Petitioner's choice of footwear was not provided, required or recommended by Respondent. The Arbitrator also notes Petitioner's consistent description of his footwear as "boots" and then on rebuttal modifying the description to low cut. The Petitioner testified that the blister developed before his job duties were changed to included cleaning the meat department, and his testimony, concerning his feet getting wet while cleaning the meat department, is absent

from any of the medical records. The records reflect an accident report was prepared for the earlier injury as soon as medical treatment was initiated, but none was prepared for the toe condition. The claim for the toe was submitted to the union health insurance on February 1, 2011. That extensive description does not mention that Petitioner's feet were ever wet. But rather states that walking on it did not allow the blister to heal. After observing the Petitioner's testimony and evaluating his credibility in conjunction with the testimony of Mr. Thomas, the medical records and opinions, the Arbitrator finds that Petitioner's testimony as to the events of the accident unpersuasive.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that he sustained accidental injuries arising out of and in the course of his employment on November 11, 2010.

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

Based upon the Arbitrator's finding with respect to Accident, the issue of Causal Connection is moot. However, because the histories provided to Dr. Carlson on December 17, 2010 and January 13, 2011 include statements that Petitioner's left knee symptoms worsened after his amputation surgery when he placed more of his weight on the left side, the Arbitrator also addresses the causal connection of the left knee symptoms to the alleged November 11, 2010 accident.

The medical opinions with respect to the causation of the left knee condition are more fully outlined and addressed in the decision in case 11 WC 27655 heard in conjunction with this matter. Neither the opinions of Dr. Weiss, Dr. Bare, Dr. Glasgow, and Dr. Coe nor the records of Dr. Carlson support the proposition that the condition of ill being in the left knee was caused or aggravated by the alleged November 11, 2010 injury. The Arbitrator therefore additionally finds that any condition of ill being of the left knee was not causally connected to any alleged accidental injuries on November 11, 2010.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, (K) Temporary Compensation, and (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's finding with respect to Accident above, the issues of Notice, Medical, Temporary Compensation, and Nature and Extent are moot.

Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARK P. REED,

Petitioner,

vs. NO: 05 WC 1756

T.H. RYAN CARTAGE COMPANY, LTD.,
DRIVERS SERVICE, INC., and
LIBERTY MUTUAL INSURANCE CO.,

Respondent,

ORDER

This matter comes before the Commission on Petitioner's Petition for Relief Pursuant to Section 4(c) and Respondent's Motion to Quash Subpoena. For the purposes of the case at bar, §4(c) of the Act provides if the Commission finds that an insurer or other applicable entities:

> practice a policy of delay or unfairness toward employees in the adjustment, settlement, or payment of benefits due such employees, the Commission may after reasonable notice and hearing order and direct that such [insurer or other applicable entities]... discontinue the writing of any such workers' compensation insurance in this State. *820 ILCS 305/4(c)* (West 2013).

As background, a previous §19(b) hearing was held and the decision, which included Respondent receiving §8(j) credit of $103,995.00, was ultimately affirmed by the Appellate Court on December 18, 2015. That decision was not appealed and became final. Subsequently, Petitioner filed a §19(g) action in the circuit court claiming Respondent had not paid the award. Apparently, at issue was Petitioner's claim that Respondent owed and was required to pay the full amount of the §8(j) credit. A copy of the circuit court's order has not been submitted to the Commission by the parties, but according to the parties' briefs, the circuit court entered a monetary judgment on November 4, 2016, for the §8(j) credit.

According to Respondent's brief, it filed an appeal on November 29, 2016. On December 5, 2016, the Appellate Court issued an order approving Respondent's appeal bond and staying enforcement of the judgment. (Respondent's Brief, Ex. A; 3/7/17 Tr., Rx1).

That same day, on December 5, 2016, Petitioner filed a Notice of Motion and Order at the

Commission requesting a hearing under §19(b), penalties under §19(k) and §19(l), attorney's fees under §16, and a §4(c) petition. However, the only attachment to the Notice of Motion is titled "Petitioner's Petition for Relief Pursuant to Section 4(c)." Petitioner argues, in part:

> 8. That the Respondents have repeatedly and without justification or notice stopped paying benefits under the existing policy of workers' compensation insurance despite liability having been clearly established, have failed to honor and meet their obligations as to the appeal bond filed in the Circuit Court, and have now flouted the Order of the 19(b) Enforcement Judgment. (Petitioner's §4(c) Petition at #8).

It appears Petitioner abandoned his request for hearing and claims under §§19(b), 19(k), 19(l), and 16. Whether Petitioner, in fact, abandoned these claims as it relates to §§19(k), 19(l), and 16 is immaterial as such claims are barred by Petitioner's previous filing of a 19(g) petition in the circuit court. *See Preston v. Industrial Commission of Illinois*, 332 Ill. App. 3d 78 (2002). ("Moreover, by instituting a section 19(g) proceeding, claimant was precluded from pursuing additional compensation and attorney fees under section 19(k) and 16.") As for the claim under §19(b), jurisdiction rests with the arbitrator not the Commission.

At the review call on December 9, 2016, no record was made but the parties were asked to submit briefs on the issue of whether the Commission has jurisdiction to hear the §4(c) petition while Respondent's appeal is pending in the Appellate Court. Petitioner's attorney was also "instructed at the initial hearing that the subject subpoena, service of which was refused by Respondents at the initial hearing, be served on their registered agent in Springfield, Illinois." (Petitioner's Brief at 4).

On December 13, 2016, a subpoena was served on Liberty Mutual Insurance Company, with a return date of January 12, 2017. It demanded all IWCC awards involving Liberty Mutual, and which contained a §8(j) credit, between January 1, 2011 and November 30, 2016. (Respondent's Motion to Quash at Ex. A).

Petitioner filed his brief on December 19, 2016 and Respondent filed its brief on December 28, 2016.

On January 13, 2017, Respondent filed a Motion to Quash Subpoena. Respondent argues, among other defects in the subpoena, the return date of January 12, 2017, is not the same as the "time and place set for hearing of the cause," which would have been the next review call date on January 20, 2017. Rule 7030.50 states "unless otherwise agreed by the parties, witnesses or documents may only be subpoenaed to appear or be produced at the time and place set for hearing of the cause." Respondent also argues the subpoena is improper because "[t]here has been no ruling that Petitioner is allowed to proceed on his 4(c) petition..." (Respondent's Motion to Quash at 2).

On January 18, 2017, Petitioner filed his response to Respondent's motion to quash. On March 7, 2017, a hearing was held before Commissioner DeVriendt on the issues of jurisdiction and the motion to quash, and a record was made.

Jurisdiction

Petitioner cites *Burzic v IWCC*, 391 Ill. App. 3d 202 (2009), in which it was found that a §4(c) petition is a collateral matter, and the Commission retains jurisdiction even if the underlying case is settled/concluded:

> We believe, therefore, that the Commission had jurisdiction pursuant to section 4(c) of the Act to resolve the issue on June 22, 2007, notwithstanding the fact that it had approved the settlement contract between the claimant and Dedicated more than 20 days earlier. *Id.* at

208.

The Court went on to note, the claimant reached a settlement agreement with Respondent (Dedicated) and only proceeded on a previously filed §4(c) petition against the carrier, Zenith Insurance Co. and its representative Medenhall. The Court held the settlement agreement did not divest jurisdiction from the Commission to rule on a §4(c) petition against two separate entities not part of the settlement agreement, as such a collateral matter. *Id.*

Burzic is distinguishable as such facts do not apply to the present matter. Petitioner filed his §4(c) petition against Respondent and its insurer, Liberty Mutual Insurance Co. Petitioner continues to pursue his §19(g) petition against Respondent which presently pends in the Appellate Court. Petitioner's §4(c) petition is not a collateral matter.

The *Burzic* court also examined the question of whether a single act of unfairness is sufficient to subject an insurer to discipline under §4(c) finding:

> A policy can be defined as a course or method of action selected from alternatives and in light of given conditions used to determine present and future decisions. See Webster's Third New International Dictionary 1754 (1981). Although a single course of action may be in furtherance of an adopted policy, a single course of action in an individual case does not a policy make.
>
> We believe that, in order to justify disciplinary action under either *section 4(c)* of the Act or section 7090.20 of the Commission's Rules, the offending activity must be in furtherance of an adopted method of action used to determine present and future decisions or behavior. An isolated delay or unfair action in the settlement or payment of benefits will not satisfy either the statute or the rule unless it is in furtherance of an adopted policy. Our conclusion in this regard leads us to find that the Commission properly construed its own rule. (Emphasis added). *Id.* at 210.

Petitioner claims *Burzic* only alleged one act of unreasonable or vexatious delay in payment "but that is not applicable to the multiple acts Petitioner here will prove at the time of the trial in this matter and after obtaining the materials that he has requested from the Respondents via subpoena." (Emphasis added. Petitioner's Brief at #9).

Respondent argues the only portion of the §19(b) award that remains at issue is the §8(j) credit, which is on appeal. Respondent does not cite any case law or precedent but claims "[t]he Commission has been divested of jurisdiction to entertain Petitioner Attorney's 4(c) petition in this matter by virtue of the stay entered by the First District Appellate Court on December 5, 2016." (Respondent's Brief at #18). Respondent argues Petitioner "provides no legal basis for the Commission to entertain a section 4(c) petition when a stay of the enforcement...has been entered by the Appellate Court." (*Id.* at #12). Respondent distinguishes *Burzic* as it involved a case that was final while, in contrast, the issue involved in the claim at bar is still on appeal.

Petitioner makes several claims regarding Respondent's alleged actions such as they "attempted to delay the proceedings and payment of compensation by raising false and irrelevant issues" (Petitioner's Brief at #13), and "unfairly filed an appeal bond" (*Id.* at #14). However, the primary bases for Petitioner's §4(c) petition seem to be: 1) Respondent's failure to pay the §19(g) judgment ordered by the circuit court; and 2) Respondent's frivolous appeals. Petitioner claims:

> One of the acts of unfairness that the Petitioner alleges, however, is the Respondent's various appeals, including their most recent appeal, in and of itself is the basis of at least part of the 4(c) Petition as Petition has alleged the appeal is frivolous and not brought in good

faith. (Emphasis added. *Id.* at Para. #12).

The Commission finds the case of *Krantz v The Industrial Commission*, 289 Ill. App. 3d 447 (1997), to be instructive on the issue of whether Petitioner's claim of frivolous appeals is a sufficient basis for a §4(c) petition. Certainly *Krantz* involved petitions pursuant to §19(k) and §16, but the same principle applies to §4(c) petitions. The court found:

> [We] cannot find that the Commission's power extends to consideration of pleadings and matters which take place in the circuit court. In this regard, we note that Krantz's petition for additional compensation and attorney fees cited to the circuit court's affirmance of the PPD award and attached the briefs that were filed in the circuit court. In order to determine whether Sahara Coal's appeal to the circuit court was meritless and taken only for purposes of delay, the Commission would have to look to the circuit court's final judgment and the underlying merits of the appeal. This would amount to a review of judicial proceedings, clearly beyond the Commission's statutory powers. (Emphasis added). *Id.* at 450.

The court continued:

> Our holding that sections 16 and 19(k) do not allow the Commission to award penalties for the taking of a meritless appeal in the circuit court does not leave claimants without a remedy. *Supreme Court Rule 137* allows the circuit court to impose sanctions against a party or counsel who files a pleading or motion which is not well grounded in fact, is not warranted by existing law or a good-faith argument for the extension, modification, or reversal of existing law, or is interposed for any improper purpose. [citation]. The purpose of *Supreme Court Rule 137* is to punish litigants who plead frivolous or false matters or bring suit without any basis in law. [citation]. *Id.* at 451.

In other words, the Commission does not have the power to determine whether an appeal to the circuit court is "frivolous." Rather, the proper remedy for a claimant is *S.C. Rule 137* in the circuit court.

Siddens v. The Industrial Commission, 304 Ill. App. 3d 506 (1999), clarified that the holding in *Krantz* also applied to appeals to the appellate court:

> We now turn to Moorhead's contention that the Commission lacked the statutory power to consider Siddens' August 1992 petition for section 19(k) penalties and section 16 attorney fees. Moorhead compares the instant case with *Krantz*, 289 Ill. App. 3d 447, 681 N.E.2d 1100, 224 Ill. Dec. 479, and contends that *Krantz* is controlling authority. In *Krantz*, the claimant was awarded workers' compensation benefits for injuries he suffered while working for the respondent. The respondent eventually appealed to the circuit court of Saline County, which confirmed the claimant's award. Neither party appealed the circuit court's decision. Approximately one month later, the claimant filed a petition with the [*512] Commission seeking section 16 attorney fees and penalties under sections 19(k) and 19(l) of the Act (*820 ILCS 305/16, 19(k), 19(l)* (West 1994)). *Krantz, 289 Ill. App. 3d at 448, 681 N.E.2d at 1101.* The claimant in his petition alleged *only* "that [the respondent's] appeal to the circuit court did not present a real controversy but was merely frivolous and made for the purpose of delay." *Krantz*, 289 Ill. App. 3d at 448, 681 N.E.2d at 1101. The Commission ruled that the claimant was not entitled to section 16 attorney fees or to section 19(k) penalties. *Krantz, 289 Ill. App. 3d at 449, 681 N.E.2d at 1102.* The circuit court agreed with the Commission, and the claimant appealed to this court. We affirmed, holding that, where a circuit court

> enters a final judgment, the Commission lacks the statutory power to review the merits of the appeal in the underlying case to determine if that appeal was frivolous or made for the purpose of delay. We could not find "that the Commission's power extends to consideration of pleadings and matters that take place in the circuit court." *Krantz, 289 Ill. App. 3d at 450, 681 N.E.2d at 1103.*
>
> In the instant case, the appellate court rendered a final judgment with its July 1992 Order, affirming Siddens' compensation award. Neither party appealed. Approximately one month later, Siddens filed his August 1992 petition with the Commission, seeking section 19(k) penalties and section 16 attorney fees. Siddens alleged that Moorhead's "appeal[s] to the circuit court and [to] the Industrial Commission of the Appellate Court did not present a real controversy but [were] merely frivolous within the meaning of §19(k)." Siddens did not provide any other basis on which to support his claim for penalties and attorney fees. These facts are strikingly similar to the facts in *Krantz*. The only difference between this case and *Krantz* is that, here, the underlying appeal went to the appellate court, whereas in *Krantz* the underlying appeal stopped at the circuit court. We find this difference immaterial, however, since the roles of circuit and appellate courts in workers' compensation cases are the same--appellate only. *Gunnels v. Industrial Comm'n, 30 Ill. 2d 181, 185, 195 N.E.2d 609, 611 (1964); 820 ILCS 305/19(f)* (West 1992).
>
> We therefore find the rule of law from *Krantz* applicable. Accordingly, we hold that the Commission lacked the statutory power to determine whether Moorhead's appeals in the underlying litigation were frivolous. See *Krantz, 289 Ill. App. 3d at 450, 681 N.E.2d at 1103.* (Emphasis added). *Id.* at 512.

Both *Krantz* and *Siddens* dealt with appeals that were final and found the Commission did not have jurisdiction to determine whether those appeals were frivolous. As such, they do not directly speak to the Commission's jurisdiction while an appeal is still pending. However, the concluding remarks in *Krantz* do seem instructive:

> As we have determined that sections 16 and 19(k) of the Act do not regulate the procedure for seeking penalties for the taking of a frivolous appeal in the circuit court in order to delay payment of an award, the Act does not apply and *Rule 137* governs. *Krantz* at 452.

To reiterate, the above cases arose out of petitions pursuant to §19(k) and §16, but the principle that the Commission does not have the jurisdiction to determine whether an appeal is frivolous seems equally applicable to §4(c) petitions. Based on the above, we find the Commission does not have jurisdiction to hear a §4(c) petition which is based on a claim of frivolous appeals.

As for Petitioner's claim that Respondent has not paid the §8(j) credit as ordered by the circuit court, this also would not be a proper issue for the Commission to consider in a §4(c) petition at this point because that is the subject of the pending appeal. The Appellate Court issued a stay of the circuit court's §19(g) judgment. For us to determine whether Respondent's failure to pay the §19(g) judgment constituted a "policy or delay or unfairness" under §4(c) would be substituting our judgment for that of the Appellate Court on the ultimate issue in this case; namely, whether Respondent was required to pay the full amount of the §8(j) credit. This would not be proper.

Although Petitioner may have other examples of Respondent's behavior, on which to base a §4(c) petition in the future, the current petition asks the Commission to improperly determine whether Respondent has engaged in frivolous appeals. We do not have jurisdiction to make that determination. Petitioner also asks us to decide as a "collateral matter," whether Respondent's

failure to pay the full amount of the §8(j) credit constitutes "a policy of delay or unfairness." This is not a collateral matter and is dependent on the very question to be resolved by the Appellate Court in the underlying litigation. We find, at the very least, Petitioner's §4(c) petition is premature, and it is hereby dismissed without prejudice.

Motion to Quash Subpoena

Based on the above, we find Petitioner's subpoena is premature. Petitioner is seeking documents from Respondent related to other cases involving §8(j) credit over a five-year period. Whether those documents may be relevant to a future §4(c) petition is dependent on the resolution of this case in the Appellate Court. As such, the Commission grants Respondent's Motion to Quash Subpoena.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Relief Pursuant to Section 4(c) is hereby dismissed without prejudice.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to Quash Subpoena is hereby granted.

The party commencing 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: JUN 16 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
R: 3/7/17
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

Gwendolyn Myers,

Petitioner,

vs. NO: 05 WC 23677

17IWCC0369

State of Illinois Department of Human 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 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 June 9, 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.

DATED: JUN 19 2017
TJT:yl
o 6/6/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MYERS, GWENDOLYN
Employee/Petitioner

Case# **05WC023677**

SOI DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0369

On 6/9/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSUHA RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

5120 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH F
CHICAGO, IL 60601

1745 CMS - RISK MANAGEMENT
801 S SEVENTH ST 8M
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 9 = 2015

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

17IWCC0369

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

Gwendolyn Myers,
Employee/Petitioner
v.

Case # **05** WC **23677**

State of Illinois, Dept. of Human Services,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **November 25, 2014, March 18, 2015 and May 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 **January 13, 2004**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,688**; the average weekly wage was **$917.08**.

On the date of accident, Petitioner was **55** 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

DUE TO THE ARBITRATOR'S FINDINGS ON ACCIDENT AND CAUSATION, ALL OTHER ISSUES ARE RENDERED MOOT. THEREFORE, COMPENSATION IS HEREBY DENIED.

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

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

David A. Kane
Signature of Arbitrator

June 9, 2015
Date

JUN 9 - 2015

17IWCC0369

FINDINGS OF FACT

This case involves a Petitioner claiming a traumatic injury to her lower back and right hip from her employment with the Respondent, the Department of Human Services, with an alleged accident date of January 13, 2004. [Arb. Ex. 1.] The issues in dispute are: did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; is Petitioner's current condition of ill-being causally related to the injury; and what is the nature and extent of the Petitioner's injury. [Id.]

On January 13, 2004, the alleged accident date, the Petitioner was working as a Human Services Caseworker for the Illinois Department of Public Aid, a part of the Illinois Department of Human Services. The Petitioner worked at a facility located at 8001 S. Cottage Grove, Chicago, Illinois.

The Petitioner testified that at around 7:45 a.m. she was descending the back steps heading to the front desk to service clients when she slipped on some water. She testified that she hit a wooden railing and fell to the ground. Her buttocks hit a step. The Petitioner testified she injured her lower back and right hip. The Petitioner approximated that there were about 15 steps total and that she sustained her fall somewhere in the middle of the steps.

In her notice of injury dated January 13, 2004, the Petitioner stated, "I was going down the back stairs to report to the service desk. There was a puddle of water on the back stairs and the floor was covered with water which made me twist my ankle." [RX 2.] In the describe injury section of her notice of injury form, the Petitioner only listed her right ankle. When the Petitioner was shown her notice of injury form, she acknowledged that she did not list a lower back or right hip injury

in her form. She stated that she did not list her lower back and right hip because she did not have symptoms in those body parts when she filled out her notice of injury form. She acknowledged that she made no mention of hitting a wooden railing as she testified to. The Petitioner acknowledged that these pieces of information were important and that she should have included them in her notice of injury form.

The Petitioner testified she first received medical treatment for her January 13, 2004 accident on June 1, 2004, nearly five months after the accident date.

On June 1, 2004, the Petitioner presented at an Advocate Health Center and was seen by Dr. Patricia Burke. [PX 2.] Dr. Burke stated in her notes that the Petitioner fell down steps and twisted her ankle and struck her hip against a poll. [Id.] The Petitioner now complained of pain in her lower back. [Id.] Dr. Burke noted the Petitioner had increased bladder pressure and discomfort and back twisting. [Id.] Dr. Burke noted the Petitioner had a family history of kidney stones from her mother. [Id.] Dr. Burke's impression was hematuria, or blood in the Petitioner's urine, right lower back pain which could have been muscular in nature, and possible urinary issues consisting of a urinary tract infection or a kidney stone. [Id.] Dr. Burke prescribed the Petitioner Flexeril and an X-ray of her abdomen. [Id.]

On June 15, 2004, the Petitioner was scheduled for another visit with Dr. Burke but the Petitioner did not show up for her appointment. [PX 2.]

On July 19, 2004, the Petitioner presented to Dr. Thelma Evans for the first time, her primary care doctor. [PX 2.] Dr. Evans assessed the Petitioner with right lumbosacral spine muscle spasm and right hip sprain due to a fall at work on January 13, 2004. [Id.] Dr. Evans prescribed the Petitioner Vioxx, Flexeril, and

Tylenol 3. [Id.] The Petitioner was given a work restriction of limited stair climbing and walking for 4 weeks. [Id.]

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On September 8, 2004, the Petitioner next presented to Dr. Evans. [PX 2.] The Petitioner was assessed with right lumbosacral sprain and right hip sprain due to fall on January 13, 2004 and chronic anemia due to menorrhagia. [Id.] Dr. Evans continued to have the Petitioner take Vioxx, Flexeril, and Tylenol 3 as needed, and continued work restrictions of limited stair climbing and walking for 4 more weeks. [Id.]

On February 28, 2006, the Petitioner presented to Dr. Evans. [PX 2.] She complained that her back was still painful. [Id.] Dr. Evans noted mild tenderness of the lumbosacral spine, of the right sacroiliac area and the lateral right hip with positive straight leg raising on the right side at approximately 45 degrees. [Id.] Dr. Evans assessed the Petitioner with chronic right hip and low back pain. [Id.] Dr. Evans continued the Petitioner on work restrictions of limited stair climbing and walking for the next three months. [Id.]

On July 14, 2005, the Petitioner presented to Dr. Evans with chronic right hip and low back pain among other issues. [PX 2.] Dr. Evans noted that the Petitioner continues to have pain in her back and her hip along with spasm in her right side if she attempts to do too much stair climbing or walking or lifting. [Id.] Dr. Evans did not set out any work restrictions on this date. [Id.]

The Petitioner confirmed that she received no injections or physical therapy for her injury. She testified that pain in her lower back and right hip have never gone away. She continues to take Flexeril and Tylenol as needed. On cross-

examination, the Petitioner acknowledged that she was taking Flexeril and Tylenol to address other pain symptoms she had even prior to her January 13, 2004 accident.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner sustained an accident due to a fall on January 13, 2004 causing an injury only to her right ankle. The Arbitrator finds that the Petitioner failed to sufficiently establish an accident as to her lower back and right hip injuries in light of the facts that the Petitioner did not report an injury to these body parts in her notice of injury form [*see* RX 2], and the Petitioner did not seek any medical treatment whatsoever for her lower back and right hip until June 1, 2004, nearly five months after the accident date. Surely, had the Petitioner sustained an accident causing injuries to her lower back and right hip, she would have presented sooner to a medical care provider to seek treatment for these parts.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her alleged work accident on January 13, 2004. As to her right ankle injury, a review of the Petitioner's medical records reveals that the Petitioner received no medical treatment whatsoever and the injury resolved itself with time. As to the Petitioner's lower back and right hip injury, the Arbitrator finds that any such injury is not causally related to her January 13, 2004 accident considering the nearly 5 month period where the Petitioner did not seek or receive medical treatment whatsoever for these body parts.

3. With regard to the nature and extent of the Petitioner's injury, the Arbitrator notes that where the Petitioner has not sufficiently established accident and causal

17IWCC0369

connection, this issue is rendered moot. However, if the Petitioner had sufficiently established accident and causal connection (which she did not), the Arbitrator finds that the Petitioner has sustained no permanent disability as to her right ankle, lower back or right hip, where the Petitioner's treatment only consisted of doctor's visits and prescription pain relievers. No award of permanent disability is warranted where no injections or physical therapy sessions were required as part of the Petitioner's treatment and the Petitioner has no permanent disability as a result of her alleged accident.

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

Gwendolyn Myers,

Petitioner,

vs.

NO: 05 WC 28382

State of Illinois Department of Human Services,

17IWCC0370

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 June 9, 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.

DATED: JUN 19 2017
TJT:yl
o 6/6/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MYERS, GWENDOLYN
Employee/Petitioner

Case# **05WC028382**

SOI DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0370

On 6/9/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

5120 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH F
CHICAGO, IL 60601

1745 CMS - RISK MANAGEMENT
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0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUN 9 - 2015

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

17IWCC0370

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

Gwendolyn Myers,
Employee/Petitioner
v.

Case # **05** WC **28382**

State of Illinois, Dept. of Human Services,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **November 25, 2014, March 18, 2015 and May 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. [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. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

17IWCC0370

FINDINGS

On **April 8, 2005**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$49,432**; the average weekly wage was **$950.61**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

Respondent ***has 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.

ORDERS

Due to the Arbitrator's findings on the issues of accident and causation, all other issues are rendered moot.

Therefore, compensation is hereby denied

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

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

David A. Kane
Signature of Arbitrator

June 9, 2015
Date

JUN 9 - 2015

17IWCC0370

FINDINGS OF FACT

This case involves a Petitioner claiming a non-traumatic accident causing high blood pressure and migraine headaches from her employment with the Respondent, the Department of Human Services, with an alleged accident date of April 8, 2005. [Arb. Ex. 2.] The issues in dispute are: did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; is Petitioner's current condition of ill-being causally related to the injury; and what is the nature and extent of the Petitioner's injury. [Id.]

On April 8, 2005, the alleged accident date, the Petitioner was working as a Human Services Caseworker for the Illinois Department of Public Aid, a part of the Illinois Department of Human Services. The Petitioner worked at a facility located at 8001 S. Cottage Grove Ave., Chicago, Illinois.

The Petitioner testified that at around 9 a.m. she was at her desk pulling up some information. At that time, the Petitioner testified that someone named Eugene Davis approached her and verbally attacked her. The Petitioner testified that Davis said, "I'm here to make sure you are doing your job." The Petitioner testified that Davis came within three feet of the Petitioner and pointed his finger at the Petitioner's face. The Petitioner testified that she believed that Eugene Davis was a driver for a State of Illinois employee named Cara Adams. The Petitioner testified that she believed Davis was an administrator. The Petitioner testified that she felt dizzy and started shaking immediately following the incident.

On April 8, 2005, the same day, the Petitioner presented to Dr. Swieliang Tan, a family doctor, at 8501 S. Cottage Grove Ave., Chicago, Illinois. [RX 19.] Dr. Tan

assessed the Petitioner with hypertensive headache and dizziness and prescribed the Petitioner with Zestoretic 20/12.5 one tablet twice a day. [RX 19; PX 2.] On April 10, 2005, the Petitioner presented to the Emergency Room complaining of intermittent or continuous headache that was progressively increasing in severity. [RX 19.] The Petitioner presented to Dr. Tan a final time on April 15, 2005. [RX 19.]

On July 14, 2005, the Petitioner presented to Dr. Thelma Evans complaining of chronic right hip and low back pain. [PX 2.] This appears to be the first instance where Dr. Evans evaluated the Petitioner's blood pressure. [Id.] On that date, the Petitioner's blood pressure was 132/100 and 138/100 on repeat. Dr. Evans noted that the Petitioner weighed 286 pounds and was 5'5" in height. Dr. Evans' noted that the Petitioner had a recent severe elevation of her blood pressure following a stressful episode at work and noted that Dr. Tan had prescribed the Petitioner Zestoretic. [Id.] Dr. Evans assessed the Petitioner with uncontrolled hypertension and instructed the Petitioner to continue taking her hypertension medication. [Id.] This appears to be the final treatment for the Petitioner in regards to her April 8, 2006 accident.

In her notice of injury dated April 11, 2005, the Petitioner described her injury as severe headaches. [RX 5.] The notice of injury also indicates that the Petitioner took 3 hours of vacation time and that she sought medical attention from Dr. Tan and Dr. Evans. [Id.] Attached to her notice of injury form, the Petitioner included a letter dated April 8, 2005, which recounted the incident between the Petitioner and Davis, which the Petitioner testified was accurate and signed by her. [Id.] The April 8 letter implies that Davis engaged in a pattern of malicious verbal

harassment towards the Petitioner but does not describe any previous instances. [Id.]

17IWCC0370

The Petitioner testified that she believed that Davis was disciplined for the incident.

The Petitioner testified that she had not been diagnosed with high blood pressure before April 8, 2005 and was not prescribed blood pressure medication prior to April 8, 2005.

The Petitioner testified that she presently suffers from occasional headaches, some of which are migraines following her April 8, 2006 accident. She testified that she takes prescription strength Tylenol III for her other physical ailments and which alleviates her headache symptoms.

A review of the Petitioner's pre-accident medical records shows that the Petitioner had elevated blood pressure levels prior to her April 8, 2006 accident. On June 1, 2004, the Petitioner's blood pressure was 132/80. [PX 2.] On July 19, 2004, the Petitioner's blood pressure was 150/100; she weighed 276 pounds and was 5'5" in height. [PX 2.] On September 8, 2004, the Petitioner's blood pressure was 124/80 and 122/90. [PX 2.] On December 22, 2004, the Petitioner's blood pressure was 130/94 she weighed 286 pounds on this date. [PX 2.] On February 28, 2005, the Petitioner's blood pressure was 120/80 and 122/80 and Dr. Evans assessed the Petitioner as morbidly obese. [PX 2.] On March 16, 2005, the Petitioner's blood pressure was 118/90. [PX 2.]

The Petitioner testified that she takes hypertension medication presently but could not provide the name of the medication. The Petitioner's medical records indicate that she takes hypertension medication irregularly, if at all. [PX 2.] Dr. Evans' treating note for the Petitioner dated January 9, 2007 indicates that the Petitioner has not been taking her antihypertensive because it causes too much urination and the Petitioner has to get up at night to go to the bathroom. [PX 2.] The Petitioner's treating records do not indicate whether any subsequent prescriptions for hypertension were provided to the Petitioner by any of her treaters.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner did not sustain an accident due to a verbal altercation on April 8, 2005. Although the Arbitrator finds that the verbal altercation occurred in the course of the Petitioner's employment with the Respondent, the Arbitrator finds that the verbal altercation did not arise out of the Petitioner's employment where the Petitioner was not exposed to a risk greater than to the general public. A verbal altercation with another individual can happen at any time and can cause a temporary elevation in blood pressure as well as a stress induced headache.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her alleged work accident on April 8, 2005. The Petitioner testified that she has occasional headaches due to her accident, but the Arbitrator finds that the frequency of such headaches is no more frequent than normal. The Arbitrator also finds that the Petitioner's elevated blood pressure is not causally connected to her April 8, 2005 accident because the Petitioner's own pre-accident medical records reflect elevated blood pressure levels and fluctuations in blood pressure. No expert testimony was provided by either party opining on the disputed issue of causal connection.

17IWCC0370

3. With regard to the nature and extent of the Petitioner's injury, the Arbitrator notes that where the Petitioner has not sufficiently established accident and causal connection, this issue is rendered moot. However, if the Petitioner had sufficiently established accident and causal connection (which she did not), the Arbitrator finds that the Petitioner has sustained no permanent disability as to her present occasional complaints of headaches and elevated blood pressure. The Arbitrator notes that the Petitioner's own medical records indicate that she is not taking blood pressure medication regularly. The Arbitrator declines to render any award for PPD pursuant to Sections 8(d)2 or 8(e) 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

Gwendolyn Myers,

Petitioner,

vs.

NO: 05 WC 38359

17IWCC0371

State of Illinois Department of Human 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 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 June 9, 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.

JUN 19 2017

DATED:
TJT:yl
o 6/6/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MYERS, GWENDOLYN
Employee/Petitioner

Case# **05WC038359**

SOI DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0371

On 6/9/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
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CHICAGO, IL 60654

5120 ASSISTANT ATTORNEY GENERAL
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SPRINGFIELD, IL 62794-9255

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

JUN 9 = 2015

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

17IWCC0371

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

Gwendolyn Myers,
Employee/Petitioner
v.

Case # **05** WC **38359**

State of Illinois, Dept. of Human Services,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **November 25, 2014, March 18, 2015 and May 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 **August 2, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$49,926**; the average weekly wage was **$960.11**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

Respondent ***has 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

Due to the Arbitrator's findings on the issues of accident and causation, all other issues are rendered moot.

Therefore, compensation is hereby denied

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

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

David A. Kane
Signature of Arbitrator

June 9, 2015
Date

JUN 9 - 2015

FINDINGS OF FACT

17IWCC0371

This case involves a Petitioner claiming a traumatic work-related accident causing a left knee injury while the Petitioner was ascending stairs as part of her employment with the Respondent, the Department of Human Services, with an alleged accident date of August 2, 2005. [Arb. Ex. 3.] The issues in dispute are: did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; is Petitioner's current condition of ill-being causally related to the injury; and what is the nature and extent of the Petitioner's injury. [Id.]

On August 2, 2005, the alleged accident date, the Petitioner was working as a Human Services Caseworker for the Illinois Department of Public Aid, a part of the Illinois Department of Human Services. The Petitioner worked at a facility located at 8001 S. Cottage Grove Ave., Chicago, Illinois.

The Petitioner testified that the 8001 S. Cottage Grove facility is a two-story building that has three sets of stairs in the building. The Petitioner testified that after seeing a client at the front of the building, she ascended stairs while carrying records and she fell on to concrete steps hitting both of her knees. The Petitioner testified that she slipped on water. The Petitioner testified that the stairs were accessible to everyone. Despite testifying that she hit both of her knees, on cross-examination the Petitioner clarified that she only injured her left knee.

The Petitioner testified that she reported her accident to her supervisor, Elice Smith. The Petitioner confirmed that an accurate copy of the Petitioner's notice of injury was marked as Petitioner's Exhibit 8. [*See also,* RX 6.] In her notice of injury, the Petitioner stated that Lulu Hobbes told her that the elevator was broken.

[RX 6.] The Petitioner wrote, "I fell up the stairs and hit my left knee. The steps had sweat due to the heat outside." [RX 6.]

17IWCC0371

On direct examination, the Petitioner testified that she slipped on water while ascending the steps. On cross-examination, the Petitioner testified that she wrote that she slipped on sweat in her notice of injury. To clarify why she wrote sweat instead of water in her notice of injury, the Petitioner testified that sweat is water and that she meant that she slipped on water. The Petitioner did not know what color the liquid she slipped on was. The Petitioner testified that the stairs were indoors and the area where the stairs were located was not air conditioned. On re-direct examination, the Petitioner testified that she did not mean that there was human sweat that had fallen off of someone but rather there was condensation on the stairs.

The Petitioner's medical records indicate that she first presented to Dr. Shantala Sreerama at Advocate Health Centers in Chicago on August 4, 2005. [PX 2.] The Petitioner complained of left knee pain following a fall on concrete at work. [PX 2.] An X-ray of the Petitioner's left knee was negative for fractures or infiltrative processes of bone. [PX 2.] The August 4 note indicates the Petitioner slipped and fell and noticed pain and swelling. [PX 2.] The August 4 note indicates the Petitioner took Tylenol #3 and Flexeril she had been given to treat her back pain. [PX 2.] Dr. Sreerama assessed the Petitioner with a left knee contusion and released the Petitioner to work as of August 8, 2005. [PX 2.]

On October 6, 2005, the Petitioner presented to Dr. Thelma Evans at Advocate Health Centers in Chicago. [PX 2.] The Petitioner complained of left knee pain and swelling on that date. [PX 2.] On examination, Dr. Evans noted that the

17IWCC0371

Petitioner's left knee was slightly tender and mildly edematous and that the Petitioner complained of pain with attempted flexion and extension of the left knee. [PX 2.] Dr. Evans assessed the Petitioner with left knee pain due to a recent left knee contusion at work. [PX 2.] Dr. Evans prescribed the Petitioner with Flexeril and Tylenol #3 and instructed the Petitioner to follow up in three months or as needed. [PX 2.]

The Petitioner testified that she last treated for her left knee injury on October 25, 2005 but no medical record for that treatment date was admitted into evidence for the Petitioner. Without the supporting medical record for that treating date, the Arbitrator will infer that no such treatment occurred on that date.

The Petitioner testified that she did not miss any work because of her accident and is not seeking TTD for any period of time as a result of her alleged work-related accident.

The Petitioner testified that as of the date of hearing she sometimes has swelling in her left knee after going up the stairs. She testified that the medication she takes for her other physical ailments helps relieve her left knee symptoms.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner did not sustain a traumatic accident which caused a left knee injury on August 2, 2005. A simple fall while ascending public stairs does not expose the Petitioner to a risk that is greater than to the general public. The Arbitrator finds the Petitioner's testimony and notice of injury form inconsistent as to what liquid she allegedly slipped on, whether water, sweat or condensation. The Arbitrator calls the Petitioner's recollection into question as her answers on direct and cross-

examination were evasive and as such, lack credibility. The Petitioner on direct examination testified she slipped on water, but on cross-examination confirmed that she slipped on what she thought was sweat. She then testified that sweat is water. On re-direct examination, the Petitioner clarified that what she referred to as sweat in her notice of injury was condensation which had accumulated on the stairs. Even assuming as true that there was condensation on the stairs as the Petitioner testified, any such condensation which accumulated naturally would again not expose the Petitioner to a risk of slipping that is greater than to the general public. As such, the Arbitrator finds that the Petitioner did not sustain a work-related accident.

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her alleged work accident on August 2, 2005. The Arbitrator's finding as to causal connection is based primarily on the finding that the Petitioner did not sustain a work-related accident.

3. With regard to the nature and extent of the Petitioner's injury, the Arbitrator notes that where the Petitioner has not sufficiently established accident and causal connection, this issue is rendered moot. However, if the Petitioner had sufficiently established a work-related accident and causal connection (which she did not), the Arbitrator finds that the Petitioner sustained no permanent disability as to her present occasional left knee condition which consists of mere occasional swelling. The Arbitrator notes that the Petitioner's own medical records indicates, and which is also supported by the Petitioner's testimony, that the Petitioner only received treatment as to her left knee injury on August 4 and October 6, 2005, respectively. The Petitioner was prescribed some pain relief medication but did not receive any injections or physical therapy for her left knee. Further, at the Petitioner's present

age of over 65 years old, the Petitioner has failed to establish that her current knee symptoms are any worse as a result of her alleged accident as opposed to normal age related knee symptoms. The Petitioner's August 4, 2005 left knee X-ray indicated patellofemoral compartmental degenerative joint disease. [PX 2.] Under these circumstances, the Arbitrator declines to render any award for PPD pursuant to Section 8(e) 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

Gwendolyn Myers,

Petitioner,

vs. NO: 06 WC 38040

State of Illinois Department of Human Services,

17IWCC0372

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 June 9, 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.

DATED: JUN 19 2017
TJT:yl
o 6/6/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MYERS, GWENDOLYN
Employee/Petitioner

Case# **06WC038040**

SOI DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0372

On 6/9/2015, 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 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

JUN 9 = 2015

17IWCC0372

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

Gwendolyn Myers,
Employee/Petitioner

Case # 06 WC 38040

v.

State of Illinois, Dept. of Human Services,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **November 25, 2014, March 18, 2015 and May 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [x] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

17IWCC0372

FINDINGS

On **January 26, 2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$50,797**; the average weekly wage was **$976.87**.

On the date of accident, Petitioner was **57** 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 **$23,883.80** 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

Due to the Arbitrator's findings on the issues of accident and causation, all other issues are rendered moot.

Therefore, compensation is hereby denied

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

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

David A. Kane
Signature of Arbitrator

June 9, 2015
Date

JUN 9 - 2015

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FINDINGS OF FACT

This case involves a Petitioner claiming a repetitive trauma work-related accident causing a bilateral carpal tunnel syndrome injury during the Petitioner's employment with the Respondent, the Department of Human Services, with an alleged accident date of January 26, 2006. [Arb. Ex. 4.] The issues in dispute are: did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; is Petitioner's current condition of ill-being causally related to the injury; what temporary benefits are in dispute; and what is the nature and extent of the Petitioner's injury. [Id.]

The parties stipulated to the periods for which the Petitioner is seeking TTD based on the Respondent's attendance records. [*See* RX 15 and 16.] The periods of alleged TTD are as follows: **8/10/07-2/18/08; 7/17/09-5/9/10; 6/2/10-3/25/12; 8/21/12-10/28/12 and 12/11/12-3/4/13** (emphasis added).

On January 26, 2006, the alleged accident date, the Petitioner was working as a Human Services caseworker for the Illinois Department of Public Aid, a part of the Illinois Department of Human Services. The Petitioner worked at a facility located at 8001 S. Cottage Grove Ave., Chicago, Illinois.

The Petitioner testified that she was previously a Data Input Operator for the Respondent from 1973 to September 1984, during which time the Petitioner input data in a terminal, which was like an electronic typewriter, for over 6 hours per day. On cross-examination, the Petitioner clarified that she was a Data Input Operator for Cook County in 1973 and began working for the Respondent in the same position in 1974. The Petitioner testified that in 1985, the Data Input Operator position was phased out and Human Services caseworkers assumed the data input activities previously handled by Data Input Operators in 1986.

The Petitioner testified she started working as a Human Services Caseworker in 1984 at 8001 S. Cottage Grove Ave. As a caseworker, the Petitioner's job duties consisted of servicing clients, setting up and approving cases including but not limited to for the aged, dependent children, food stamps, and Medicaid. The Petitioner testified that to service clients, she would input information into the computer. The Petitioner testified that her job as a Human Services caseworker involved data entry

into the computer for 5 hours per day. The Petitioner typically worked 5 days per week but occasionally worked overtime and on Saturdays. The Petitioner testified that she would constantly carry or lift files as part of her job.

On cross-examination, the Petitioner testified that she started using a computer to input data in 1986. Prior to 1986, the Petitioner testified she used a terminal to input data. The Petitioner testified that she would do her typing in a database but there was a section for narrative typing. The Petitioner testified that typing fields into a database comprised the great majority of her typing activities at work and typing in narrative did not occur daily. The Petitioner testified that the typing she would do to fill out fields typically consisted of names, social security numbers, and birth dates. The Petitioner testified that she would sometimes type paragraphs. To navigate the database which the Petitioner used, the Petitioner testified she would use the F keys on the keyboard.

The Petitioner testified that she sent e-mails at work but not every day. The Petitioner did not recall when she got a work e-mail address and did not know what her work e-mail was. The Petitioner testified that she was a union steward and part of her role as a union steward included assisting with grievances, which could require some typing including but not limited to e-mail.

On re-direct examination, the Petitioner testified that she would type out letters as part of her job, but she did not type letters on a daily basis. On re-cross examination, the Petitioner testified that the letters she typed were form letters where she needed to fill in blanks and were not narrative letters. The Petitioner testified that typing a letter took more than 3 minutes but less than 5 minutes.
On cross-examination, the Petitioner testified that her daily activities varied and that she would conduct interviews as part of her job on people receiving public aid. The Petitioner testified that she would interview between 5-10 people per day and there were days where she would meet with a person for several hours. The Petitioner testified she would go downstairs to meet people and bring them to her desk on the second floor. The Petitioner testified that it typically took 5 minutes to get a person and escort them to her desk. The Petitioner testified that she would walk people out. The Petitioner testified that she would take notes on the computer while interviewing people.

The Petitioner testified that she noticed her hands started to swell and become numb. She testified that she went to Advocate Health Center on October 25, 2005 for her hands as well as for injuries from a previous workers' compensation case. However, no record of an October 25, 2005 visit was offered by the Petitioner and admitted into evidence. As such, the Arbitrator will infer that no such visit took place.

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On January 25, 2005, the Petitioner had an EMG of her upper extremities which confirmed mild bilateral carpal tunnel syndrome in the Petitioner's wrists. [PX 2.]

The Petitioner testified that on January 26, 2005, Dr. Thelma Evans called her and told the Petitioner she needed to see Dr. Evans right away. The Petitioner testified that on that date her hands turned black. The Petitioner testified that she went to see Dr. Evans on January 26, 2005 and that Dr. Evans told the Petitioner she had very bad carpal tunnel syndrome. This is inconsistent with the Petitioner's EMG report indicating mild bilateral carpal tunnel syndrome. The Petitioner also testified that Dr. Evans told her that her carpal tunnel syndrome was caused by typing and lifting. The Petitioner testified that Dr. Evans gave the Petitioner wrist braces on January 26, 2005 until she had surgery. At hearing, the Petitioner failed to enter any treating record for this date into evidence. As such, the Arbitrator will infer that no such visit took place.

The Petitioner's treating records indicate she presented to Advocate Health Centers on February 15, 2006. [PX 2.] The treating note indicated that the Petitioner presented for her EMG results and that the Petitioner had greater symptoms in her right than left hand. The February 15, 2006 record was the first record admitted into evidence confirming the Petitioner's carpal tunnel syndrome diagnosis, right greater than left. The record indicated that the Petitioner was prescribed wrist braces for the first time on this date. [PX 2.] This is inconsistent with the Petitioner's testimony that she was given wrist braces on January 26, 2005.

On March 21, 2006, the Petitioner's treating medical records indicate she presented to Advocate Health Centers complaining of right hand pain. [PX 2.] Swelling was noted and the Petitioner was assessed with carpal tunnel syndrome. The treatment plan consisted of a referral for the Petitioner to see an orthopedic specialist at Midland Orthopaedic Associates. [PX 2.]

The Petitioner testified that she was referred to Dr. John Sonnenberg on January 26, 2005, by Dr. Evans, which is inconsistent with the Petitioner's March 21, 2006 treating note. This, in addition to there being no treating note for treatment on January 26, 2005 being admitted into evidence, further supports that no such visit took place on January 26, 2005.

On April 12, 2006, the Petitioner presented to Dr. John Sonnenberg for the first time at Midland Orthopaedic Associates. [PX 1.] That the Petitioner's first visit to Dr. Sonnenberg closely followed her March 21, 2006 orthopedic referral further supports that no visit with Dr. Evans took place on January 26, 2005.

Dr. Sonnenberg's April 12 treating note refers to an injury to both of the Petitioner's hands over the years working on a computer at work. There is also a reference to a traumatic injury the Petitioner sustained on January 13, 2004 [*see* 05 WC 23677], where the Petitioner reported an injury to her back and hands during a fall. [PX 1.] It appears that this information was provided to Dr. Sonnenberg by the Petitioner from the Petitioner's responses to a form the Petitioner filled out on April 12 labeled Work-Related Injury. [PX 1.] Dr. Sonnenberg recommended steroid injections into the Petitioner's hands.

The Petitioner testified, however, that she did not receive injections to her hands from Dr. Sonnenberg on April 12, 2006. Upon further questioning from the Petitioner's attorney, the Petitioner testified that she did not remember whether she had injections to her hands on April 12, 2006. However, the Petitioner's treating records indicate that the Petitioner received injections into her hands on April 12, 2006. [PX 1 & 2.]

On April 17, 2006, the Petitioner presented to Advocate Health Centers to request a release to return to work from her primary care provider. [PX 2.] The records indicate that the Petitioner was told by Advocate that she did not need such a release based on Dr. Sonnenberg's April 12 treating note. [PX 2.]

The Petitioner testified that she continued to work for the Respondent regular duty.

The Petitioner's treating records indicate that she complained of persistent symptoms in her hands to Advocate Health Centers [PX 2], and she was again referred to Midland Orthopedics on June 9, 2006.

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On August 11, 2006, the Petitioner presented at Advocate Health Centers complaining of hand swelling and was assessed with carpal tunnel syndrome in the right hand and taken off work for 1 week and prescribed Tylenol #3. [PX 2.] The Respondent's attendance records for the Petitioner indicate the Petitioner was not off work during this time. [RX 15 & 16.]

The Petitioner testified that she saw Dr. Sonnenberg on October 25, 2006. The Petitioner testified that Dr. Sonnenberg released her to limited work consisting of using the computer 4-6 hours per day. However, no treating record for this date was admitted into evidence by the Petitioner, and as such, the Arbitrator will infer that no such visit with Dr. Sonnenberg took place on this date.

Rather, the Petitioner's treating records indicate that she presented to Dr. Thelma Evans at Advocate Health Centers on October 25, 2006. [PX 2.] The Petitioner indicated to Dr. Evans that she was still having severe pain in both wrists and would like a referral to see an orthopedist for carpal tunnel release surgery. [PX 2.] Dr. Evans referred the Petitioner to Dr. Sonnenberg for consideration for carpal tunnel surgery. [PX 2.] Dr. Evans also limited the Petitioner to 4 hours of computer use per shift. [PX 2.]

The Petitioner testified that she went to Dr. Sonnenberg on November 26, 2006. However, no treating record for that date was admitted into evidence at hearing and as such, the Arbitrator infers that no such treatment took place on that date.

The Petitioner's treating records indicate she presented to Dr. Sonnenberg on November 22, 2006. [PX 1 & 2.] Dr. Sonnenberg noted that the Petitioner had 4 to 6 weeks of relief of her carpal tunnel syndrome symptoms following her April 12, 2006 injections but that now her symptoms had worsened. [PX 1.] Dr. Sonnenberg opined that the Petitioner will probably need surgery but that the Petitioner did not want to have surgery at that time. [PX 1 & 2.] Dr. Sonnenberg recommended a course of Celebrex and Lyrica treatment to try to reduce the inflammatory response and carpal tunnel syndrome symptoms. [PX 1 and 2.]

On January 9, 2007, the Petitioner presented to Dr. Thelma Evans at Advocate Health Centers. [PX 2.] The Petitioner complained of increasing pain in both hands with the right hand worse than the left. [PX 2.] Dr. Evans's note indicates that the Petitioner is scheduled to have surgery on her hands within the next couple of months when it is authorized by workers' compensation. [PX 2.] On physical examination, Dr. Evans noted that both the Petitioner's wrists were tender with positive Tinel's signs bilaterally. [PX 2.] Dr. Evans limited the Petitioner to 4 hours of computer use per shift at work. [PX 2.]

On April 16, 2007, the Petitioner presented at Advocate Health Centers complaining of swollen hands and continued numbness and tingling in her fingertips. [PX 2.] She was again referred to Midland Orthopaedic Associates. [PX 2.]

On April 25, 2007, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg scheduled the Petitioner for right hand surgery on June 9, 2007. [PX 1.]

On August 10, 2007, Dr. Sonnenberg performed surgery on the Petitioner consisting of a right carpal tunnel release and neurolysis with synovectomy. [PX 1.]

The Petitioner's attendance records indicate that the Petitioner was off work from August 10, 2007 through February 18, 2008 (**8/10/07-2/18/08**). [RX 15 & 16 (emphasis added).]

Petitioner is Off Work

On August 22, 2007, the Petitioner presented to Dr. Sonnenberg to have her sutures removed. [PX 1.] Dr. Sonnenberg instructed the Petitioner to receive physical therapy for rehabilitation exercises. [PX 1.]

On September 5, 2007, the Petitioner presented for initial evaluation for physical therapy at Midland Orthopedic Associates. [PX 1.] A hand therapy progress note dated September 24, 2007 indicated the Petitioner progressing with physical therapy. [PX 1.]

On September 26, 2007, the Petitioner presented to Dr. Sonnenberg who noted that the Petitioner was engaged in hand therapy. [PX 1.] Dr. Sonnenberg prescribed an additional four weeks of hand therapy and kept the Petitioner off work. [PX 1.]

An October 22, 2007 hand therapy progress note indicated that the Petitioner had made good progress overall with the right hand. [PX 1.]

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On October 24, 2007, the Petitioner presented to Dr. Sonnenberg who noted that the Petitioner had made progress after the Petitioner's right carpal tunnel release. [PX 1.] Dr. Sonnenberg noted that the Petitioner was being bothered in the left hand and discussed surgical intervention in the left hand with the Petitioner. [PX 1.] Dr. Sonnenberg tentatively scheduled surgery on the Petitioner's left hand on November 16, 2007 and kept the Petitioner off of work. [PX 1.]

On November 16, 2007, Dr. Sonnenberg performed a left carpal tunnel release and neurolysis on the Petitioner. [PX 1.]

On November 28, 2007, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg indicated that the Petitioner would start an exercise program on her own because she did not feel that she needed hand therapy. [PX 1.]

On January 2, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] On that date, Dr. Sonnenberg noted the Petitioner did not have numbness in the median nerve distribution but had some numbness in the ulnar nerve distribution. [PX 1.] Dr. Sonnenberg was concerned that the Petitioner may have developed cubital tunnel syndrome. [PX 1.] Dr. Sonnenberg kept the Petitioner off work. [PX 1.]

On February 6, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] He noted that the Petitioner had some tenderness over the scar but her range of motion in the left hand was good and her numbness was completely gone. [PX 1.] Dr. Sonnenberg returned the Petitioner to work as of February 18, 2008 with the limitation that the Petitioner not lift any records. [PX 1.]

The Petitioner testified that she returned to work on February 18, 2008. However, the Petitioner's attendance records reveal that she returned to work as of February 19, 2008. [RX 15 & 16.]

Petitioner is at Work

The Petitioner testified that her hands began to hurt like before upon returning to work.

The Petitioner's medical records indicate she presented to Advocate Health Centers on February 21, 2008. [PX 2.] The February 21 treating note indicated that the Petitioner returned to work on February 19 and that she noticed pain, swelling and discoloration in her left wrist. [PX 2.] The Petitioner was assessed with pain in the left wrist related to carpal tunnel syndrome. [PX 2.]

On March 3, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg indicated that the Petitioner presented complaining of pain around her wrist and swelling over her hand but could not detect any swelling upon examination. [PX 1.] Dr. Sonnenberg indicated that the Petitioner had overuse tendinitis of the dorsal aspect of the left wrist and persistent radial pillar pain. [PX 1.] Dr. Sonnenberg injected the Petitioner's left wrist over the radial pillar of her left hand and placed her in a wrist brace. [PX 1.] Dr. Sonnenberg prescribed the Petitioner Celebrex. [PX 1.] The Petitioner testified that Dr. Sonnenberg took her off work on March 3, but no such indication appears in Dr. Sonnenberg's treating note. As such, the Arbitrator will infer that the Petitioner continued to work during this time. Further, the Respondent's attendance records for the Petitioner indicate that the Petitioner continued to work until July 16, 2009. [RX 15 & 16.]

However, contrary to the Respondent's attendance records for the Petitioner, the Petitioner testified that Dr. Sonnenberg took her off work for one week and that when she returned, her hands were no longer hurting. The Petitioner testified that she next presented to Dr. Sonnenberg on March 14, 2008, but no such treating record for this date was admitted into evidence at hearing. As such, the Arbitrator will infer that no such visit took place.

On March 14, 2008, the Petitioner presented to Dr. Thelma Evans at Advocate Health Centers. [PX 2.] The Petitioner complained of pain in her left wrist. Dr. Evans' treating note indicated that the Petitioner attempted to return to work on March 10, 2008, but she was unable to tolerate work

because of pain and swelling in her left wrist. [PX 2.] Dr. Evans noted that the Petitioner was scheduled for an orthopedic appointment on March 19, 2008. [PX 2.]

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Dr. Evans advised the Petitioner to continue taking Vicodin and Celebrex for her wrist pain and kept the Petitioner off work until March 20, 2008 with instructions to elevate her left wrist and hand and to apply ice periodically throughout the day to reduce swelling. [PX 2.] The Respondent's attendance records for the Petitioner show that the Petitioner was still working at this time. [RX 15 & 16.]

On March 19, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg noted that the Petitioner was having problems with her left hand and may be related to overuse and typing all day. [PX 1.] He assessed the Petitioner with overuse tendinitis of the left hand and restricted the Petitioner to three hours typing in the morning and three hours typing in the afternoon. [PX 1.]

The Petitioner testified that she returned to work on March 20, 2008. The Respondent's attendance records for the Petitioner, however, indicate that the Petitioner was not off work during this time. [RX 15 & 16.]

On April 21, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg restricted the Petitioner to light duty consisting of 3 hours typing in the morning and 3 hours typing in the afternoon. [PX 1.]

On June 2, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg indicated that a repeat X-ray of the Petitioner's hands showed very good alignment and that the Petitioner's carpal tunnel did not show any abnormalities. Dr. Sonnenberg noted that the Petitioner had persistent radial pillar tenderness but no more numbness in her hand. [PX 2.] Dr. Sonnenberg gave the Petitioner a steroid injection into the radial pillar. [PX 1.] Dr. Sonnenberg's June 2, 2008 treating note is unclear as to which hand he administered the injection into. The Petitioner testified that the injection was to the Petitioner's right wrist.

On July 7, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg returned the Petitioner to light status work as of July 10, 2008 restricted to 3 hours of typing in the morning and 3 hours in the afternoon. [PX 1.]

On July 28, 2008, the Petitioner presented to Dr. Sonnenberg. Dr. Sonnenberg noted that she had a little bit of tenderness in the radial pillar. [PX 1.] Dr. Sonnenberg released the Petitioner to her normal work duties as of July 29, 2008. [PX 1.] The Petitioner continued to work for the Respondent during this time.

On September 26, 2008, the Petitioner presented to Advocate Health Centers complaining of left wrist pain. [PX 2.] The Petitioner was given an orthopedic referral for a possible steroid injection. [PX 2.]

On October 27, 2008, the Petitioner presented to Dr. Sonnenberg complaining of swelling in her right and left hands. Although Dr. Sonnenberg did not detect any swelling on examination, he assessed the Petitioner with some swelling due to overuse syndrome. [PX 1.] Dr. Sonnenberg prescribed the Petitioner Celebrex. [PX 1.]

On December 15, 2008, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg noted that the Petitioner was restricting the amount of typing she was doing at work which was relieving her pain symptoms. Dr. Sonnenberg recommended the Petitioner continue working modified duty. [PX 1 and 2.]

On January 12, 2009, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg noted that the Petitioner was off work for about 3 weeks and was asymptomatic in her hand. [PX 1.] Dr. Sonnenberg recommended the Petitioner continue with typing no more than 3 hours in the morning and 3 hours in the afternoon. [PX 2.] The Respondent's attendance records for the Petitioner indicate that the Petitioner was on vacation and off work from November 22, 2008 through December 4, 2008, and from December 23, 2008 through January 7, 2009. [*See* RX 15.] During these periods, the Petitioner was off work but not as a result of her alleged work-related accident.

On February 23, 2009, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg could not find any swelling in the Petitioner's hands despite her complaining of swelling. [PX 1.] Dr.

Sonnenberg continued to restrict the Petitioner to typing no more than 3 hours in the morning and 3 hours in the afternoon at work and believed she was approaching MMI. [PX 1.]

On April 13, 2009, the Petitioner presented to Dr. Sonnenberg. [PX 1.] As of that date, Dr. Sonnenberg indicated that the Petitioner continued to work modified duty consisting of 3 hours typing in the morning and 3 hours typing in the afternoon. [PX 1.] Dr. Sonnenberg found that the Petitioner had reached MMI as of this date and noted that the Petitioner expressed to him that the Petitioner wanted to go on disability. [PX 1.]

On June 17, 2009, the Petitioner presented to Dr. Necholas Aboughannam at Advocate Medical Group complaining of left hand pain and swelling and requesting an orthopedic referral. [PX 2.]

The Respondent's attendance records for the Petitioner indicate that the Petitioner was off work from July 17, 2009 through May 9, 2010 (**7/17/09-5/9/10**). [RX 15 and 16 (emphasis added).]

Petitioner is Off Work

On August 28, 2009, the Petitioner presented to Dr. Tony Hampton of Advocate Medical Group complaining of left wrist pain and swelling. [PX 2.] The Petitioner continued to have pain without medication.

On November 19, 2009, the Petitioner presented to Dr. Tony Hampton of Advocate Medical Group complaining of right arm pain. [PX 2.] The Petitioner was instructed to continue taking Vicodin for her carpal tunnel syndrome symptoms. [PX 2.]

On December 9, 2009, the Petitioner presented to Dr. Tony Hampton of Advocate Medical Group complaining of right arm pain. [PX 2.] Dr. Hampton's note indicated that the Petitioner attempted to go back to work on December 7 and 8 and developed severe arm pain with lifting and swelling and was unable to continue working due to severe pain. [PX 2.] Dr. Hampton instructed the Petitioner to continue taking Vicodin and told the Petitioner to stay off work. [PX 2.] Dr. Hampton gave the Petitioner an EMG referral. [PX 2.] The Respondent's attendance records for the Petitioner show no evidence that the Petitioner returned to work in December 2009. [RX 15 & 16.]

On January 25, 2010, the Petitioner presented to Dr. Sonnenberg. [PX 1and 2.] Dr. Sonnenberg's note indicated that the Petitioner had been off work since July 2009 but returned to work in December 2009. [PX 1 and 2.] Dr. Sonnenberg indicated that the Petitioner had significant swelling of both forearms upon returning to work and was sent home. [PX 1 and 2.] Dr. Sonnenberg noted that the Petitioner had mild swelling of both proximal forearms with tenderness over the forearm musculature, but she did not have a recurrence of carpal tunnel syndrome. [PX 1 and 2.] Dr. Sonnenberg returned the Petitioner to work but was doubtful that the Petitioner would be able to type in the future. [PX 1 and 2.] The Respondent's attendance records for the Petitioner indicate that the Petitioner did not return to work in December 2009 as Dr. Sonnenberg's treating note suggests. [RX 15 & 16.]

Contrary to what the medical records indicate, the Petitioner testified that she worked continuously from April 13, 2009 to January 25, 2010. To the extent the Petitioner's testimony is contradicted by her own treating medical records as well as the Respondent's attendance records for the Petitioner [*see* RX 15 & 16], the Arbitrator finds that the Petitioner's testimony is not reliable.

The Petitioner testified that without being able to type, there were no jobs available for her to do working for the Respondent.

On February 8, 2010, the Petitioner presented to Dr. Sonnenberg. [PX 1 and 2.] Dr. Sonnenberg noted that the Petitioner had not been back to work since he prohibited the Petitioner from typing. [PX 1 and 2.] The Petitioner still had soreness in her forearms and her hands were getting better. [PX 1 and 2.] Dr. Sonnenberg continued to prohibit the Petitioner from typing but otherwise returned the Petitioner to work. [PX 1 and 2.]

On February 18, 2010, the Petitioner presented to Dr. Tony Hampton at Advocate Medical Group. [PX 2.] The Petitioner's right wrist was swollen and muscle strength was decreased. [PX 2.] Dr. Hampton kept the Petitioner off work. [PX 2.]

On March 22, 2010, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg noted that the Petitioner had been off work and that she still had pain in the right upper extremity. [PX 1.] Dr.

Sonnenberg administered a steroid injection to the Petitioner's right elbow to treat the Petitioner's recent flare up over the lateral epicondyle. [PX 1.]

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The Petitioner testified that she received steroid injections to both elbows. Based on the Petitioner's medical records, the Arbitrator finds that the Petitioner received an injection to only her right elbow.

On March 30, 2010, the Petitioner submitted to an IME with Dr. John Fernandez of Midwest Orthopedics Hand & Shoulder Center at Rush at the request of the Respondent. [*See* RX 10.] The Petitioner showed Dr. Fernandez how she positioned her hands when typing and Dr. Fernandez noted that the Petitioner's hands and arms exhibited "10 to 20 degrees of wrist extension with approximately 70 degrees of elbow flexion." [RX 10.] On examination, Dr. Fernandez noted that the Petitioner's grip strength was 15 pounds on the right versus 10 pounds on the left, but that when the Petitioner was asked to do a rapid exchange her grip strength increased to 25 pounds on the right and 20 pounds on the left, which was indicative of submaximal effort or symptom magnification. Dr. Fernandez opined that there was no evidence to support a causal relationship between the Petitioner's development of her carpal tunnel syndrome or her underlying arm pain and residual numbness and tingling. [RX 10.] Dr. Fernandez believed that the Petitioner may have had some underlying condition such as fibromyalgia or myofascial pain syndrome, but opined that those were not work related or aggravated by work activities. Dr. Fernandez found that the Petitioner had reached MMI and was capable of returning to work full duty. [RX 10.]

On April 5, 2010, the Petitioner presented to Dr. Sonnenberg following her IME with Dr. Fernandez. [PX 1.] The Petitioner indicated to Dr. Sonnenberg that her right elbow was doing much better after the injection over the lateral epicondyle. [PX 1.] Dr. Sonnenberg proposed some physical therapy for the Petitioner's right arm and raised the possibility that the Petitioner may need to find a different occupation that doesn't require her to type. [PX 1.]

On May 3, 2010, the Petitioner next presented to Dr. Sonnenberg. Dr. Sonnenberg was provided a copy of Dr. Fernandez's IME report, and based on Dr. Fernandez's recommendation that the Petitioner be returned to work full duty, Dr. Sonnenberg released the Petitioner to full duty work. [PX 1.]

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The Respondent's attendance records for the Petitioner indicate that the Petitioner returned to work as of May 10, 2010 (**5/10/10**). [RX 15 & 16 (emphasis added).]

Petitioner is at Work

The Petitioner testified she returned to work on May 10, 2010. The Respondent's attendance records for the Petitioner indicate that the Petitioner worked from May 10, 2010 May 13, 2010. [RX 15 & 16.]

On May 13, 2010, the Petitioner presented to Dr. Katherine Granberry of Advocate Medical Group complaining of pain and swelling in her wrists. [PX 2.]

Petitioner is Off Work

On May 14, 2010, the Petitioner presented to Dr. Tony Hampton of Advocate Medical Group. [PX 2.] Dr. Hampton prescribed the Petitioner Vicodin, took the Petitioner off work, and gave the Petitioner an orthopedic referral. [PX 2.]

The Respondent's attendance records for the Petitioner indicate that the Petitioner was off work from May 14, 2010 and she used sick time, personal days, holidays and vacation days to cover her absence until she was taken off work relating to this claim from June 2, 2010 through March 25, 2012 (**6/2/10-3/25/12**). [RX 15 & 16 (emphasis added).]

On May 24, 2010, the Petitioner presented to Dr. Sonnenberg. [PX 1.] The Petitioner testified that at this point, she had returned to work for about 2 weeks. [PX 1.] The Petitioner testified that she felt numbness and pain in her hands and arms and Dr. Sonnenberg took her off work at that time. [PX 1.] It should be noted that the Petitioner had only returned back to work for 3 days (from May 10, 2010 through May 13, 2010). [RX 15 & 16.]

Dr. Sonnenberg's May 24, 2010 note indicated that the Petitioner complained of swollen forearms but he could not tell if there was swelling. [PX 1.] Dr. Sonnenberg noted that the Petitioner's right forearm was slightly larger than the left. [PX 1.] Dr. Sonnenberg prohibited the Petitioner from typing activities and put her on a Medrol Dosepak to try to reduce the Petitioner's inflammatory response. [PX 1.]

The Petitioner also testified that Dr. Sonnenberg recommended therapy for her. However, no such recommendation for therapy appears in Dr. Sonnenberg's May 24, 2010 treating note, and as such, the Arbitrator finds that no such recommendation was made by Dr. Sonnenberg on that date.

On June 1, 2010, the Petitioner presented to Dr. Sonnenberg reporting she felt significantly better after the Medrol Dosepak. [PX 1.] Dr. Sonnenberg noted that the Medrol Dosepak seems to have reduced the Petitioner's acute inflammation around her forearm on the right side. [PX 1.] Dr. Sonnenberg recommended the Petitioner be placed in therapy to rehabilitate her hand and forearm for 3 weeks. [PX 1.] Dr. Sonnenberg kept the Petitioner off work. [PX 1.]

The Petitioner's treating medical records indicate the Petitioner presented for a hand therapy initial assessment on June 10, 2010 but no subsequent records were admitted into evidence supporting subsequent hand therapy sessions. [PX 1.]
On June 21, 2010, the Petitioner presented to Dr. Sonnenberg indicating that soreness over her proximal right forearm had significantly reduced. [PX 1.] Dr. Sonnenberg noted he talked with the Petitioner's physical therapist who wanted to work with the Petitioner for another 3 to 4 weeks. [PX 1.]

On August 2, 2010, the Petitioner presented to Dr. Sonnenberg after appearing to have received additional hand therapy treatment. [PX 1.] Dr. Sonnenberg noted the Petitioner's hand grip strength was nearly equal but was concerned that the grip strength was unexpectedly low. [PX 1.] Dr. Sonnenberg believed the Petitioner's grip strength was being affected by lateral epicondylitis and administered an injection to the right lateral epicondyle. [PX 1.] Dr. Sonnenberg instructed the Petitioner to complete an additional 3 weeks of therapy. [PX 1.]

On August 23, 2010, the Petitioner presented to Dr. Sonnenberg after having apparently finished her therapy program. [PX 1.] Dr. Sonnenberg released the Petitioner to return to work but prohibited typing activities and lifting records. [PX 1.]

The Petitioner testified that there was no light duty position available for her to return to work with the Respondent.

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On September 27, 2010, the Petitioner presented to Dr. Sonnenberg. [PX 1.] Dr. Sonnenberg noted that the Petitioner had not returned to work after he released the Petitioner to modified duty but prohibited her from typing. [PX 1.] Dr. Sonnenberg continued the Petitioner on the same work restrictions. [PX 1.]

On October 25, 2010, the Petitioner presented to Dr. Sonnenberg complaining of left elbow pain. [PX 1.] Dr. Sonnenberg administered a left elbow injection into the Petitioner's lateral epicondyle. [PX 1.] The Petitioner testified that Dr. Sonnenberg administered injections into both of her elbows, but based on the Petitioner's treating records, the Arbitrator finds that the Petitioner only received a left elbow injection.

On November 29, 2010, the Petitioner presented to Dr. Sonnenberg complaining of right elbow pain. Dr. Sonnenberg noted that the Petitioner's left elbow symptoms had improved from an injection and administered a right elbow injection. [PX 1.] Dr. Sonnenberg restricted the Petitioner to modified duty prohibiting typing and heavy lifting. [PX 1.] Dr. Sonnenberg assessed the Petitioner with bilateral lateral epicondylitis but did not believe the Petitioner was a surgical candidate. [PX 1.]

On January 10, 2011, the Petitioner presented to Dr. Sonnenberg complaining of left elbow pain. [PX 1.] Dr. Sonnenberg noted that the Petitioner had not been working and was not sure why her left elbow pain had returned. [PX 1.] Dr. Sonnenberg administered an injection into the Petitioner's left elbow. Dr. Sonnenberg restricted the Petitioner to light duty. [PX 1.]

On February 21, 2011, the Petitioner presented to Dr. Sonnenberg complaining of left elbow pain and tenderness over the lateral epicondyle. [PX 1.] Dr. Sonnenberg noted that the Petitioner had been put on disability because light duty work was not available. [PX 1.] Dr. Sonnenberg administered a left elbow injection on the Petitioner. [PX 1.]

On April 4, 2011, the Petitioner presented to Dr. Sonnenberg complaining of numbness and tenderness in her right hand and tenderness over the lateral epicondyle on the right elbow. [PX 1.]

Dr. Sonnenberg administered injections into the Petitioner's right carpal tunnel and right lateral epicondyle. [PX 1.]

On May 16, 2011, the Petitioner presented to Dr. Sonnenberg and received from him an injection to the left lateral epicondyle. [PX 1.]

On June 27, 2011, the Petitioner presented to Dr. Sonnenberg complaining of right wrist pain. [PX 1.] Dr. Sonnenberg noted that the Petitioner had risk factors for recurrence of carpal tunnel syndrome including significant obesity. [PX 1.] Dr. Sonnenberg could not explain why the Petitioner was symptomatic in her right wrist despite not doing repetitive duties with her right wrist. [PX 1.] Dr. Sonnenberg recommended a repeat EMG and nerve conduction study on the Petitioner's right upper extremity to test for recurrence of carpal tunnel syndrome. [PX 1.]

On October 5, 2011, the Petitioner had an EMG performed by Dr. Arthur Itkin of Neurologic Associates, Ltd. [PX 1.] Dr. Itkin noted right median neuropathy at the level of the right wrist involving motor and sensory fibers with predominant demyelinating features. [PX 1.]

On November 7, 2011, the Petitioner presented to Dr. Sonnenberg for her EMG results. [PX 1.] Dr. Sonnenberg noted that the recent EMG indicated that there was evidence of worsening carpal tunnel symptoms in her right hand including evidence of distal conduction velocity abnormalities in the motor branch. [PX 1.] Dr. Sonnenberg found the Petitioner's carpal tunnel syndrome progression troubling. [PX 1.] Dr. Sonnenberg administered an injection into the Petitioner's carpal canal. [PX 1.] Dr. Sonnenberg restricted the Petitioner from lifting and typing activities at work and recommended Dragon dictation software to minimize the Petitioner's work typing. [PX 1.] The Petitioner had not worked since May 13, 2010. [RX 15 & 16.]

On December 12, 2011, the Petitioner presented to Dr. Sonnenberg complaining of carpal tunnel symptoms. [PX 1.] The Petitioner indicated to Dr. Sonnenberg that the right hand injection did not help. [PX 1.] Dr. Sonnenberg prescribed a Medrol Dosepak to the Petitioner and advised her to use a brace at night. [PX 1.]

On December 19, 2011, the Petitioner presented to Dr. Sonnenberg reporting that she was dramatically better after the Medrol Dosepak. [PX 1.] Dr. Sonnenberg indicated that he believed that the light duty restrictions that he had given the Petitioner were permanent. [PX 1.]

On January 20, 2012, the Petitioner presented to Dr. Sonnenberg complaining of problems around her fourth and fifth digits of her right hand. [PX 1.] Dr. Sonnenberg administered an injection to the Petitioner's right carpal tunnel. [PX 1.] Dr. Sonnenberg released the Petitioner to work with limited typing. [PX 1.]

On February 20, 2012, the Petitioner presented to Dr. Sonnenberg indicating that she had a good reaction to the last right carpal tunnel injection. Dr. Sonnenberg noted that there may be a linkage between the Petitioner's median and ulnar nerves. [PX 1.] Dr. Sonnenberg released the Petitioner to work with Dragon dictation software. [PX 1.]

On March 19, 2012, the Petitioner presented to Dr. Sonnenberg complaining of some achiness in her left forearm. [PX 1.] Dr. Sonnenberg noted the Petitioner had multiple trigger points in the right forearm. [PX 1.] Dr. Sonnenberg released the Petitioner to work but gave the Petitioner a 3 pound lifting restriction and use of Dragon dictation software at work. [PX 1.]

The Respondent's attendance records for the Petitioner indicate that the Petitioner returned to work on March 26, 2012 (**3/26/12**). [RX 15 & 16 (emphasis added).]

Petitioner is at Work

On June 6, 2012, the Petitioner presented to Dr. Necholas Aboughannam at Advocate Medical Group complaining of pain and swelling to both arms and hands. [PX 2.] Dr. Aboughannam recommended the Petitioner see Dr. Sonnenberg. [PX 2.]

On July 23, 2012, the Petitioner presented to Dr. Sonnenberg complaining of pain in both of her forearms. [PX 1.] Dr. Sonnenberg noted that the Petitioner had been tearing tickets with her hands and the Petitioner claimed that this was causing her increasing pain. [PX 1.] On evaluation Dr. Sonnenberg noted the Petitioner had tenderness over the lateral epicondyle of both elbows. [PX 1.] She had pain radiating to the carpal tunnels from both forearms. [PX 1.] She had tenderness over

the median nerves in the proximal forearms. [PX 1.] She had minor tenderness over the ulnar nerves in the cubital tunnels bilaterally. [PX 2.] Dr. Sonnenberg noted that the Petitioner had sensitivity to any type of activity with her upper extremities. [PX 2.] Dr. Sonnenberg recommended a repeat EMG to evaluate whether the Petitioner had sustained further deterioration of her neurological status of the median nerves. [PX 1.]

Petitioner is Off Work

The Respondent's attendance records for the Petitioner indicate that the Petitioner was off work from August 21, 2012 through October 28, 2012 (**8/21/12-10/28/12**). [RX 15 & 16 (emphasis added).]

On September 21, 2012, Dr. Arthur Itkin of Neurologic Associates, Ltd. conducted an EMG study of the Petitioner's right and left wrists. [PX 1 and 2.] Dr. Itkin's impression indicated evidence of right median neuropathy at the level of the wrist involving sensory fibers only with demyelinating features. [PX 1 and 2.] Dr. Itkin noted there was evidence for left median neuropathy at the level of the wrist involving sensory fibers only with demyelinating features which can be seen in very mild carpal tunnel syndrome on the left. [PX 1 and 2.]

On October 15, 2012, the Petitioner presented to Dr. Sonnenberg complaining of continuous numbness in her hands, but more in the right than the left. [PX 1.] Dr. Sonnenberg reviewed Dr. Itkin's EMG report indicating slight residual carpal tunnel syndrome in the left wrist and slight improvement in the Petitioner's right wrist. [PX 1.] Dr. Sonnenberg evaluated and determined that additional surgery would not be appropriate for the Petitioner. [PX 1.] Dr. Sonnenberg believed that the Petitioner had reached MMI as of this date. [PX 1.]

On October 26, 2012, the Petitioner presented to Dr. Tony Hamilton at Advocate Medical Group and was released to work but prohibited from typing. [PX 2.]

The Respondent's attendance records for the Petitioner indicate that the Petitioner returned to work on October 29, 2012 (**10/29/12**). [RX 15 & 16 (emphasis added).]

Petitioner is At Work

On November 26, 2012, the Petitioner presented to Dr. Sonnenberg complaining of pain in both of her hands and dropping objects. [PX 1.] Dr. Sonnenberg's note indicated that the Petitioner was

working but doing little typing at this time. [PX 1.] Dr. Sonnenberg took the Petitioner off work and off typing activities. [PX 1.]

The Respondent's attendance records for the Petitioner indicate that the Petitioner was off work from December 11, 2012 through March 4, 2013 (**12/11/12-3/4/13**). [RX 15 & 16 (emphasis added).]

Petitioner is Off Work

On December 12, 2012, the Petitioner presented to Dr. Sonnenberg indicating that she had not been working and was feeling much better. [PX 1.] The Petitioner most recently worked on December 7, 2012 (the last date she ever worked for the Respondent). [RX 15 & 16.] Dr. Sonnenberg limited the Petitioner to a permanent 3 pound lifting limit and minimal typing. [PX 1.]

On February 11, 2013, the Petitioner presented to Dr. Sonnenberg who noted that the Petitioner had not returned to work because she was not given a Dragon dictation system. [PX 1.] Dr. Sonnenberg referred the Petitioner to a rheumatologist to determine whether an underlying rheumatoid disorder could be a risk factor in the Petitioner's upper extremity symptoms. [PX 1.] Dr. Sonnenberg released the Petitioner to modified duty work with the use of a Dragon dictation system. [PX 1.]

On March 4, 2013, the Petitioner presented to Dr. Sonnenberg following rheumatoid testing results which came back normal. [PX 1.] Dr. Sonnenberg indicated the Petitioner had reached MMI and instructed the Petitioner to avoid repetitive activity such as typing and lifting at work. [PX 1.] Dr. Sonnenberg discharged the Petitioner from his care. [PX 1.] This is the last date for which the Petitioner alleges she is entitled to TTD. [Arb. Ex. 4.]

The Petitioner asserts that she is entitled to maintenance from March 4, 2013 through November 25, 2014, but there does not appear to be any explanation provided by the Petitioner at hearing for why she is entitled to maintenance during this period. [Arb. Ex. 4.]

The Respondent's attendance records for the Petitioner indicate that following her most recent date of work with the Respondent on December 7, 2012, the Petitioner has not worked for the Respondent to the present. [RX 15 & 16.]

On August 22, 2013, the Petitioner testified that she presented to Dr. Jay Pomerance for an IME at the request of the Respondent. [*See* RX 12.] Dr. Pomerance opined in his IME report that the Petitioner's carpal tunnel syndrome was not related to her job activities. [RX 12.] Dr. Pomerance opined that the Petitioner did not have a diagnosis of lateral epicondylitis as of the date he examined the Petitioner. [RX 12.] Dr. Pomerance found that the Petitioner did not require additional treatment but may consider a repeat nerve conduction study to get objective information regarding the Petitioner's current complaints. [RX 12.] Dr. Pomerance opined that the Petitioner should return to work without restrictions. [RX 12.] Dr. Pomerance stated that "based on numerous studies currently published in the hand and orthopedic literature the theory of carpal tunnel syndrome being associated with computer keyboard and mouse use is false." [RX 12.]

The Petitioner testified that at some point, the Respondent provided Dragon dictation software on her work computer. She did not recall when this was. The Petitioner testified that using the Dragon dictation software at work was not a success.

The Petitioner testified that she has been on social security disability since September 2010 and that she has not worked since that time. This testimony is contradicted by the Respondent's attendance records for the Petitioner showing that the Petitioner's last date worked was December 7, 2012. [RX 15 & 16.] She later testified that she hasn't worked since 2012.

The Petitioner testified that prior to working for the Respondent in 1973, she did not have any issues with her hands and that she did not previously use a computer.

The Petitioner testified that she still seeks care for her hands and elbows from her primary care doctor, who prescribes Vicodin and anti-inflammatory medication. The Petitioner testified she takes medication 3-4 times per week. The Petitioner testified that today her hands are in a little pain and that her left arm is swollen such that she is wearing a left wrist brace. The Petitioner testified that she sleeps in wrist braces which were prescribed to her by Dr. Sonnenberg.

At some point, the Petitioner testified she was assigned a position as a greeter by the local office administrator for the Respondent, Mr. McIntosh. She testified that as a greeter, she would have to tear tickets all day and write information about clients and take the information to caseworkers, if

necessary. The Petitioner testified that she was paid the same as before when she was working as a Human Services caseworker. The Petitioner testified that she stopped working as a greeter and was told to go back upstairs to work as a caseworker. The Petitioner testified that she believed she was told to return to work as a caseworker because the Dragon dictation system had been installed on her computer.

The Petitioner's July 23, 2012 treating note mentions that the Petitioner was tearing tickets at work. The Arbitrator finds that the Petitioner was working as a greeter sometime before July 23, 2012.

The Petitioner testified that the union told her that there was no longer a greeter position available for her. The Arbitrator finds this is hearsay. The Petitioner testified that Darnice Cooper, the union president, filed a grievance in regards to caseworkers working as greeters when it was not in their job description. The Arbitrator finds this testimony lacks foundation and is hearsay. The Petitioner testified that even if there was no union grievance, she would not have continued working as a greeter because it required repetitive movements of tearing tickets that caused swelling and pain in her hands.

The Petitioner did not know how long she worked as a greeter and was not aware of whether there were still greeters working at the Respondent's 8001 S. Cottage Grove Ave. facility.

A copy of the Petitioner's notice of injury was marked as Respondent's Exhibit 7. [*See also,* RX 8 & 9.]

Elice Smith-Mitchell's Testimony

The Respondent called Elice Smith-Mitchell to testify at hearing in its defense. Ms. Smith Mitchell testified that she currently was employed by the Respondent as a Human Service Casework Manager at 8001 S. Cottage Grove Ave. in Chicago, Illinois since November 2004 to the present. Ms. Smith-Mitchell testified she manages Human Service caseworkers. Ms. Smith-Mitchell testified that she managed the Petitioner since November 2004 until when the Petitioner went downstairs as a greeter, which was sometime before July 23, 2012. Ms. Smith-Mitchell testified that she previously worked as a Human Service Caseworker for the Respondent from June of 1999 to December 2000 but at the

Auburn Park local office. Smith-Mitchell testified that the Human Services caseworkers were using terminals to input data until 1999, which was when they were given Gateway computers. This is inconsistent with the Petitioner's testimony that she started using a computer in 1986.

Smith-Mitchell testified that a Human Service Caseworker types approximately 3.5-4 hours per day. She testified that 85% of the typing consists of data entry. Smith-Mitchell clarified that data entry is typing into various fields. She testified that the remaining 15% of the typing consisted of narrative typing on a 514. The typing would be intermittent and throughout the entire course of the workday.
Smith-Mitchell testified that she was the Petitioner's direct supervisor from November of 2004 through May 31, 2011. Smith-Mitchell testified that the primary application that the Petitioner used was called Automatic Case Management, ACM, which the Petitioner used over 80% of the time when typing at work. Smith-Mitchell confirmed that Respondent's Exhibit 18 had screenshots of ACM and identified all of the fields that the Petitioner had to type in as part of her job as a Human Services caseworker. Smith-Mitchell testified that in each field the Petitioner could type a number or letter, date, month, year, enter, or a three digit code. Smith-Mitchell testified that the Petitioner could toggle to different fields on the ACM screen by hitting tab on the keyboard, using the arrow keys, or using a mouse. Smith-Mitchell testified that the Petitioner could type some narrative in the forms section but the narrative typing was intended to be brief and would not take longer than 5 minutes to type. Smith-Mitchell testified that the Dragon dictation software which was installed on the Petitioner's computer was not compatible with ACM and so the Petitioner was not able to use it to reduce her typing at work. Smith-Mitchell did not recall when the Dragon dictation was installed on the Petitioner's computer.
Smith-Mitchell also testified that the Petitioner would use a program called Extra daily but the typing involved with that program was limited to entering a customer's social security number, case identification number or name. Smith-Mitchell testified that the Petitioner had access to a program called IPACS, which the Petitioner used once or twice per day. Smith-Mitchell testified that the Petitioner did have a work e-mail address and did use e-mail at work.

Smith-Mitchell testified that at some point in July 2011, the 8001 S. Cottage Grove Ave. facility became a task based system. Smith-Mitchell testified that this changed the caseworker position from having a caseload to doing specific tasks. This was for the purpose of streamlining the

casework process. Smith-Mitchell testified that at some point the Petitioner was assigned as a greeter, which is a part of the interview team, which is a part of service coordination. Smith-Mitchell testified that when the Petitioner was a greeter, she was not required to do any typing. Smith-Mitchell testified that the greeter position is still available and effective today and remained available for the Petitioner to continue working in. Smith-Mitchell testified that the greeter position is within the classification for human service caseworkers. Smith-Mitchell testified that greeters are paid the same as other human service caseworkers. Smith-Mitchell testified that she was not aware of any union grievance filed over the greeter position. Smith-Mitchell testified that the greeter would take tickets, answer questions from people, and direct people to the service desk or to be interviewed. Smith-Mitchell testified that the greeter position is the easiest job within the caseworker classification and is the most sought after position at the facility.

Dr. Sonnenberg's Deposition Testimony

The evidence deposition of Dr. John Sonnenberg was taken on March 19, 2013 [*see* PX 4] and May 7, 2013, respectively. [PX 5.] Dr. Sonnenberg testified that he first saw the Petitioner on April 12, 2006. [PX 4, 7:6-8.] As part of his evaluation of the Petitioner, Dr. Sonnenberg took a history of the Petitioner including that the Petitioner worked on the computer every day. [PX 4, 7:15-19.]

Dr. Sonnenberg testified that the Petitioner identified typing as the aggravating cause of her hand symptoms. [PX 4, 7:15-8:6.] Dr. Sonnenberg testified that based on the history he had received from the Petitioner, that the Petitioner's bilateral carpal tunnel syndrome was a "work-related phenomenon due to typing day in and day out and other repetitive tasks." [PX 4, 10:11-23.] Dr. Sonnenberg testified that the Petitioner told him that the Petitioner's work consisted primarily of typing and occasional lifting of records. [PX 4, 26:16-20.] Dr. Sonnenberg testified that repetitive activities at work including typing caused the Petitioner's bilateral carpal tunnel syndrome. [PX 4, 61:20-62:7.]

On cross-examination, Dr. Sonnenberg testified that the Petitioner did not specify how much of her work day was comprised of typing activities or repetitive tasks such as paperwork. [PX 5, 81:15-24.] Dr. Sonnenberg testified that he did not observe the Petitioner typing at work and did not know how long she was employed as a Human Services caseworker. [PX 5, 82:1-6.]

Dr. Sonnenberg testified that carpal tunnel syndrome is a multifactorial condition that can be caused by various different factors. [PX 5, 84:6-10.] He testified that one single trauma can cause carpal tunnel syndrome and there are instances when a compilation of microtrauma can cause carpal tunnel syndrome. [PX 5, 84:11-21.] Dr. Sonnenberg also testified that there are predisposing factors for carpal tunnel syndrome, including gender, obesity, rheumatoid arthritis, thyroid condition, diabetes and chronic renal disease. [PX 5, 84:22-85:24.] Dr. Sonnenberg testified that one of these factors alone can predispose one to developing carpal tunnel syndrome. [PX 5, 85:9-12.] Dr. Sonnenberg testified that despite obesity being the only predisposing factor in a patient, that obesity does not necessarily cause carpal tunnel syndrome. [PX 5, 137:11-138:15.] Dr. Sonnenberg testified that a predisposing factor merely makes it more likely for a person to develop a condition but doesn't mean they will develop it. [PX 5, 138:13-15.] Dr. Sonnenberg testified that diabetes is the most important risk factor for carpal tunnel syndrome. [PX 5, 85:13-19.] Dr. Sonnenberg testified that he has come across patients with carpal tunnel syndrome whose only predisposing factor was obesity. [PX 86:6-9.]

Dr. Sonnenberg testified that repetitive motions can cause carpal tunnel syndrome and typically, repetitive motions with a wrist in flexion cause an increased risk of developing carpal tunnel syndrome as opposed to repetitive motions with a wrist in extension. [PX 5, 95:7-96:14.] Dr. Sonnenberg testified that typing can be a repetitive motion with a wrist in flexion that can potentially cause carpal tunnel syndrome but not always with a wrist in extension depending on the height of one's keyboard. [PX 5, 99:9-19.] Dr. Sonnenberg testified that carpal tunnel syndrome can also be idiopathic in cause. [PX 5, 101:1-17.]

With regards to the Petitioner, Dr. Sonnenberg testified that the Petitioner had two major risk factors for developing carpal tunnel syndrome in that she is obese and female. [PX 5, 102:14-103:3.] He further testified that he believed the Petitioner was highly sensitive to repetitive stress injury. [PX 5, 103:4-6.] Dr. Sonnenberg cited that the Petitioner's symptoms would only come about as a result of typing and they subsided when she was not typing as the basis for his opinion that typing caused the Petitioner's carpal tunnel syndrome. [PX 5, 102:14-106:8.] Dr. Sonnenberg testified that many times, one cannot exactly pinpoint the cause of carpal tunnel syndrome in a person. [PX 5, 139:14-19.] But Dr. Sonnenberg testified that typing activities at work caused the Petitioner's carpal tunnel syndrome

because the Petitioner's typing at work continued to aggravate her carpal tunnel syndrome symptoms. [PX 5, 139:14-140:18.]

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Dr. Sonnenberg testified that lateral epicondylitis is caused by micro tears of the tendinous structures outside on the outside aspect of the elbow near the lateral epicondyle typically underneath the extensor carpi radialis brevis tendon. [PX 5, 86:13-22.] Dr. Sonnenberg testified that common causes of lateral epicondylitis are poor body mechanics, trying to lift something heavier than one should, and poor muscle tone. [PX 5, 87:5-9.] Dr. Sonnenberg testified that pulling activities or lifting with the palms down can cause lateral epicondylitis, but the motion does not necessarily have to be repetitive in nature to cause lateral epicondylitis. [PX 4, 46:1-19.] Dr. Sonnenberg testified that the Petitioner's bilateral lateral epicondylitis was probably caused by some type of lifting activity. [PX 4, 63:2-12.]

On cross-examination, after having gone through his treating notes, Dr. Sonnenberg opined that the Petitioner's right and left lateral epicondylitis was not causally related to her work activities. [PX 5, 135:23-136:4; *see also*, PX 5, 117:12-118:21, 119:2-10, and 122:8-123-17.] Dr. Sonnenberg testified that he wanted the Petitioner to see a rheumatologist to determine whether an underlying rheumatoid disorder was the cause of her subsequent hand/elbow condition. [PX 5, 129:3-20.]
Dr. Sonnenberg confirmed in his testimony that the Petitioner has a permanent no typing and three pound lifting restriction. [PX 4, 63:23-64:2.]

The Deposition Testimony of Dr. John Fernandez

The evidence deposition of the Respondent's IME doctor, Dr. John Fernandez, was taken on March 21, 2014. Dr. Fernandez testified that there is "no causal or aggravating effect between data entry and the development or aggravation of carpal tunnel syndrome." [RX 11, 10:21-11:4; 20:6-17.] In support of his opinion, Dr. Fernandez testified that there was "no valid scientific evidence that [] a link" existed between carpal tunnel syndrome and data entry, and that "[t]here has been various studies that have shown a lack of a link between carpal tunnel syndrome and data entry . . ." [RX 11, 11:5-13.] Dr. Fernandez testified that his opinion as to data entry type activities stayed the same even assuming the Petitioner was engaged in data entry activities for 36 years. [RX 11:14-24.]

Dr. Fernandez elaborated on his diagnosis of the Petitioner having myofascial pain as of March 30, 2012, the date on which the Dr. Fernandez's IME of the Petitioner took place, stating that "it's basically a constellation of symptoms similar to the ones that she has without any significant objective findings," where the Petitioner complained of "bilateral complaints, multiple levels, meaning hand, wrists, forearm, and elbow and [] even [] shoulder." [RX 11, 13:15-15:17.] Dr. Fernandez testified that myofascial pain is an idiopathic condition and is essentially fibromyalgia in the arms. [RX 11, 14:8-15:17; 16:8-11.]

Dr. Fernandez testified that repetitive activities, including lifting, can cause carpal tunnel syndrome, but that it typically involves force of over 20 pounds and the activity must be done at least one-third or one-half of the workday. [RX 11, 20:20-21:5; 27:18-29:21.] Dr. Fernandez testified that certain repetitive tasks can cause carpal tunnel syndrome, but if there is no element of force involved, there must be repeated flexion and extension through the wrist. [RX 11, 27:18-29:21.] Dr. Fernandez testified that based on his understanding of the Petitioner's duties and responsibilities, none of the Petitioner's work activities involved the type of forceful, repetitive motions that could cause carpal tunnel syndrome. [RX11, 30:20-31:18.]

The Deposition Testimony of Dr. Jay Pomerance

On March 28, 2014, the evidence deposition of Dr. Jay Pomerance was taken. [*See* RX 13.] Dr. Pomerance testified that on the date of his examination of the Petitioner on August 22, 2013, the Petitioner was not exhibiting symptoms of lateral epicondylitis. [RX 13, 10:6-16.] Dr. Pomerance testified that repetitive lifting activities can cause lateral epicondylitis but only if the lifting is done in a certain manner. [RX 13, 11:233-12:5.] Dr. Pomerance testified that repetitive lifting activities which cause overload of the extensor mechanism biomechanically, where the elbow is in an extended posture, the forearm is pronated and the wrist is working against resistance, can initiate or aggravate lateral epicondylitis. [RX 13, 30:2-20.] Dr. Pomerance testified that there wasn't anything in the Petitioner's written job description or the verbal job description that the Petitioner gave to Dr. Pomerance which would lead him to think medically that the Petitioner's job duties had any relationship to the development of lateral epicondylitis. [RX 13, 14:6-15.]

Dr. Pomerance testified that there was no reason why the Petitioner should have permanent work restrictions of no typing activities and a 3 pound lifting restriction and the Petitioner can return to work full duty. [RX 13, 19:23-20:9.]

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Dr. Pomerance testified that whether an activity aggravates certain symptoms does not establish a causal connection relationship. [RX 13, 21:12-22:5.] Dr. Pomerance testified that scientific studies have been conducted on the theory of repetitive stress injury or typing as causing carpal tunnel syndrome which found that patients who were engaged in clerical or keyboarding type activity had no greater incidence of developing carpal tunnel syndrome than the general population. [RX 13:22:6-24.] Dr. Pomerance cited a study done by the Mayo Clinic and published in the Journal of Neurology in 2007 as support for his opinion. [RX 13:22:6-24.] Medical research articles which Dr. Pomerance relied upon in finding that there is no causal relationship between typing and carpal tunnel syndrome were marked as Respondent's Exhibit 4 to Dr. Pomerance's deposition transcript. [*See* RX 13, Ex. 4.]

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet her burden of proof on the issue of whether she sustained a repetitive trauma accident on January 26, 2006 in regards to her bilateral carpal tunnel syndrome as well as to her hand and elbow symptoms following her bilateral carpal tunnel releases, during which time she was at work off and on.

First, the Arbitrator notes that there are many factual inconsistencies between the Petitioner's testimony and her treating medical records [PX 1 & 2], as well as her attendance records [RX 15 & 16], which put the Petitioner's veracity into question. The Petitioner is claiming that she sustained injuries due to repetitive trauma from repetitive work activities. However, the evidence presented at arbitration hearing indicates that the Petitioner's job duties were varied in nature which included, but were not limited to, data entry typing, lifting files, and conducting interviews with recipients of public aid. The Arbitrator also notes the discrepancy in the Petitioner's testimony that she typed 5 hours per day as a Human Services caseworker for the Respondent and Ms. Smith-Mitchell's testimony that the Petitioner typed 3.5-4 hours per day.

The Arbitrator notes the lack of any evidence presented at hearing by the Petitioner indicating the forcefulness of the Petitioner's typing activities.

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Further, and in regards to the Petitioner's post-carpal tunnel release symptoms in her hands and elbows, the Petitioner has not sufficiently proved an accident because the Petitioner's complaints of symptoms in her hands and elbows took place during periods when the Petitioner had been off work, and as such, could not have been caused by a work-related accident. For example, when the Petitioner was off work from July 17, 2009 through May 9, 2010, the Petitioner received a right elbow injection on March 22, 2010. When the Petitioner was off work from June 2, 2010 through March 25, 2012, she received a left elbow injection on October 25, 2010, January 10, 2011, and February 21, 2011; a right hand and right elbow injection on April 4, 2011; a left elbow injection on May 16, 2011; and a right hand injection on November 7, 2011 and January 20, 2012. The Petitioner's own treating doctor could not find an explanation for the Petitioner's hand and elbow symptoms during the periods that the Petitioner was off work, and even referred the Petitioner for rheumatoid testing to determine whether there may have been an underlying rheumatological cause. [*See* PX 1; PX 5, 129:3-20.]

As such, the Arbitrator finds that the Petitioner failed to sufficiently establish a repetitive trauma accident in regards to her bilateral carpal tunnel syndrome, as well as to the Petitioner's post-carpal tunnel release symptoms in her hands and elbows. The Arbitrator's finding for no accident is also based on the finding that the Petitioner did not sufficiently establish causal connection (see below).

2. With regard to the issue of causation, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to her alleged work related accident on January 26, 2006.

The Arbitrator notes that the Petitioner remained symptomatic for carpal tunnel syndrome in her hands as well as had additional symptoms in her elbows after her August 10, 2007 right carpal tunnel release and her November 16, 2007 left carpal tunnel release, and more importantly, after the Petitioner had stopped working for the Respondent for various periods of time. This strongly suggests that the Petitioner's bilateral carpal tunnel syndrome is attributable to some other cause as opposed to her work activities. The Petitioner failed to address or rule out other causes for her symptoms during periods when she was not working for the Respondent.

Further, the Arbitrator finds the opinions of Dr. Fernandez and Dr. Pomerance, the Respondent's IME doctors, more persuasive than the opinion of the Petitioner's treating doctor, Dr. Sonnenberg. Dr. Sonnenberg's sole basis for his opinion that the Petitioner's bilateral carpal tunnel syndrome was work related was that the Petitioner would become symptomatic in the hands upon returning to work after engaging in typing and lifting activities. [PX 5, 139:14-140:18.] However, that an activity merely aggravates certain symptoms is not sufficient to establish a causal relationship. The Arbitrator further discredits Dr. Sonnenberg's opinion because Dr. Sonnenberg did not even know how much of the Petitioner's work day was comprised of typing activities or repetitive tasks such as paperwork [PX 5, 81:15-24]; and did not know how long the Petitioner was employed as a Human Services caseworker. [PX 5, 82:1-6.] These pieces of information are vital for one who is making a causal connection opinion to consider and Dr. Sonnenberg didn't bother to ascertain this information when he surely should have. As such, his causal connection opinion is not given significant evidentiary weight.

Furthermore, the Arbitrator relies on the opinions of Dr. Fernandez and Dr. Pomerance that neither the Petitioner's bilateral carpal tunnel syndrome nor her post-carpal tunnel release symptoms in her hands and elbows were related to the Petitioner's work activities as a Human Services caseworker. The Arbitrator notes that only Dr. Fernandez asked the Petitioner to show her the posture of her hands while she typed. [*See* RX 10.] The Arbitrator finds that Dr. Pomerance reasonably utilized the medical resources cited in his deposition testimony as support for his opinion that patients who were engaged in clerical or keyboarding type activity had no greater incidence of developing carpal tunnel syndrome than the general population. [RX 13:22:6-24.]

As to the Petitioner's post-carpal tunnel release symptoms in her hands and elbows, the Arbitrator notes that the Petitioner's own treating doctor, Dr. Sonnenberg, acknowledged in his deposition testimony that her post-carpal tunnel release symptoms in her hands and elbows were not causally related to her work activities given that the Petitioner's symptoms occurred during periods that the Petitioner was not working for the Respondent. [*See* PX 5, 135:23-136:4; *see also*, PX 5, 117:12-118:21, 119:2-10, and 122:8-123-17.]

3. Based on the Arbitrator's findings above, the remaining disputed issue of the nature and extent of the Petitioner's injury is rendered moot. To the extent that the Petitioner has sufficiently established accident and causation (which she has not), the Arbitrator should only make an award of PPD pursuant to Section 8(e) of the Act. The Petitioner is not entitled to a loss of trade pursuant to Section 8(d)2 of the Act because the Respondent has established at hearing that the Petitioner can return to work for the Respondent as a greeter, which is within the Petitioner's classification as a Human Service caseworker and within the Petitioner's permanent restrictions of no typing and no lifting greater than 3 pounds.

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(c)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eric Gilmore,

Petitioner,

vs.

NO. 09WC 35814

17IWCC0374

City of Chicago

Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

17IWCC0374

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: JUN 20 2017
SJM/sj
5/25/2017
44

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GILMORE, ERIC
Employee/Petitioner

Case# **09WC035814**

17IWCC0374

CITY OF CHICAGO
Employer/Respondent

On 12/6/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4564 ARGIONIS & ASSOCIATES LLC
ALFRED A KORITSARIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

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

17IWCC0374

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Eric Gilmore
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # 09 WC 35814

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **October 28, 2016** and **November 22, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **08/07/2009**, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$72,342.92**; the average weekly wage was **$1,391.21**.

On the date of accident, Petitioner was **48** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$189,316.58** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$189,316.58**.

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

ORDER

- For the reasons set forth in the attached addendum, the Arbitrator finds that Petitioner's injury resulted from an accident that did arise out of and in the course of his employment.

- The Arbitrator further finds that petitioner's current condition of ill being relative to his nose and headaches are casually related to the August 7, 2009 accident at work, but finds that petitioner failed to prove that his psychiatric and emotional complaints are causally related to the August 7, 2009 work accident.

- The Arbitrator finds that Petitioner failed to prove he is entitled to TTD benefits. Respondent shall be given a credit of $189,316.58 for TTD payments for a total credit or $189,316.58.

- The Arbitrator further finds that Petitioner is entitled to have and receive from Respondent the sum of **$664.72** /week for a period of 87.5 weeks, because the injuries sustained caused the partial disability of said Petitioner to the extent of **17.5%** under 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.

David A. Kane
Signature of Arbitrator

December 6, 2016
Date

DEC 6 - 2016

17IWCC0374

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Eric Gilmore, Petitioner,	)	
vs.	)	No. 09 WC 35814
City of Chicago, Respondent.	)	

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties' agree that on August 7, 2009, the Petitioner and Respondent were operating under the Illinois Workers' Compensation or Occupational Diseases Act and their relationship was that of Employer and Employee. The parties agree that the Petitioner gave Respondent notice of the accident within the time limits stated in the Act. The parties agree that Petitioner's earnings in the year preceding the injury were $72,342.92 and his average weekly wage is $1,391.21.

The disputed issues in this matter include: 1) whether Petitioner's accident arose out of and in the course of his employment, 2) whether Petitioner's current condition of ill being is causally connected to this injury or exposure, 3) whether the medical services that were provided to Petitioner were reasonable and necessary, 4) whether Respondent paid all appropriate charges for reasonable and necessary medical services, 5) whether Petitioner is entitled to TTD benefits, 6) nature and extent of Petitioner's injury.

STATEMENT OF FACTS

Petitioner testified he was employed by the, City of Chicago as a construction laborer for approximately 18 years. Petitioner testified that his job duties for the City included water and sewer maintenance and construction. Petitioner testified that on August 7, 2009 at approximately 12:00 p.m. Petitioner was working for the City cleaning a job site. Petitioner testified at that time a back hoe struck him in the face causing him to briefly lose conscious and fall to the ground. Petitioner testified he sought immediate medical treatment and was transported to Loreto Hospital via ambulance. At that time, Petitioner complained of pain, head, nose, eye pain. Petitioner testified he was bleeding on the face, eventually requiring stitches on his nose. There were no records from Loretto Hospital submitted into evidence.

Petitioner testified he followed up with Mercy Works which he described to be a medical agency for the City of Chicago. Petitioner testified he was placed on work restrictions and paid benefits while off work. Petitioner eventually followed up with his primary care physician, Dr. Malone. There were no records from Mercy Works submitted into evidence.

The first medical record submitted into evidence is an operative note dated February 17, 2010, 6 months after the alleged accident. On February 17, 2010 petitioner underwent an open septorhinoplasty and bilateral inferior turbinectomy as a result to his diagnosis of post traumatic nasal airway obstruction and post traumatic nasal deformity. This procedure was performed by Dr. David Morris. (PX 1, Page 74-76)

Petitioner was evaluated by Dr. Mir with Schwab Rehabilitation Hospital seven months later on September 16, 2010. Petitioner reported suffering a blunt head trauma at work. Petitioner reported hitting his head

with a pride bar resulting a loss of consciousness and injury to his face and nose causing him to fall backwards onto concrete. Petitioner reported feeling headaches and pain since that injury. Petitioner underwent an MRI of his brain on August 9, 2010 which was negative. Petitioner was admitted into an Occupational therapy rehabilitation program. Petitioner was discharged by Dr. Mir on October 28, 2010. These records do not document any lost time from work. (PX3)

Petitioner presented to Dr. Yogi Ahluwalia with Sinai Psychiatry and Behavioral Health on November 15, 2010. It was noted that Petitioner had been off work since August 2009. Petitioner claimed that his symptoms began after a work related accident on August 7, 2009. Petitioner reported that his symptoms had gotten progressively worse. Petitioner reported recurrent thoughts about his accident and about an accident of a co-worker who died. Petitioner denied having nightmares though he reported he had flashbacks. Petitioner claimed that he was not sleeping well and was averaging five hours per night every night. (RX2; p.1)

Eleven months later, petitioner presented to Mount Sinai Hospital on October 4, 2011. Petitioner presented as being a 50 year old African American male with a history of a severe head trauma from two years prior. Petitioner also complained of psychiatric problems and was referred for psychiatric admission. Petitioner was admitted into the psychiatric unit at Mount Sinai Hospital. Hospital staff noted Petitioner had circumstantial speech and stated that all of his problems begin two years before after he suffered a head trauma while at work. Petitioner apparently had been seen by seven different doctors and was prescribed medication. Petitioner was assessed with post-traumatic stress disorder and major depressive

disorder. Petitioner was admitted for medication adjustment. Petitioner was released to be followed up by his primary care doctor. (PX1, Page 18-21)

Petitioner continued to treat with Dr. Ahluwalia on a monthly basis through April 9, 2013. Petitioner reported sleeping well of decreasing anxiety. Petitioner claimed that he was unable to exercise because he had a recent foot surgery. Petitioner allegedly continued to complain of severe headaches. There were no comments on Petitioner's ability to return to work. (PX2)

Petitioner began treating with Dr. James Young on August 2, 2011 Petitioner was assessed with a facial injury with post-concussion headaches, psychomotor retardation, and myofascial pain. Petitioner returned to Dr. Young on September 9, 2011. Petitioner continued to treat with Dr. Young through June 29, 2012. Dr. Young noted that he was going to order a functional capacity evaluation. These records do not comment on petitioner's ability to return to work.(PX4)

Petitioner was evaluated by Dr. Landre pursuant to Section 12 of the Act. Dr. Landre drafted a report dated April 24, 2012. It was noted that Petitioner's level of effort during this exam appeared to be "superficially adequate." Formal effort testing yielded abnormal findings indicating that petitioner did not consistently provide its best effort during his testing. Petitioner was administered a self-report screening measured that was specifically develop to detect malingering. On this exam Petitioner's total score was thirty, being markedly elevated above the recommended cut off score of fourteen for identification of an individual susceptive malingering. This indicated that petitioner endorse a high frequency of symptoms that were a typically impatience with genuine psychiatric or cognitive disorders which would raise suspicion for malingering.

Petitioner was also administered a comprehensive personality test, MMPI-2, which upon the results suggested significant over reporting of symptoms. It was noted that Petitioner is likely to be more impaired / distress and was actually the case and would raise question regarding the credibility of petitioner's self reporting. Dr. Landre indicated that he would expect that Petitioner should be able to resume driving and work activity as of the date of this report. It was recommended that because petitioner had such a prolonged absent from work but a gradual resumption of those activities would be recommended at a light duty status at least initially. (RX1)

Petitioner underwent an IME with Dr. Teich on June 13, 2013. Dr. Teich diagnosed the Petitioner with malingering symptoms, opiate abuse, and mixed personality disorder, following an injury to nasalis and family stresses. Dr. Teich noted that from a psychiatric stand point Petitioner was fully capable of returning to work at a full duty status without any restrictions. Dr. Teich noted that Petitioner was at maximum medical improvement with respect to his psychiatric complaints. (RX2)

Petitioner returned to work for the City in June 2013. Petitioner returned to his regular employment as a construction laborer. Petitioner earned the same wages as prior to the accident. Petitioner worked the same number of hours as prior to the accident. Petitioner earned the same benefits as prior to the accident. Petitioner did no require glasses, contact lenses, or eye surgery. Petitioner's headaches and dizziness spells have ended.

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to C (accident), the Arbitrator finds as follows:

At the time of the October 28, 2016 the parties placed the issue of Accident into dispute. This dispute initially arose from the fact that petitioner was missing contemporaneous medical records in support of his accident. On November 22, 2016 the parties stipulated to reopening proofs at which time additional medical records were submitted into evidence from Mount Saini Hospital without objection.

The arbitrator finds that petitioner's testimony is corroborated by the contemporaneous medical records. Therefore, the Arbitrator finds that petitioner did suffer and accidental injury that both arose out of and in the course of his employment with the City on August 7, 2009.

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

With respect to petitioner's alleged mental and emotional injuries, The Arbitrator concludes that Petitioner failed to prove that his current condition of ill being is causally related to the events of August 7, 2009. The medical evidence submitted at trial is vague and incomplete. There are no opinions in the records submitted at trial establishing a link between petitioner's mental complaints and the events of August 7, 2009. On the other hand, the Independent Medical exam with Dr. Landre in 2012, and Dr. Teich in 2013 show clear and convincing evidence of symptom magnification and malingering.

Dr. Landre concluded that Petitioner's level of effort during this exam appeared to be "superficially adequate." Formal effort testing yielded abnormal findings indicating that petitioner did not consistently provide its best effort during his testing. Dr. Landre administered a self-report screening measured that was specifically developed to detect malingering. The recommended cut off score was 14, where petitioner scored 30, raising suspicions of malingering

Dr. Landre also administered a comprehensive personality test, MMPI-2, which upon the results suggested significant over reporting of symptoms. Dr. Landre noted that Petitioner was likely to be more impaired / distressed and was actually the case and would raise question regarding the credibility of petitioner's self reporting of his symptoms. Dr. Landre concluded petitioner could return to work as of the date of April 24, 2012

Furthermore, Petitioner underwent an IME with Dr. Teich on June 13, 2013. Dr. Teich diagnosed the Petitioner with malingering symptoms, opiate abuse, and mixed personality disorder, injury to nasalis and family stresses. Dr. Teich noted that from a psychiatric stand point Petitioner was fully capable of returning to work at a full duty status without any restrictions. Dr. Teich noted that Petitioner was at maximum medical improvement with respect to his psychiatric complaints.

The conclusions of Dr. Landre and Dr. Teich are unrebutted. None of Dr. Ahluwalia's records establish a causative link between the events of August 7, 2009 and his psychiatric symptoms. Dr. Ahluwalia's records do not contain any causation opinions. The arbitrator therefore concludes that petitioner failed to prove that his current condition of ill being is causally related to an August 7, 2009 date of accident.

In support of the Arbitrator's decision with respect to J (medical bills), the Arbitrator finds as follows:

In light of the Arbitrator's findings with respect to accident and causation, the Arbitrator denies Petitioner's claim with respect to all medical services provided.

In support of the Arbitrator's decision with respect to K (temporary total compensation), the Arbitrator finds as follows:

Further, a close review of the medical evidence does not support petitioner's claim for TTD benefits, In each of petitioner's exhibits, the Arbitrator is unable to locate a single record where the treating physician authorizes petitioner off work in any capacity. The Arbitrator notes that petitioner was paid TTD benefits for the period of August 11, 2010 through July 9, 2013 (RX3). It is well established law, however, that a Respondent's payment of workers' compensation benefits is not an admission of liability. 820 ILCS 305/8(a). Respondent remains entitled to all available defenses at the time of trial.

Finally, Dr. Landre concluded that petitioner was at maximum medical improvement as of April 24, 2012. This was confirmed by Dr. Teich on June 13, 2013. As there is no medical evidence to the contrary, the Arbitrator relies on the opinions of Dr. Landre and Dr. Teich. Therefore petitioner's claim for TTD benefits from August 7, 2009 through June 13, 2013 is denied. Respondent shall be issued a credit for any TTD benefits paid prior to arbitration.

In support of the Arbitrator's decision with respect to L (nature and extent), the Arbitrator finds as follows:

The Arbitrator has had an opportunity to review the totality of the evidence in determining Petitioner's permanent disability with respect to an August 7, 2009 accident. Though not supported by any contemporaneous medical records for several months after the accident, petitioner testified he was injured when a back hoe struck him in the face. Petitioner sustained injuries to his head and nose. On February 17, 2010, petitioner underwent an open septorhinoplasty and bilateral inferior turbinectomy as a result to his diagnosis of post traumatic nasal airway obstruction and post traumatic nasal deformity.

Petitioner was paid 204 weeks of TTD benefits, though the medical evidence does not support any lost time from work. The arbitrator is unable to locate a single off work note in petitioner's medical records.

Petitioner returned to full duty work effective June 2013. Petitioner returned as a construction laborer for the City. Petitioner testified he earned his same wages and benefits was before his injury. Petitioner worked the same number of hours per week as before his injury. Petitioner was paid the same benefits as before his injury.

Petitioner testified he continued to treat with a psychologist following his June 2013 return to work. However, petitioner was unable to testify how many times he saw this psychologist. Petitioner was not aware of the psychologist's name or practice. No records were admitted into evidence for dates of service proceeding petitioner's return to work. The arbitrator gives this little weight.

Petitioner denied having to wear contacts or glasses following his alleged injury. Petitioner testified that his migraines and headaches have ceased since his June 2013 return to work. Petitioner testified that his dizziness symptoms have ceased.

Therefore, based on the totality of the evidence submitted at trial, the Arbitrator finds that petitioner sustained permanent disability in the amount of 17.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

In support of the Arbitrator's decision relating to (O), the proofs being re-opened to submit Exhibit 1(a), the Arbitrator finds the following facts:

On November 22, 2016, the proofs in this matter were re-opened. Petitioner's Exhibit 1, which were the medical records from Mt. Sinai Hospital, were admitted during the original hearing date on October 28, 2016. Following that day, it was discovered that several pages were errantly omitted from Exhibit 1. Therefore, the parties stipulated to re-open proofs to enter the missing pages into evidence. On November 22, 2016, Petitioner admitted Exhibit 1(a) which represents the rest of the medical chart from Mt. Sinai Hospital.

ORDER OF THE ARBITRATOR

For the reasons set forth above, the Arbitrator finds that Petitioner's injury resulted from an accident that did arise out of and in the course of his employment.

The Arbitrator further finds that petitioner's current condition of ill being relative to his nose and headaches are causally related to the August 7, 2009 accident at work, but finds that petitioner failed to prove that his psychiatric and emotional complaints are causally related to the August 7, 2009 work accident.

The Arbitrator finds that Petitioner failed to prove he is entitled to TTD benefits. Respondent shall be given a credit of $189,316.58 for TTD payments for a total credit or $189,316.58.

Based on the totality of the evidence submitted at trial, the Arbitrator finds that petitioner sustained permanent disability in the amount of 17.5% loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Evelyn Magpantay,

Petitioner,

vs. NO: 10 WC 2436

17IWCC0383

Vista Health Systems,

Respondent.

DECISION AND OPINION ON REVIEW

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

I. FINDINGS OF FACT

A) Testimony of Petitioner (6/25/15)

Petitioner, a 43 year old registered nurse, testified that she received a Bachelor degree in nursing in her native Philippines in 1993 and that she came to the U.S. in 1995, settling first in Waukegan and now living in Gurnee, Illinois. (T.10-11,16). She indicated she worked as a nurse in several nursing homes and began working for Vista East in 1999. (T.12). She noted she took off a few years to raise her child and returned to Vista East in 2008. (T.14). Petitioner stated that from 2008 to 2009 she worked in the psychiatric unit at Vista West. (T.14). She stated that her duties involved dealing with mental patients, doing bedside nursing, blood draws, CPR/first aid, and coordinating with doctor's and other departments for patient care. (T.15). Petitioner noted that there was a lot of lifting involved since not all of the patients were ambulatory. (T.15). She indicated that every three (3) months she would have to undergo training in the psychiatric unit, and that in college she took psychiatric nursing as one of her specialties. (T.15-16). She stated that she was able to perform all of her duties in 2008 and 2009. (T.16).

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Petitioner testified that on 12/19/09 she was working the third shift from 11:00 pm to 7:30 am. (T.16-17). She noted that at night most patients are sleeping, but that there are some that need medication and that in the morning blood is drawn. (T.17). On the night in question she was assigned multiple patients in the PIT unit, which is the locked unit. (T.18-19). Petitioner noted that one of her patients woke up at 1:00 am asking for medication. (T.19). She indicated the next time she saw him was during 15 minute rounds when he yelled at her and said "I told you not to open that door again." (T.20). She stated that she went to the next room and opened the door, not realizing that the patient who had yelled at her had followed her and was at her back. (T.20). She noted that the patient was about 5'7" to 6' tall and weighed about 170 pounds, while she is 5'2" and 123 pounds. (T.20).

Petitioner testified that she tried to close the door as the patient tried to open it, but that he was stronger than she was. (T.21). She noted that she could see "... the rage from his eyes" as he punched her and grabbed her by the hair and threw her out into the hallway. (T.22). She indicated that she didn't know what happened other than she "bumped [her] face onto the tile floor" and that she was bleeding from her mouth. (T.22). She noted that she tried to get up and went to the corner, but that he was still at her side attacking her with his closed fists until the other CNA saw her and rescued her from the PIT unit and the patient. (T.22-23). She indicated that she believed there were two nurses and two aides working that night. (T.24). Petitioner testified that she had been attacked a month earlier by a female patient while she was doing rounds. (T.23). However, she indicated that she was able to close the door and waited for help, but nobody came. (T.23).

Petitioner indicated that following the incident on 12/10/09 she noticed that her mouth was bleeding and that her arm and both knees hurt. (T.24-25). She stated that she then went down to the emergency room on the first floor and "... said to the nurse that I was attacked by a patient and because I was so terrified I just said, 'I can't go back to that floor again,' I was so terrified." (T.25). She indicated that she told them she was hurting and that "... the first pain that I said was the left wrist. And then both knees." (T.25). Petitioner was given Darvocet for the pain and x-rays were performed of her left wrist and, she believed, her left knee. (T.27-28). She noted that nothing was broken and she was discharged at that time. (T.28). Petitioner stated that she was still feeling pain, including a headache, when she went back upstairs to her floor, so she grabbed her belongings and went back to the emergency room. (T.28-29). She indicated that she also felt dizzy and that she was limping on her right leg. (T.29). She noted that they did a neuro assessment and that she requested a CT scan of her head, but that she was told the radiation would counteract with the medication she was given. (T.29). She was discharged and thereupon drove herself home. (T.31).

Petitioner testified that she then dropped by the dentist where they took x-rays and told her that she "... broke the cap and the teeth inside because inside the cap there is still teeth that is holding the cap." (T.31-32). She noted that the cap was replaced about a month later. (T.32).

Petitioner noted about two days later she followed up with corporate health, as instructed, and "... complained still of the headache and the pain in my neck, the spine, the hip and the knees. And I got bruises that were more visible on the knees already... [and] on my hip part.

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And she ordered a CT scan of the brain." (T.33). The CT scan was negative. (T.34).

Petitioner testified that she then saw her primary care physician, Dr. Bhalala, about three days later with "... the same complaints: headache,... right-eye pain and then my neck and then I am limping on my right leg and I said, 'I am having heart palpitations and I am having jerking movements.'" (T.34). She noted that Dr. Bhalala ordered an MRI of the brain, spine and knees. (T.35). She indicated that she discussed the results with her doctor and that "... he was mostly focused on the neck area... [a]nd the worst is the C-5, I believe, to C-7." (T.35-36). She described the pain as sharp and rated it as a ten. (T.36). Petitioner testified that "... if I move my neck fast I feel dizzy and nauseated. And I have sharp pain with wrong movement. I can feel sharp pain. And there is a pain on the base of my right skull up to the right frontal and right temporal part of my head, and also to my right eye, which is – that's where the pains are, and also pain on my right. Now the right wrist is better. I cannot say there is no pain, but it is better. But the right arm, I still feel the pain on the right arm." (T.36).

Petitioner testified that the pain she was experiencing a few days after the accident is similar to the pain she is still feeling today. (T.36-37). She indicated that as she sits here today (at arbitration) the pain she is experiencing is still an eight to ten, but that with medication it goes down to five. (T.37). Petitioner testified that a few days after the MRIs were taken she was "... still complaining of pain on my knees, and there were still bruises. And ... Dr. Blalala said that I can wear a brace and there is no, like, meniscus tear, but there is, like, a diffusion, effusion." (T.38). Petitioner indicated that she was unable to work at that time, noting that she was "... complaining of the heart palpitations, the jerky movements, the headache, the pain in my neck and on my spine, the hip down to my both knees. And, then, at night I cannot sleep. I'm having night-mares. I feel so – I am crying. I keep on crying. I am so depress[ed]. I feel so hopeless and helpless." (T.38).

Petitioner testified that Dr. Bhalala referred her to a neurologist, a Dr. White, who was not available. (T.39). She was then given the name of Dr. Chhabria whom she saw about three weeks after the accident. (T.39). She noted that she complained to Dr. Chhabria "about the same things" including "... pains from the right eye to the right head, to the base of my skull, to my neck, the my right shoulder and arm, right arm, to my spine, down below the lower part of my ribs, to my right back, right hip, down to my right groin, to the inner thigh and both knees." (T.40). Dr. Chahabria did a neuro assessment, prescribed Aleve for pain and Xanax for anxiety and suggested she see a psychiatrist. (T.40-41).

Petitioner began treating with Dr. Tylkin thereafter. (T.41). She indicated that she told Dr. Tylkin about her physical symptoms – including, right eye pain, blurred vision, headache, neck ache, shoulder and right arm pain – and that "... I was so depressed, that I am always crying. And I was so scared. I'm having nightmares and flashbacks and I cannot sleep at night and I'm always having heart palpitations. And I don't even recognize if it's because of the anxiety or the pain, because both are very active." (T.42). Petitioner denied that this was an anxiety she had experienced before the incident. (T.44). She also noted that the anxiety would come on and she will take her medication and it would subside, only to come back again. (T.44). She indicated that she experiences the flashbacks especially at night when she is resting, noting that she has been in bed for weeks "... because I am really in pain. And it was just coming to my mind and

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it's just there. And then when I sleep the nightmares – the nightmares come every night. Every night. The flashbacks, when I am alone. And it just comes into my mind because I am – I can really feel the pain and all the discomfort." (T.45). She noted that over the past five or six years these conditions have improved with medication "... but without the effect of the medicine it comes back." (T.45). Petitioner testified that she was diagnosed with PTSD, anxiety disorder, chronic pain and depression. (T.46). She noted that following the incident her depression was constant and that currently "[i]t still comes back." (T.46).

Petitioner testified that in addition to psychiatric treatment, Dr. Chhabria recommended that she go back to work far from mentally ill patients, and Petitioner told her that "... I need to see a psychiatrist and I have no teeth yet... [t]hey were still fixing it... [and] [Dr. Chhabria] did not see the MRI results yet and she released me to go to work." (T.49). Petitioner indicated that she discussed this with Dr. Bhalala and he ordered complete bedrest. (T.49). As a result, she did not go back to work. (T.49).

Petitioner then visited a neurologist, Dr. Allen with complaints of right eye pain, "...blurred vision, then right forehead, right temporal, right base of my skull, right sharp pain on my head down to my neck. Then the right-arm pain, then the spine pain, right hip, right – in the groin, right inner thigh, both knees, and even I complained about the calf at that time. I don't know, I felt that it's more, like, numb." (T.50). She noted that Dr. Allen did not follow Dr. Chhabria's suggestion to return to work but ordered physical therapy, suggested an EMG with NCS, a vestibular test and prescribed Sofarin tablets for her dizziness and nausea. (T.51). She indicated that she is still treating with Dr. Allen, as well as Dr. Bhalala, and that she continues to have the same complaints, although the walking is better, albeit with pain in her right hip, groin and thigh. (T.51-52).

Petitioner indicated that she was prescribed physical therapy by both Dr. Allen and Dr. Bhalala and that she received same on both occasions at Vista Rehab. (T.52-53,56). She noted that she was discharged from therapy having met her goals "... but not [for] the vestibular, because, you know, at that time it's really – it's so hard to do therapy with dizziness and feeling nauseated." (T.54-55). She indicated that this is the same dizziness and nausea she experiences to this day. (T.55). Along these lines, she noted that "... if I move my eyes and my neck fast or frequently I feel the nausea and the dizziness. And if I feel anxious I feel the nausea and the dizziness and I feel like I am going to faint. And then it's followed by heart palpitations and depression." (T.55). She stated that she almost lost consciousness once when her child had an accident and she was "... really affected emotionally." (T.55). Petitioner denied experiencing any of these symptoms before the incident. (T.56). She also noted that the therapy would help for a time and then she would go back to what she felt like before. (T.57).

Petitioner testified that she sees Dr. Allen every three months and that he told her that she cannot work. (T.59-60). She also indicated that she was in an automobile accident and that she went to Condell emergency room "...because of heart palpitations... [and] also because of pain ..." (T.62-63). She noted that it was a "small accident" involving another vehicle and her car, and that Condell told her that "... nothing changed from the incident to the present time..." (T.61). She described the car accident as "not hard" and that she "... rear-ended the car [ahead of her], but it's not a big bump or something." (T.62). Petitioner could not recall the date of the

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car incident. (T.63).

Petitioner indicated that she also continues to treat with her psychiatrist, Dr. Tylkin, every month. (T.63-64). She noted that she is still having the same problems with sleeping, flashbacks and heart palpitations, and that her condition has not improved at all. (T.64). She stated that Dr. Tylkin ordered psychotherapy, and that she visits psychologist Dr. Bortnik for same. (T.64-65). She also sees a counselor named Carol Vengenberg every week. (T.65). She noted that she went to Dr. Bortnik "like two times" when her depression and anxiety is worse. (T.66).
She testified that to this day she is still treating with Dr. Bhalala, Dr. Tylkin and Dr. Allen and that none of these doctors have released her back to work. (T.66-67). She also noted the problems for which she is treating with these physicians are related to the incident with the patient in 2009. (T.67).

Petitioner was asked about the neck brace and cane that she had arbitration, and noted that she uses these assistive devices "[b]ecause the cane was given to me by or recommended by the physical therapist at Vista because I'm limping... [a]nd then the neck, the soft neck brace, when I went to Condell because of the terrible neck pain when I move, so one of the discharge orders was to put a neck brace on, as needed." (T.67-68). She agreed that neither Dr. Tylkin, Dr. Bhalala nor Dr. Allen ordered the neck brace; instead, she claimed it was from the emergency room visit not related to her car accident. (T.68).

Petitioner testified that she is still able to drive short distances that she is familiar with "... because it's hard for me to drive because of my headache and my eye pain and I feel dizzy and nauseated and then the heart palpitations, when I get anxious it's there. So it is difficult for me to drive, you know, long distances." (T.69). She indicated that her "significant other" would drive her to her doctor appointments. (T.69).

At the request of Respondent, Petitioner visited Dr. Hartman for a §12 examination and testing. (T.70-72). She noted that on the day of this testing she was "... still having pain. And I'm still feeling, you know, the nausea and vomiting – I mean, I'm not really vomiting, but when I feel anxious that – anxiety makes me feel nauseated and dizzy and then I have this heart palpitation and I still feel so depressed at that time." (T.72).

In addition, Petitioner was interviewed and underwent a neuro exam with Dr. Kessler at the request of Respondent. (T.73). Petitioner noted that at the time of this visit she was "... so sick. I'm still sick. And then I've got all the pains, the dizziness, the headache, the heart palpitation. I am so forgetful." (T.73).

Petitioner agreed that she has not worked as a nurse for six years. (T.74). She testified that "I can't do any nursing job because, first of all, of all the pain; second, because of the dizziness and nausea, the anxiety, the memory problems, the word processing is slow, the depression, the pains, the heart palpitations." (T.74). She also did not think that she could go back to working in a nursing home with older people or work at a desk as a reception nurse in a doctor's office. (T.75). She indicated that she did not believe she could perform these jobs "... because it would be hard for me because you need to move your neck fast, your eyes, you need to be more, you know, attentive, and my problem with focusing and concentration, it would affect my head, my

neck, my face, my depression and my anxiety." (T.75). Petitioner stated that she did not experience these things before the incident in 2009. (T.75-76).

On cross, Petitioner testified that her daughter was born in 2002 and that she took off work for "[p]robably a year...", then agreed it was for a few years following the birth. (T.78-79). When asked about her prior testimony that she returned to Vista in 2008 following the birth of her child, Petitioner claimed that she was still at Vista and "...lost track of the year." (T.78-79).

Petitioner agreed that she has a valid driver's license, owns a car and can drive for short distances; otherwise, her significant other will drive her if she is unable to do so. (T.79-80). She also agreed that she is capable of using a computer, noting that she sometimes uses it for her child in order to "... look something up for her education." (T.80). She indicated that she has one child and that she is now 13 years old. (T.81). She noted that her daughter takes the bus to school and is involved in extracurricular activities, namely band. (T.81). She indicated that she attends winter and spring performances but that she does not attend practices, noting that "I just drive her, because that is a short distance from our house. It's just five minutes away. So I just drive her if there is no school bus, and then I will pick her up." (T.82). She also noted that during the summer she sometimes takes her daughter to tennis practice once a week. (T.83).

Petitioner denied taking any family vacations in the past year. (T.84). She also indicated that she and her significant other do the grocery shopping and that she just needs assistance in carrying heavy bags. (T.84).

Petitioner acknowledged that she had not looked for any jobs or worked anywhere since December of 2009. (T.86-87). In fact, she agreed that she had not filled out a single job application in five and a half years "[b]ecause of all of my symptoms. As I said, the pain, the dizziness, the nausea, the heart palpitations, the memory problems, the headaches." (T.87). She indicated that she believed these symptoms would prevent her from working in an office or at a retail store. (T.87-88). She also stated that she did not think she could work for Vista Health if they offered her a job today. (T.88).

Petitioner indicated that she is receiving Social Security Disability and that she has no other source of income. (T.88). She also noted that she currently takes Norco (every four to six hours as needed), Xanax (twice a day), Cymbalta (once a day), Lisinopril (once a day), Pro-Air inhaler, Ativan (as needed) and Sofarin (every six hours as needed). (T.90).

Petitioner agreed that she is a long-time patient of her primary care physician, Dr. Bhalala, going back 20 years when she first came to this country. (T.91). She noted that Dr. Bhalala had been the one to recommend that she see Dr. Chhabria, whom she has visited on less than five occasions. (T.92). She also agreed that Dr. Chhabria had recommended that she return to work, only in a different wing of the facility. (T.93). However, she did not return to work at that time. (T.93). In addition, she visited Dr. Mercury on one occasion at the recommendation of Dr. Allen. (T.94). She indicated that a friend recommended that she see Dr. Allen. (T.94). She also noted that after having been told to see a psychiatrist she found Dr. Tylkin's name on the internet. (T.95). Furthermore, when the order for psychotherapy was given she asked for a name from Dr. Tylkin and was told about Dr. Bortnik. (T.95). Petitioner testified that she has treated

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the most with Drs. Allen, Tylkin and Bhalala. (T.96).

When asked whether she lost consciousness during the incident in question, Petitioner testified that she was "... dazed or in shock, but I'm not really conscious about when he threw me to the floor... I am conscious when I bumped my mouth already on the floor... When he threw me out, then I rolled, and then, you know, I hit my mouth on the tile floor, with my knee and my arms." (T.97). She agreed that she did not sustain any broken bones as a result of the incident and that she hasn't undergone any surgery, with the exception of the caps on her teeth. (T.97). She also agreed that no other surgery has ever been discussed by any of her physicians. (T.97-98).

When asked about use of the cervical collar, she noted that she wears it when she is in the car and cooking, when "there is some exertion" and she "need[s] some support." (T.98). As far as the cane is concerned, she noted that she has to use it every time she walks because she is limping and her "walking is not balanced." (T.99-100). She noted that Condell emergency room personnel had recommended the neck brace the one time she was there and that the physical therapist had recommended the cane, but no other physician had recommended either. (T.100). Petitioner claimed that she had never experienced headaches prior to December of 2009. (T.101). She also indicated that she had never been depressed prior to December of 2009. (T.102).

On re-direct, when asked whether she had ever experienced headaches before in her entire life, Petitioner responded: "[n]ot this kind of headache." (T.105). She went on to state that "[o]f course, I do have some headaches, but I don't need to take any medication. If I do, that's very, very seldom..." (T.105). She indicated that before she would take Tylenol for a headache, and that now she has a headache every day. (T.106). She also noted that she experiences eye pain "... if I move my eyes, especially going to the left side, I feel the pain and there is, like, blurring of vision if I, you know, if I focus too much on things, like reading." (T.107). Petitioner indicated that she is able to read but can only do it "intermittently", noting that she can last 30 minutes to an hour but that it is hard without any neck support. (T.107). She rated her neck pain at the time of trial as a ten out of ten. (T.107). She described the pain as "[j]ust a dull pain." (T.108).

B) Selected Medical Records

X-rays of the left wrist and left knee performed on 12/19/09 revealed no evidence of a fracture. (PXB).

A brain CT without contrast performed on 12/21/09 was interpreted as negative. (PXB).

In a slip dated 12/21/09, primary care physician Dr. Bhalala indicated that Petitioner was able to return to work "until further notice." (PXB). The Commission notes that it appears Dr. Bhalala meant that Petitioner was ***not*** able to work until further notice.

In a report dated 1/4/10, neurologist Dr. Shakuntala Chhabria noted that Petitioner was physically assaulted by a patient and that "[d]uring the injury, her cap fell off. Her head smashed onto the floor. She had neck and back pain. She was emotionally and physically distraught...

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[S]he went to the ER at Vista West where x-rays were done. She had a bruise to the left hand and knee." (PXC). Dr. Chhabria noted complaints of headaches, neck pain and palpitations. (PXC). He noted that the headaches were on the right side, in the forehead, behind the neck, and around the eyes and are intense (8-9/10). Following his examination, Dr. Chhabria's impression was 1) cerebral concussion, 2) post concussion headaches, 3) anxiety, 4) posttraumatic stress disorder and 5) possible hypertension. (PXC). Dr. Chhabria recommended an EEG, psychiatry and psychological evaluation and an MRI of the brain to rule out any contusions. (PXC).

An MRI of the lumbar spine performed on 1/4/10 was interpreted as normal. (PXA).

An MRI of the thoracic spine performed on 1/4/10 was interpreted as follows: 1) mild thoracic dextroscoliosis; 2) otherwise normal MRI evaluation of the thoracic spine; 3) incidental note is made of a focal syringohydromyelia within the visualized lower portion of the cervical spine cord at the C6-C7 level, pre and post contrast MRI evaluation of the cervical spine was advised. (PXA).

An MRI of the right knee performed on 1/4/10 was interpreted as follows: 1) minimal joint effusion; 2) moderate chondromalacia patella with degenerative subchondral changes in the medial patellar facet; 3) minimal degenerative spur formation along the medial and lateral compartments of the knee; 4) mild grade 2 myxoid signal within the medial and lateral menisci without evidence of grade 3 meniscal tear; and 5) no additional knee pathology identified. (PXA).

An MRI of the cervical spine performed on 1/5/10 was interpreted as revealing: 1) mild broad based central disc protrusions at C3-C4 and C4-C5 abutting the cervical cord but producing no cord effacement; 2) annular disk bulge with superimposed broad based left paracentral disk protrution at C5-C6 producing mild cervical cord effacement and impression upon the left ventral C6 nerve root; 3) 11 x 3 mm syringohydromyelia at the C6-C7 level with no associated surround myelopathy or post contrast enhancement, presumably benign in nature; and 4) straightening of the cervical lordosis suggestive of muscle spasm. (PXA). The Commission notes that the record also contains a previous cervical MRI report dated 5/25/06, or three years prior to the accident, performed as a result of complaints of right sided neck pain at back down through right shoulder with weakness of right hand. (PXH). This prior study was interpreted as revealing 1) no evidence of Chiari malformation, short segment C6-C7 central cord signal abnormality with expansion, most consistent with a syrinx, with a recommendation for further evaluation to rule out underlying cord tumor; and 2) moderate degenerative changes throughout the cervical spine with mild central stenosis at C5-C6. (PXH).

An MRI of the brain with gadolinium performed on 1/5/10 revealed no intracranial mass or hemorrhage, but did note several time foci of increased T2 signal intensity within the right cerebral white matter, with no evidence of acute infarct. (PXB). Otherwise, no additional intracranial abnormalities were noted, although some mild mucosal inflammatory changes were found within the ethmoid and maxillary sinuses. (PXB).

In a report dated 1/8/10, Dr. Chhabria noted that Petitioner was suffering from 1) traumatic brain injury; 2) post-concussion headaches; 3) a marked degree of anxiety; 4) posttraumatic

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stress disorder; 5) cervical and lumbosacral strain. (PXC). Dr. Chhabria also indicated that the patient "... ha[s] been getting night terrors that wake her up three to four hours after sleep." (PXC). Dr. Chhabria recorded that the MRI of the cervical spine showed a disk protrusion at C3-C4 and C4-C5 with an annular bulging disk at C5-C6 and an 11 x 3 mm syringomyelia at the C6-C7 level with no evidence of myelopathy or post contrast enhancement which felt was probably benign in nature. (PXC). He also noted straightening of the cervical lordosis consistent with muscle spasm. (PXC). Following his examination, Dr. Chhabria's recommended continued use of Xanax as needed for anxiety, melatonin for sleep and a visit to a psychiatrist for management of posttraumatic stress disorder. (PXC). Dr. Chhabria also stated that "[f]rom a work perspective, she is advised to do work that is away from patient contact within her limitations." (PXC).

In a slip dated 1/11/10, Dr. Bhalala indicated that "Patient to remain on complete rest until next follow up on 01-25-10." (PXB). In another slip dated 1/19/10, Dr. Bhalala indicated that "Patient to remain on complete rest until next follow up on 02-02-10." (PXB).

In a letter addressed "[t]o [w]hom [i]t [m]ay [c]oncern", psychiatrist Dr. Elen Tylkin noted that Petitioner had been evaluated on 1/27/10 and was diagnosed with posttraumatic stress disorder and major depressive disorder. (PXH). Dr. Tylkin indicated that "[t]hese disorders might have a chronic cause and required continues [sic] pharmacological and psychological treatment. Presently Mrs. Magpantay is on anti-depressive and sedative medications. She was referred for individual psychotherapy. She is temporary [sic] disable [sic] due to the mental disorder. The time of recovery is uncertain and depends on her response to the treatment..." (PXH).

An MRI of the right hip performed on 2/25/10 was unremarkable other than an incidental finding of an intrauterine fibroid measuring approximately 2 cm. (PXB).

In a disability parking placard certificate signed 3/27/10, Dr. Bhalala indicated that due to a diagnosis of cervical and LS sprain Petitioner could not walk without the assistance of another person, prosthetic device, wheelchair or other assistive device. (PXB).

In a Long-Term Disability Attending Physician's Statement dated 4/19/10, Dr. Bhalala noted diagnoses of toothache, knee pain, insomnia, cervical muscle strain, LS strain, cerebral contusion, headache. (PXB). Dr. Bhalala indicated that Petitioner was severely limited physically and incapable of minimum (sedentary) activity, and was slightly limited due to mental impairment. (PXB).

In a report dated 6/21/10, Dr. Elizabeth Kessler noted that she saw Petitioner on 6/7/10 "... for an independent neurological evaluation only." (RX4, Ex.C). Following her interview and review of the records, Dr. Kessler noted that Petitioner "... reports symptoms and inability to function grossly out of proportion to objective evidence of any injury sustained in the 12/19/09 incident. The records indicate that she sustained injury to the caps on her teeth, apparently contusions of her knees and she may also have had neck and back muscle strains. The contusions and muscle strains are temporary injuries that will improve within days and will resolve by about a month." (RX4, Ex.C). Dr. Kessler went on to state that she did not see "...

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evidence of an injury sustained by Ms. Magpantay in the 12/19/09 incident that would account for her continued complaints of pain in her neck, shoulder, back or hip. She did not sustain cervical or lumbar radiculopathies and there is no objective evidence of a physical injury that could account for her various upper or lower extremity complaints." (RX4, Ex.C).

In addition, Dr. Kessler found no evidence that Petitioner sustained a vestibular injury or any injury that could account for the headaches she reports. (RX4, Ex.C). She noted that Petitioner did not sustain a traumatic brain injury as a result of the 12/19/09 incident, since she had no loss or impairment in consciousness, amnesia or other transient neurological deficit at that time. (RX4, Ex.C). Furthermore, Dr. Kessler stated that "[i]t is unclear from the information that I have if Ms. Magpantay has had symptoms that would meet criteria for PTSD. The diagnosis is made in the medical records in the absence of any supporting evidence." (RX4, Ex.C). With respect to Petitioner's claim of a persistently down mood with crying and hopelessness, which could be consistent with major depression, Dr. Kessler indicated that "[m]ajor depression could not have resulted from this incident" and that "... her pain, lightheadness, nausea, memory loss and difficulty focusing cannot be explained by any injury sustained in the incident." (RX4, Ex.C).

Dr. Kessler concluded that "I do not see evidence of physical or brain injury sustained by Ms. Magpantay on 12/19/09 that would prevent her from returning to all of her usual activities, including at work and at home... I do not see an indication of any injury sustained by Ms. Magpantay on 12/19/09 that would prevent her from driving... At this time, prior to my review of her other medical records, I do not see evidence of consequences of the 12/19/09 incident that would prevent Ms. Magpantay from returning to work at least on light duty, with limited contact with patients." (RX4, Ex.C).

In a report dated 7/21/10, and following his testing, licensed clinical psychologist Dr. Michael Mercury noted that Petitioner "... endorsed Severe depression and hopelessness with Moderate Anxiety. Performance on tests measuring effort were mixed. On two tests, effort was deemed appropriate but on the third it was outside of the expected range. As a results [sic], the following scores should be interpreted with caution as they may be underestimating true ability." (PXD). Dr. Mercury noted that "[t]he neuropsychological profile reveal[ed] executive functioning, visuospatial, language and memory. Nonverbal memory was overall intact but demonstrated retrieval memory problems. Retrieval memory problems are often seen with depression which Ms. Magpantay is endorsing here. The possible sleep disorder could be further compromising her cognitive abilities." (PXD). Dr. Mercury recommended 1) a sleep evaluation; 2) follow-up with Dr. Allen, psychiatry and psychotherapy and consider consultation for pain management; 3) talk to child psychiatrist to evaluate and treat daughter "who clearly is having a difficult time with your injury"; 4) "Identify nursing position with less risk"; 5) put a "in case of emergency" listing in cellphone in case she is unconscious; 6) promote memory and brain health by emphasizing basic health habits; and 7) consider neuropsychological evaluation in about 6 months or sooner if clinically indicated. (PXD). Dr. Mercury's diagnosis was "memory loss." (PXD).

Petitioner visited the Condell Medical Center emergency department on 9/30/10 following a motor vehicle accident. Nursing consultation notes from that visit reflect that Petitioner was

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the restrained driver of a car that rear-ended another vehicle, and that her car was going about 5 mph at the time, resulting in no damage to the cars and no airbag deployment. (PXF). Petitioner denied hitting her head or losing consciousness. (PXF). She complained of neck pain, headache and nausea, but denied radiating pain, changes in vision, weakness, numbness, tingling, loss of sensation or vertigo. (PXF). It was noted that the patient "[s]tates she has a h/o chronic neck pain and low back pain s/p being thrown by a patient while she was working as an RN in Dec 2009. Now the same pain is worse after today's accident + nausea now. No vomiting. Arrived immobilized on backboard and c-collar." (PXF). The primary diagnosis was MVA and cervical strain. (PXF).

A CT scan of the cervical spine performed on 9/30/10 was interpreted as revealing 1) reversal of the normal lordotic curve, which may be due to pain or position; 2) mild degenerative changes most severely at C3-4 and C4-5, and 3) no evidence of fracture or subluxation. (PXF).

A CT scan of the head performed on 9/30/10 revealed 1) no acute intracranial abnormalities and 2) chronic maxillary sinus disease. (PXF).

On 1/26/11 Petitioner visited Dr. David Hartman, PhD for a neuropsychological evaluation. (RX2). Following his clinical interview and testing, Dr. Hartman noted that Petitioner "... produced malingered results on *every* test that assessed the validity of symptoms... The likelihood that malingered results on eight tests occurred by chance is virtually nil; the only reasonable explanation for Ms. Magpantay's extreme exaggeration is that it is made in the context of various secondary gains including work avoidance; having others take on aversive household duties and compensation for work disability." (Italicized portion in original) (RX2, p.13). Dr. Hartman stated that while he could not "... rule out the possibility that Petitioner had some psychological reaction to whatever event she experienced at work on December 19, 2009..., her presentation in [his] office, including trying to force herself to cough until she gagged, was so extreme and unrealistic that it would never be found in an ambulatory patient. Her current presentation renders completely speculative any possibility of initial or ongoing psychological symptom development. There is no possibility of neuropsychological symptom development related to the event in question." (RX2, p.14).

Furthermore, Dr. Hartman indicated that "[t]here is currently no credible reason for Ms. Magpantay to remain away from employment and no credible psychological argument for light duty... If the claimant insists she is afraid of working in a psychiatric unit, consider nursing duties in a non-psychiatric unit." (RX2, p.14). Dr. Hartman stated that "[t]he only diagnosis that can be made to a reasonable degree of neuropsychological and psychological certainty based on objective data is Malingering with factious features." (RX2, p.15). When asked whether there is a causal relationship between Petitioner's current condition and the incident on 12/19/09, Dr. Hartman responded: "[o]nly in the sense that the alleged incident provided Ms. Magpantay with an opportunity to globally malinger symptoms." (RX2, p.15). Dr. Hartman also indicated that "Ms. Magpantay's symptoms of PTSD are malingered. She is willing to admit to any symptoms that she infers may enhanced [sic] a diagnosis of PTSD, even (in the case of her MENT results) when those 'symptoms' do *not* actually occur in any significant frequency among genuine PTSD patients[]."(Italicized portion in original) (RX2, p.15).

In a Long-Term Disability Attending Physician's Statement dated 4/15/11, Dr. Bhalala noted diagnoses of cervical sprain, LS sprain, cerebral contusion and post traumatic syndrome. (PXB). Dr. Bhalala also indicated that Petitioner was "... severely limited & must remain on bed rest." (PXB).

Petitioner visited the Condell Medical Center emergency department on 12/1/11 complaining of "... exacerbation of chronic neck pain. Pt states she turned her head today and the pain became significantly worse. Pt c/o of feeling light headed. + Nausea and two episodes of emesis..." (PXF). The impression was "[p]ain in neck." (PXF).

In a letter dated 1/24/12 and addressed to "[t]o whom it may concern", Dr. Tylkin diagnosed Petitioner as suffering from PTSD and major depressive disorder. (PXL, Ex.2). She noted that she prescribed antidepressants and anti-anxiety medication and that Petitioner received "... Cognitive-Behavior and EMDR therapy in order to desensitize her trauma triggers. I also provided her with psycho education and supportive therapy." (PXL, Ex.2). Dr. Tylkin noted that in her opinion "... Ms. Magpantay's disorder is a result of the work incident on December 19, 2009 and she is not capable to return to full duty to the same working environment at this point." (PXL, Ex.2).

In a letter dated 8/15/12 and addressed to "[t]o whom it may concern", Dr. Tylkin reiterated her diagnosis of PTSD and major depressive disorder, noting that "[h]er illness [is] chronic, [she] is] incapacitated and require[s] a long term pharmacological and psychological treatments." (PXL, Ex.3). Dr. Tylkin went on to note that "[p]resently Mrs. Magpantay receives anti-depressive and sedative medications... She was referred for individual psychotherapy. She is disabled due to the mental disorder." (PXL, Ex.3).

In a "Confidential Report of Psychological Evaluation" dated 10/31/12, Dr. Karina Bortnik, Psy.D diagnosed major depression due to chronic pain, generalized anxiety disorder, headaches, chronic hip and shoulder pain, and declines in memory and daily functioning skills. (PXM). Dr. Bortnik noted that Petitioner was experiencing "...severe vegetative and psychological symptoms of depression including sleeping a less than usual [amount], loss of appetite, loss of interest and pleasure, indecisiveness, worthlessness, fatigue, crying and excessive self-criticism. Ms. Magpantay also presents with significant symptoms of anxiety, which include fears of the worst happening and of losing control, nervousness, feeling scared and terrified, heart pounding and racing, being unable to relax, unsteady, and having difficulty breathing when nervous. Adpatively, Ms. Magpantay also demonstrated weeknesses as compared to her peers in the areas of community use, functional academics, health and safety, leisure and self-direction. In addition to her current symptoms,... [s]he described that after having been traumatized at work, she could never feel herself again due to chronic pain, inability to work and hopelessness. Ms. Magpantay's neurological declines manifested in her memory, deficits in executive functioning seem to have exacerbated her depression and negativity towards herself and her future." (PXM).

In a narrative report dated 2/17/14, Dr. Neil Allen at Consultants in Neurology at no time during course of his treatment from September of 2010 through September of 2013 "... did I find any significant disorders of memory except for the patient's symptomatic complaint of loss of

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memory… A neuropsychological evaluation has been done; however, I do not claim at this time that the patient has any significant neuropsychological disturbances, evidence of clear-cut memory loss that is of an organic or structural nature, and that is consistent other than the patient's fear, hesitancy and slowness in perception of processing which were a natural result of the terrible situation that faced her at Vista in the psychiatric unit." (PXG). Dr. Allen stated that he did not agree with Dr. Chhabria's diagnosis "… that the patient necessarily had a cerebral concussion, although it was within the original differential diagnosis. I do agree with the concept of anxiety, hypertension and posttraumatic stress disorder." (PXG). Dr. Allen went on to opine that "… it is more probable than not that Evelyn Magpantay has suffered from posttraumatic stress disorder related to her injury and directly related to her injury of 2009 in the Psychiatric Ward of Vista Health Services. It is my opinion that she has been affected in a long-term manner by the aforementioned trauma; that she indeed did hit her head by virtue of the fact that her upper jaw was injured, and is documented by her dentist, enough to fracture an incisor and to loosen her bridge." (PXG). In addition, Dr. Allen was of the opinion that Petitioner was "… suffering from pain in her leg that causes her to use a cane to avoid discomfort and make it easier for her to walk." (PXG).

In an office note dated 1/10/15, Dr. Bhalala recorded that Petitioner had mild depression based on the depression screening, that she continues to have problems and pain with her right leg as well as pain on both sides of her neck, headaches and pain in her legs radiating down to the legs. (PXB). The assessment at that time was 1) cervical disc syndrome, 2) depressive disorder, 3) unspecified backache, 4) post traumatic amnesia. (PXB).

In an office note dated 3/14/15, Dr. Bhalala recorded continued complaints on both sides of the neck, pain over the lower back, ongoing complaints "… of anxiety and the depression and the frustration from the recurrent pain." (PXB). The assessment was 1) cervical disc syndrome, 2) depressive disorder, 3) unspecified backache, 4) post-trauma response. (PXB).

In an office note dated 4/11/15, Dr. Bhalala noted Petitioner's complaints of pain over both sides of the neck, recurrent headache and continued lower back pain. (PXB). The assessment was 1) cervical disc syndrome, 2) unspecified backache, 3) post-trauma response. (PXB). This appears to be the last office note of Dr. Bhalala prior to arbitration.

C) Testimony of Dr. Neil Allen (8/28/14)

Dr. Allen is board certified in psychiatry and neurology as well as internal medicine and disability evaluation. (PXI, Dep.Ex.A). Dr. Allen noted a diagnosis of cervicogenic headache, post-traumatic stress disorder, and various myofascial pain syndromes. (PXI, p.15). He indicated that he did not believe Petitioner was capable of working as a registered nurse given the symptoms she was having as of 2/22/10. (PXI, p.10). Dr. Allen opined "… within a reasonable degree of medical and surgical certainty that the most probable, and, in fact, the only probable cause of Mrs. Magpantay's complaints and symptoms [including neck and hip pain] was the incident that she sustained on – December 19, 2009…" (PXI, p.16).

When asked whether he felt Petitioner could return to work as a registered nurse, based on her physical abilities, Dr. Allen responded: "Well, I don't know… if you take a look at the post-

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traumatic stress disorder issue and the fears that she has, there is a tremendous fear in going back to doing what she's doing. And the issue of her being a psychiatric nurse I think might be different than her going back to nursing in any role. And that's part of the picture. But she's got issues of depression, issues of stress, issues of anxiety, issues of palpitations to the heart, and tachycardia. She also has chronic pain, which is being perpetuated in part by her anxiety and other emotional situations which occurred as a result of the trauma she sustained." (PXI, pp.17-18). He noted that Petitioner "... could be affected by the medications that she's currently taking. And therefore, pharmacologically... there might be some restriction in her ability to work" as a nurse, and that "[o]n an emotional basis, she also suffers from the depression and fearfulness of being accosted in a manner similar to that which she was in that December day. So there is the emotional component as well. From the physical component, whether she – she walks from time to time with a cane, because I think she has gradually become invalided. She has become an invalid secondary to her tremendous emotional distress that she has gone through." (PXI, pp.19-20).

In addition, Dr. Allen noted that he believed Petitioner "... wears a neck brace because she has pain. And to her, each of these things are crutches. They are both physical crutches and emotional crutches." (PXI, p.20). When asked whether he felt it was reasonable and necessary for Petitioner to wear a neck brace, Dr. Allen stated: "I think if it relieves her discomfort, then it is a valid and competent reason for wearing it." (PXI, p.21).

Dr. Allen opined that "[i]f it hadn't been for the incidence of December of 2009, [Petitioner] would be currently continuously working." (PXI, p.21). Dr. Allen also appears to take issue with Dr. Kessler's opinion to the affect that Petitioner did not sustain an injury on 12/19/09 that would account for complaints of neck, shoulder, back or hip pain. (PXI, pp.22-23). He also disagreed with Dr. Kessler's opinion that Petitioner did not meet the criteria for post-traumatic stress disorder, noting that while he is not a psychiatrist he had been "informed" and had "discussed" Petitioner's problem with her psychiatrist and he would "... have to rely upon Mrs. Magpantay's psychiatrist to make that clinical diagnosis with a reasonable degree of medical and surgical certainty." (PXI, pp.23-24). He went on to opine that "... more probably than not there is a direct and causative relationship between the injuries sustained by Mrs. Magpantay and her current state of ill being. And it is directly and indirectly related to her injuries, given the fact that she had a prior cervical spine injury, which did not cause her to have cervical spondylosis. And it was enough trauma to cause her to have a syrinx, which is a cleft in her spinal cord. And that may have been aggravated by the injury described on December 9th." (PXI, p.26). Dr. Allen concluded that "[a]ll those conditions contribute to her difficulty in being able to sustain [her] occupation as a nurse prescribing medical care in the State of Illinois." (PXI, p.26).

On cross, Dr. Allen agreed that his diagnosis at the time of his evaluation in September of 2010 was cervicogenic headache, post-traumatic stress disorder and various myofascial pain syndromes. (PXI, p.27). He also indicated that even though he is not a psychologist he believes he is "... qualified as being sufficiently versed in post-traumatic stress disorder to have received not only a Colonel's Medal and an award from the United States Military for [his] contribution to the war effort ..." (PXI, p.29). Dr. Allen eventually acknowledged that he did not review the emergency room records following the accident, but instead received the history of injury from

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the Petitioner herself. (PXI, pp.32-34). In addition, Dr. Allen noted that syrinx of the cervical spine shown on MRI was "[e]ither current, congenital or due to a prior trauma. But it was not related to this accident." (PXI, p.34). He also agreed that Petitioner did not sustain a brain injury as a result of the 12/19/09 incident. (PXI, p.36).

When asked his opinion as to whether Petitioner could return to work as a registered nurse in the psychiatric unit, Dr. Allen stated: "I don't think she would be able to return to a psychiatric unit. I think it's too emotionally traumatic for her... But in addition, I think she might be able to return in some administrative nursing role if she was qualified to do it. I think it would be very, very difficult for Ms. Magpantay to have direct patient contact [specifically with psychiatric patients]. And I think that she walks around and she is very fearful." (PXI, pp.45-46). He also agreed that "[i]t could be potentially beneficial to return a patient to the source of the stress. But that's where the source of stress is evident, not where it's creeping out of every corner... I have no way to predict with Ms. Magpantay. I am not there." (PXI, pp.47-48).

Dr. Allen testified that he did not think that Petitioner had memory problems at the time of his evaluation in December 2013 and that he "... never found any memory problems at all in Mrs. Magpantay when [he] examined her", although he noted that she is "... on multiple medications that can affect her memory..." (PXI, pp.48-49). He also indicated that "[i]f I would have thought there was a reason for her not to be [driving], I would have restricted her driving." (PXI, p.51).

D) Testimony of Dr. Elen Tylkin (5/9/13 & 6/20/13)

Dr. Tylkin is a medical doctor who attended Khabarovsk State Medical School in Russia and did her psychiatry residency at the Finch University Chicago Medical School. (PXL, Ex.1). Her CV indicates that she was board eligible in 2001 and passed Part I of the boards in 2010. (PXL, Ex.1). She is currently a full-time attending physician at Stroger Hospital where she practices general psychiatry. (PXL, p.7). She noted that about 10% of her practice deals with individuals with PTSD. (PXL, pp.10-11).

Dr. Tylkin indicated that her initial evaluation of Petitioner was on 1/27/10. (PXL, p.11). Dr. Tylkin diagnosed Petitioner as suffering from PTSD and major depressive disorder on Axis I and found that she was functioning at 50 percent. (PXL, p.15). Dr. Tylkin testified that Petitioner "... was suffering with consequence of psychological trauma as well as the physical trauma. She felt that she was not able to work. She has had problems in family and then social problem related to the event that happened at work." (PXL, p.18). Dr. Tylkin indicated that she related this all back to the trauma. (PXL, p.18). Dr. Tylkin referred Petitioner to Dr. Bortnick for psychotherapy. (PXL, p.18). Dr. Tylkin agreed that Petitioner was unable to work at the time of her first visit given that Ms. Magpantay was in severe distress and "... had psychomotor retardation. Very depressed, crying." (PXL, pp.19-20).

When asked whether she would recommend that a person not work if they were taking medications such as Vicodin and Xanax, Dr. Tylkin responded: "[i]t's something I'd have to discuss with patient, if the patient is able to work", noting that it was a "[v]ery big concern" but

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that a person could work. (PXL, p.22). She went on to state that it was "[o]ne of [her] concerns" in regards to Petitioner's inability to work. (PXL, p.23).

Dr. Tylkin continued to treat Petitioner thereafter, noting as of August 2010 that Ms. Magpantay was to remain off work. (PXL, p.37). Dr. Tylkin noted that Petitioner always came to her office with a cane and bearing a cervical collar, which Dr. Tylkin noted she did not prescribe. (PXL, p.36). By September of 2010 Petitioner was still complaining of nightmares, depression, an inability to walk long and forgetfulness. (PXL, p.37). Dr. Tylkin stated that a global function assessment at that time revealed that Petitioner was functioning at 40 percent, which Dr. Tylin noted was "pretty low." (PXL, p. 40). Dr. Tylkin also noted that "40 is somebody who has a moderate to severe psychological impairment... So it means don't have motivation to do things. If she tried to do things, it takes long time to complete. Not able to concentrate. Always get distracted. Not able to tolerate stress. Don't want to leave house. In very bad condtion." (PXL, p.41).

Dr. Tylkin testified that when she saw Petitioner again in October of 2010 Petitioner felt "... even more depressed. Has crisis of relationship with her boyfriend. Afraid that he will leave her alone and she will be without support." (PXL, p.42). Along these lines, Dr. Tylkin agreed that Petitioner's condition was causing stress in her relationship. (PXL, p.43). She indicated that at the time of her visit on 12/18/10, Petitioner continued to be off work because of the accident, and that she complained of constant headaches, was limping, felt hopeless and restless, and had crying spells. (PXL, pp.48-49). Dr. Tylkin noted that none of Petitioner's conditions had improved by the time she saw her next in January 2011. (PXL, p.50).

At the time of her visit on 4/30/11 Dr. Tylkin noted that Petitioner complained of palpitation and panic attacks, but that sleeping, her flashbacks and limping were better. (PXL, p.56). She noted that this was an improvement but that it did not increase her ability to return to work. (PXL, p.57). By August of 2011 she was complaining of hip pain, shortness of breath, palpitations, poor sleep, nightmares and depression. (PXL, p.61). In September 2011 Dr. Tylkin noted that Petitioner's condition had not improved after nearly 20 months of treatment. (PXL, p.63).

Dr. Tylkin was shown her 1/24/12 report. (PXL, p.67). She noted that when she first saw Petitioner her complaints were mostly psychological, but that her report now also included muscle, cervical, hip and knee pain. (PXL, p.70). She indicated that these complaints are still with her today. (PXL, p.70). She also agreed that her statement in this report, to the affect that Petitioner's disorder was chronic and required long-term treatment, was still true. (PXL, p.74). Dr. Tylkin stated that she did not have any information about a previous psychiatric history. (PXL, p.70).

Dr. Tylkin agreed that her diagnosis of PTSD and major depressive disorder was made based on clinical appearance, detailed history of present illness, medical history and mental status. (PXL, p.71). Dr. Tylkin was of the opinion that these conditions and the treatment she prescribed were related to the 12/19/09 incident. (PXL, pp.72-73).

When asked whether she still believes that Petitioner is capable of returning to full duty

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work, Dr. Tylkin testified: "Okay. So no. When I saw her last time, it was April 27th, crying. I am tired. I don't know what happened. I am confused. She always says, 'My future never be, I am not the same person as I was before. I am not sure about my future. I am alone. I used to work hard. I was able to make good money to support my family, but not any longer.'" (PXL, p.76). Tylkin also noted that as of 5/9/13 Petitioner was still unable to work, and that this inability to work was related back to the 12/19/09 accident. (PXL, p.77).

Dr. Tylkin was shown her report dated 8/15/12. (PXL, p.86). She noted that her opinion on that date was that Petitioner was unable to work as a nurse or any other job at that time. (PXL, p.87). Dr. Tylkin indicated that "... with this combination of physical, psychological and, you know, social factors, she is not able to work" and that "... all we see now is [it is] related to the trauma that happened in December." (PXL, p.88). She also stated that it is still her opinion that Petitioner's illness is chronic, incapacitating and requires long-term pharmacological and psychological treatment. (PXL, p.88).

Dr. Tylkin noted that in February of 2013 Petitioner told her that "I will die if I force myself to work, because I am not ready." (PXL, p.92). Dr. Tylkin indicated that she has seen Petitioner on two other occasions since February of 2013 – namely, in March and April of 2013. (PXL, p.93). On cross, however, Dr. Tylkin noted that she saw Petitioner three more times – on 3/23/13, 4/27/13 and 5/25/13. (PXL, p.127). She indicated that Petitioner should remain off work, and that her current inability to work is related to the 12/19/09 work injury. (PXL, pp.93-94). She also stated that she did not see Petitioner returning to work in the near future. (PXL, p.94). Dr. Tylkin agreed that her diagnosis of PTSD related back to the 12/19/09 accident, and that as a result Petitioner is unable to perform her duties as a nurse. (PXL, pp.94-95). In addition, she indicated that she did not believe Petitioner was a malingerer. (PXL, pp.105-106).

On cross, Dr. Tylkin indicated that the history of concussion came from the patient, and that she [Dr. Tylkin] did not have any objective records noting a concussion at that time. (PXL, pp.116-117). Dr. Tylkin testified that Petitioner was unable to work when she first saw her "[b]ecause of posttraumatic stress disorder, major depressive disorder, anxiety disorder, pain disorder." (PXL, p.131). When it was pointed out that some people with these conditions work, Dr. Tylkin responded: "[w]ith her condition, not ... [b]ecause she's not able to – because of her mental disorder, she is not able to focus, to sustain concentration, to make independent decision. Not able to deal with routine work related stress, with supervision, keep attendance persistently... Plus she's taking medication, very strong medication." (PXL, pp.131-132).

Dr. Tylkin was asked to read her notes from her last visit with Petitioner on 5/25/13. They are as follows: "Complain of headache every day. It start on the skull, from front of skull goes to front of her head, affects her vision, she has blurry vision, neck pain and pain in the middle of spinal cord. And goes down to her extremities, inner thighs and both knees and she has numbness in – numbness and tingling sensation. Feels depressed. Crying on and off and not able to concentrate. Having anxiety palpitations. Not able to sleep, wakes up in the middle of the night and has nightmares. Has heart palpitations. Might sleep not more than 2 or 3 hours, per night. So I ask her about rapid eye movement treatment, if she tried it. She said she tried, but she gets dizzy and she has nausea when she tried it and anxiety is the same. So treatment didn't help. Able to function at home when taking medication. When stop taking medication,

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has more symptoms of anxiety and depression. When she's cooking or opening something she has a headache and neck pain." (PXL, pp.133-134). Dr. Tylkin noted that she suspected that "... part of [Petitioner's] pain might be explained by her depression ...", noting that "[d]epression could cause physical pain." (PXL, p.134).

When asked whether Petitioner's condition had essentially remained unchanged since her initial visit in 2010, Dr. Tylkin indicated that it "fluctuated" or waxes and wanes, and that the last time she saw her "... it was certainly not better." (PXL, pp.134-135). Dr. Tylkin also agreed that for each of her visits during the last three years she has essentially asked Petitioner about her complaints and prescribed her medications. (PXL, p.136).

Dr. Tylkin was of the opinion that Petitioner could not return to psychiatric nursing. (PXL, p.143). When asked whether she ever took Petitioner off work completely, Dr. Tylkin indicated that "... each time she was here, I give her medical leave of absence, every month." (PXL, pp.144-145). She also agreed that her removal of Petitioner from work was based solely on her psychiatric condition and not her physical condition. (PXL, p.146). Upon further questioning about Petitioner's ability to return to work, and the benefit therefore, Dr. Tylkin noted that "I encourage her to do more things, go back to normal life. That you are intelligent, you are educated ..." but that they only talked about the "... possibility [of returning to work], ... I never said to her, you are ready to go to work." (PXL, pp.157-158). Dr. Tylkin did not believe that a desire to remain off work was fueling Petitioner's reported symptoms, noting that Petitioner had "... been working before for 10 years... I think she was motivated to work, to make a career, to do better, to be a good nurse. And she did her job well before. How can I say that she now didn't have motivation?" (PXL, p.158). Dr. Tylkin indicated that she disagreed with Dr. Hartman's conclusion that Petitioner was a malingerer. (PXL, p.171).

Dr. Tylkin acknowledged that she had never performed any validity tests that gauged whether Petitioner was malingering, "[j]ust clinical observation", which she maintained was "objective testing. (PXL, p.163). When asked whether she could relate the depression to the work accident, Dr. Tylkin responded: "I think it's related. Maybe it's through posttraumatic stress disorder." (PXL, p.166).

E) Testimony of Dr. David Hartman, PhD (10/11/13)

Dr. Hartman is a clinical and forensic neuropsychologist and psychologist. (RX3, p.4). At the request of Respondent, Dr. Hartman examined Petitioner on 1/26/11. (RX3, p.6). Following his examination and testing, Dr. Hartman noted that diagnostically Petitioner "... does not have post-concussion syndrome. She doesn't have credible PTSD. What she has is a malingered presentation, a consciously feigned presentation. And there's some what are called factitious features meaning, that she is attempting to present herself with medical symptoms that are also not credible." (RX3, p.35). He noted that Petitioner "... has gone on with these symptoms far longer than mild concussion patients might typically recover. She is not a credible narrator of her symptoms, and there is some form of secondary gain attached to her symptoms. So her diagnosis much better supports a diagnosis of malingering than it does post-concussion syndrome." (RX3, p.37).

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When asked, from a neuropsychological standpoint, what if any condition Petitioner developed as a result of the December 2009 incident, Dr. Hartman stated: "... I think it's plausible to think that immediately, post her assault, she did experience some degree of pain and discomfort, maybe soft tissue injury or headache at that time. To the extent that that was consistent with concussion, one typically sees recovery from that from about two to six weeks. After that, I don't see there would be any evidence for longer-term presentation." (RX3, p.38). Dr. Hartman felt that he was dealing with "... pre-existing psychiatric disorder or a malingered presentation that is being sustained for work avoidance and the possibility of compensation." (RX3, pp.39-40). He also indicated that "[t]here's really no treatment for somebody who's feigning their symptoms for reward..." and that "[t]here's no credible evidence that [Petitioner] requires [psychological] restrictions." (RX3, pp.40-41).

On cross, Dr. Hartman agreed that a single, traumatic event can cause PTSD if it is "sufficiently severe." (RX3, p.49). He noted that Petitioner "... certainly didn't [have PTSD] when I saw her. Whether she had a temporary pain or stress syndrome at the time of her injury, I think that's plausible but not when I saw her." (RX3, p.49). He also noted that "[t]he symptoms should have largely resolved by the time that I had seen her." (RX3, p.49). Dr. Hartman indicated that Petitioner "... says her symptoms are exactly the same after these two-and-a-half years of treatment, which would lead a reasonable diagnostician to suspect that, perhaps, these are the wrong treatments or that she really doesn't have what she says she has." (RX3, p.50).

F) Testimony of Dr. Elizabeth Kessler (11/20/14)

Dr. Kessler is a board certified neurologist with a subspecialty in behavioral neurology, which is the same thing as neuropsychiatry. (RX4, pp.5-6). At the request of Respondent Dr. Kessler examined Petitioner on 6/21/10. (RX4, p.7). Dr. Kessler indicated that the evidence shows Petitioner did not suffer a brain injury as a result of the accident. (RX4, pp.9-13). Dr. Kessler noted that the tiny foci of increased signal noted on the brain scan performed on 5/10/10 were "nonspecific" and are "very common", and that they "would have no neurological significance. It wouldn't be evidence of brain injury. It wouldn't be anything that would correlate with any of the symptoms she was referring to." (RX4, pp.19-20). She also stated that the MRI of the cervical spine performed on the same date revealed degenerative changes as well as syringohydromyelia in the spinal cord, which she noted were also seen on a prior MRI scan in 2006, and which was a congenital abnormality that "... was not causing any symptoms." (RX4, p.21). She agreed that this was neither caused nor aggravated by the incident. (RX4, p.21). She also indicated that "[s]omebody who had a big spinal cord contusion could be left with syringomyelia. That obviously did not occur here." (RX4, p.21).

Dr. Kessler disagreed with Dr. Tylkin's diagnosis of PTSD, noting that "[m]ost of the information is lacking" in the latter's notes and that what Petitioner "... reported to [Dr. Kessler] that [she] asked [Petitioner] in more detail would not meet criteria for PTSD." (RX4, p.29). Dr. Kessler also stated that "[a]ccording to the DSM-IV-TR at that time, [Petitioner's nightmares] should be specifically of the incident", and that Ms. Magpantay's reported nightmares "... had nothing to do with anything like this incident", such as being chased by something and her parents who had died." (RX4, pp.29-30).

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In addition, Dr. Kessler indicated that Petitioner's claim that she was so depressed and cheered up by nothing could be a symptom of depression, not PTSD, and that "... if somebody had major depression, then the same symptoms can't be used to say that they also have PTSD (RX4, p.30). Likewise, she stated that Petitioner's report of constant crying, feeling frustrated and hopeless dids not correlate to PTSD. (RX4, pp.30-31).

Dr. Kessler testified that "[a]t the time that [she] saw [Petitioner], she had no physical or psychiatric problems that would have prevented her from driving." (RX4, p.31). She went on to state that Petitioner provided "...various explanations for her difficulty driving. She did not have objective evidence of anything wrong with her neck that would have prevented her from turning her head. She did not have objective evidence or symptoms of a vestibular abnormality that would account for any of her dizziness that could have interfered with her ability to drive." (RX4, pp.31-32). Dr. Kessler stated that this would apply "...from the time of this incident on", based on the medical records and what Petitioner described to her. (RX4, p.32).

Dr. Kessler indicated that Petitioner's complaints of dizziness and nausea, etc. were not evidence of something that was causally related to the incident, noting that "Ms. Magpantay has a number of symptoms, pain, weakness, tingling, dizziness, other symptoms that do not actually correspond to evidence of a physical explanation for the symptoms, so I wouldn't tell her she's not feeling what she says she's feeling, but there isn't a physical basis for what she says she's feeling." (RX4, p.33).

Dr. Kessler also noted that the testing and physical examination did not reveal evidence of vestibular dysfunction, including the vestibular imbalance evaluation done at Vista Medical Center East on 3/18/10, and the fact that she exhibited no abnormal eye movements or nystagmus. (RX4, pp.34-35). As a result, Dr. Kessler testified that "...the records do not provide evidence, nor did my evaluation provide evidence, that Ms. Magpantay had vestibular dysfunction due to this incident." (RX4, p.36).

Dr. Kessler indicated that even though Petitioner brought a cane with her to the evaluation "[s]he could walk – her gait was the same with or without holding the cane. There is clearly no evidence of any injury to her back or her leg that would account for any of her leg symptoms... So she did not require a cane for any injury that caused right leg weakness or for any other injury that she sustained. She didn't get a brain injury, a vestibular injury, low back lumbar radiculopathy, a leg injury, anything else that could have accounted for that." (RX4, p.38).

With respect to her neurological examination, Dr. Kessler noted that Petitioner did not have any consistent abnormalities with respect to memory or cognition and that her cranial nerves appeared to be normal, although she noted that Ms. Magpantay "... repeatedly had blinking for which there was no physical explanation..." (RX4, p.39). She noted some "mild reduction in cervical range of motion, which would not have any specific relationship to this incident." (RX4, p.39). In addition, Dr. Kessler indicated that the tenderness to light touch that Petitioner exhibited over the right cervical midline, right upper back, shoulder and right low back was "not physiological" and "would not have a physical explanation." (RX4, p.39). Dr. Kessler also noted give-way on strength testing of both upper and lower extremities, and that Petitioner "... reported the loss of vibratory sensation that...couldn't result from any kind of physical problem."

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(RX4, pp.39-40). Furthermore, Petitioner exhibited normal coordination and "... reported patchy reduction of pin sensation over both of her upper extremities that also did not follow any kind of neuroanatomical pattern and would have no physical explanation." (RX4, p.40).

When asked if Petitioner exhibited any residual disability with respect to her host of complaints, Dr. Kessler testified that "[i]nitially, what the records reflect is that Ms. Magpantay had some contusion, some bruises, which would clearly be painful. These would be temporary soft tissue kind of injuries. She may have had some muscle strain associated with it. That also would be temporary, so any symptoms related to this, and I'm not a dentist, so I'm not going to comment on that, but any other symptoms related to this would resolve, typically, within a week or two, sometimes taking up to about a month. There is no evidence of any injury that she sustained in this incident that would explain headaches, neck pain, back pain, right leg pain, weakness, any numbness or tingling, or any other symptoms that persisted for weeks or months after this." (RX4, pp.41-42).

In addition, Dr. Kessler indicated that "... bedrest would not be used for a muscle strain kind of pain" and that "... even if someone has a concussion, bedrest is not helpful. They should not be forcing themselves to try to do things that are too taxing and exhausting, but that's very different than bedrest. There is no indication for complete bedrest in this situation." (RX4, p.52).

Based on his examination and review of the record, Dr. Kessler opined that there was no evidence of a vestibular injury, cervical lumbar left or right upper extremity, and/or lower extremity residual injuries resulting from the incident in December of 2009. (RX4, p.56). In addition, while Dr. Kessler noted that "[i]t's a little hard to tell because of the vagueness of the medical records...", he believed that Petitioner did not have symptoms of PTSD. (RX4, p.56). Dr. Kessler stated that "[i]n general, Ms. Magpantay reports symptoms that are considerably out of proportion to objective evidence of any kind of pathology." (RX4, p.56). Dr. Kessler also felt that Petitioner "... could work. If she was very anxious about returning to the job she had had, she could still return – I was waiting for some more medical records that I didn't actually get, but, clearly, she was able to be employed in a full-time position at the time that I saw her." (RX4, p.57).

On cross, Dr. Kessler indicated that treating patients with PTSD is part of her practice. (RX4, p.59). She noted that treating PTSD patients is part of her expertise and that she is also on a traumatic brain injury team. (RX4, pp.59-60). Dr. Kessler agreed that Dr. Tylkin's handwritten notes are difficult to read, but she did not agree that there would be more evidence to substantiate the PTSD claim if they were easier to read. (RX4, p.61). She noted that "[t]he part of the record that I can read are the clear parts where the information is lacking that would support that diagnosis. And it's not because of her handwriting, it's because there is no information provided." (RX4, p.61). Dr. Kessler noted that Dr. Tylkin "clearly" did not take proper notation, but that she [Dr. Kessler] "... also evaluated Ms. Magpantay as far as whether she had PTSD or not, and I did not find it, after doing a more complete evaluation." (RX4, p.61).

Dr. Kessler agreed that Petitioner had what could potentially be perceived as a life-threatening event occur to her. (RX4, pp.61-62). When asked whether Petitioner should go back to working as a psychiatric nurse, Dr. Kessler testified: "I don't know that I have enough

information at this point to know. She, clearly, could be employed in a full-time position at the time that I saw her. I think I wanted to have more information to be able to make the determination of particularly what kind of work she could do, but, as far as being able to work in a full-time nursing position, I did not see a reason why she could not do that." (RX4, p.63).

Dr. Kessler indicated that he did not believe Petitioner suffered any mental illness as a result of the incident. (RX4, p.63). She did concede, "[a]s hypothetical in general", that it was possible that anxiety alone can be so great that it would prevent somebody from being able to engage in employment. (RX4, p.64). However, Dr. Kessler agreed that there was nothing in her examination which showed that Petitioner's anxiety was of such a level that she shouldn't work. (RX4, p.64). When asked whether Petitioner could have hit her head at the time of the accident, Dr. Kessler stated that "... she hit her teeth on the floor. That's – the face is kind of part of the head, yeah. It doesn't mean that somebody had a brain injury." (RX4, p.65).

II. CONCLUSIONS OF LAW

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 236 Ill.2d 132, 142, 337 Ill.Dec. 707, ___, 923 N.E.2d 266, 271 (2010).

In the present case, the Arbitrator found that "... as a result of the accidental injuries sustained on December 19, 2009 she sustained physical injuries consisting of multiple contusions and sprains to the neck, knees and left wrist and the injury to the lip and teeth, and psychological injuries of anxiety and depression." (Arb.Dec., p.12). With respect to Petitioner's physical injuries, the Arbitrator determined that Petitioner reached maximum medical improvement ("MMI") as of the date of Dr. Kessler's examination on June 21, 2010. (Id., p.10-11). However, with respect to Petitioner's psychological injuries – specifically, anxiety and depression, and not PTSD -- the Arbitrator determined that Petitioner had reached MMI as of the date of Dr. Hartman's deposition testimony on October 11, 2013.

The Commission modifies the decision of the Arbitrator to find that the more appropriate date on which to base a finding of MMI with respect to Petitioner's psychological injuries would be the date of Dr. Hartman's §12 examination, January 26, 2011, and not the date of his deposition testimony. As a result, the Commission finds that Petitioner was temporarily totally disabled from 12/19/09 through 1/26/11, for a period of 57-5/7 weeks.

Furthermore, based on the above, the Commission finds that Petitioner failed to prove her entitlement to medical expenses after January 26, 2011, or the date of MMI. Along these lines, the Commission once again relies on the opinion of Dr. Hartman and the evidence of malingering found not only at the time of his examination, but which is also replete in the record.

Finally, the Commission modifies the Arbitrator's award to find that Petitioner sustained permanent partial disability to the extent of 20% person-as-a-whole, pursuant to §8(d)2 of the Act. Not unlike the Arbitrator, the Commission questions the severity of Petitioner's ongoing disability, particularly with respect to her various complaints of pain and psychological issues.

17IWCC0383

More to the point, the Commission finds unpersuasive the opinions of Drs. Bhalala, Tylkin and Allen and chooses instead to rely upon the opinions of Drs. Kessler and Hartman as to Petitioner's current medical condition and capacity to return to work. Indeed, but for the aforementioned concerns as to malingering and secondary gain, the evidence would seem to indicate that Petitioner is more than capable of returning to a full-time nursing position, albeit maybe not as a psychiatric nurse. As a consequence, the Commission finds that Petitioner failed to prove that she suffered a loss of her regular occupation, as the Arbitrator had determined. As such, the Arbitrator's permanency award is excessive under the circumstances. The Commission further notes that since the date of accident (12/19/09) preceded the effective date of the amendment (9/1/11), an analysis pursuant to §8.1b of the Act is not required.

All other aspects of the Arbitrator's decision are otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $787.66.68 per week for a period of 57-5/7 weeks, from 12/19/09 through 1/26/11, 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 the reasonable and necessary medical expenses through 1/26/11 pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 20% 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 $68,000.00. 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: JUN 26 2017
o:4/24/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAGPANTAY, EVELYN
Employee/Petitioner

Case# **10WC002436**

VISTA HEALTH SYSTEMS
Employer/Respondent

17IWCC0383

On 8/28/2015, 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 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1600 MALMAN, STEVEN J LAW OFFICES
TERRENCE DAVEY
205 W RANDOLPH ST SUITE 1040
CHICAGO, IL 60606

0560 WIEDNER & McAULIFFE LTD
JASON T STELLMACH
1 N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

17IWCC0383

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Evelyn Magpantay
Employee/Petitioner

v.

Vista Health Systems
Employer/Respondent

Case # 10 WC 02436

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 Friedman**, Arbitrator of the Commission, in the city of **Waukegan**, on **June 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 19, 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 **$61,437.48**; the average weekly wage was **$1,181.49**.

On the date of accident, Petitioner was **43** years of age, *single* with **1** dependent child.

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

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

Respondent shall be given a credit of **$44,221.48** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$44,221.48**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $950.00 to Dr. Tylkin, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $787.66/week for 198 6/7 weeks, commencing December 19, 2009 through October 11, 2013, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $44,221.48 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 250 weeks, because the injuries sustained caused the 50% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner benefits that have accrued from December 19, 2009 through June 25, 2015, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

August 27, 2015
Date

AUG 28 2015

Statement of Facts

Petitioner, Evelyn Magpantay, testified that on the date of accident she was employed by the Respondent, Vista Health System, as a registered nurse in the psychiatric ward of the Vista East Medical Center. She testified that she received a BA in nursing from the Philippines in 1993. She had courses in psychiatric nursing in college. She came to the United States in 1995. Prior to her present employment, she was employed by several nursing homes. She also worked for Vista Health in the telemetry unit in 1999. She then suspended her employment with the respondent for approximately six years following the birth of her daughter. When Petitioner returned employment with Respondent in 2008, she was assigned to the psychiatric unit. Her duties were to deal with patients with mental conditions including bedside nursing, blood draws, CPR, firsts aid, IVs, and coordinating with the doctors in other departments. Her job required lifting and moving patients.

Petitioner testified that on December 19, 2009, her shift began at 11:00 p.m. She had worked the night shift for prior employers as well. Petitioner described an incident which occurred at approximately 1:00 a.m. involving a patient. Petitioner testified that she had provided a patient with medication. When she opened the door to his room to check on him, he yelled for her to close the door. The patient followed Petitioner into the next room where he pushed her, then lifted her and threw her into the hallway. Petitioner described the patient as approximately 5'6" to 5'7", weighing 170 pounds. Petitioner testified that she tried to run to another room but the patient was able to open the door before she could lock it. Petitioner was grabbed by the patient, again, and thrown out of the second room onto the hallway floor. She testified that the male patient was much larger than her. She testified that she felt immediate pain in both knees, her mouth/front teeth and left wrist. She was rescued by another CNA. She testified she was terrified.

Petitioner testified that she presented to the Vista West Emergency Room. The records report that she arrived at about 4:00 a.m. (Px A, p 170). She provided a history of the attack by the patient and was complaining of pain in both of her knees, her mouth (particularly upper and lower lips), front teeth and left wrist (Px A, p 172). The intake form records complaints of left wrist pain, a mouth contusion with loosened front cap on tooth, and left anterior knee pain. The report states no neck pain, back pain (Px A, p 167). There were bruises on her bilateral knees. X-ray of the left wrist showed no evidence of fracture. X-ray of the left knee showed no evidence of fracture (Px A, p 175-176). The clinical impression was contusion of mouth, contusion left knee and ligamentous strain of left wrist (Px A, p 169). Petitioner was discharged 6:45 a.m. and advised to follow up with her primary care physician.

The Petitioner testified that upon leaving the emergency room she went back to the psychiatric floor to retrieve her belongings when she had headaches and dizziness. She then went back to the emergency room at 7:30 a.m. The chief complaint was dizziness. The examination did not reveal any evidence of head trauma. Petitioner reported no loss of consciousness. Examination of the cervical spine recorded no tenderness to palpation. No spasm or tenderness. There was full range of motion without pain. The back examination found no evidence of trauma. Petitioner was noted to be anxious and expressed anxiety over work place issue with potentially violent patients. This was the second event in two years and she did say she is afraid to go back to job environment. The petitioner was given Tylenol for her headache and was discharged with a diagnosis of multiple contusions (Px A, p 153-157). Petitioner testified that she had requested a CT scan of the head, which was denied. Petitioner was discharged, and she drove herself home from the emergency department.

Later on December 19, 2009, Petitioner saw her dentist Dr. Milagros Galvez. His records document a broken lip and teeth. A dental bridge had fallen out of her mouth due to her hitting the floor. A new "URPD" (upper right partial denture) was ordered and installed. Dr. Galvez' saw Petitioner on five occasions from December 19, 2009 through March 29, 2010 (Px E).

On December 21, 2010, Petitioner saw Dr. Gopal Bhalala. She testified that Dr. Gopal Bhalala had been her primary care physician for almost 20 years. Dr. Bhalala's records were admitted as Petitioner's Exhibit B. Petitioner underwent a brain CT scan on December 21, 2009 which was negative (Px B, p 223). Petitioner saw Dr. Bhalala on December 28, 2009 and December 31, 2009. Dr. Bhalala completed a Vista Health System medical provider assessment and treatment form on December 31, 2009. The diagnosis was multiple soft tissue injuries, headache, right knee sprain, cervical sprain, and LS sprain. Dr. Bhalala indicated that Petitioner could not work until June 28, 2010 and was to remain on complete rest until further notice (Px B, p 204).

Petitioner underwent a MRI of the right knee on January 4, 2010 which showed minimal joint effusion and degenerative changes. Petitioner underwent a MRI of the thoracic spine which showed mild thoracic dextroscoliosis, with an otherwise normal MRI evaluation of the thoracic spine. Petitioner underwent a MRI of the lumbar spine which was described as normal (Px B, p 218-222).

At the referral of Dr. Bhalala, petitioner attended an initial evaluation with Dr. Shakuntala Chhabria on January 4, 2010. Dr. Chhabria's records were admitted as Petitioner's Exhibit C. Petitioner reported headaches with an intensity level of 8-9/10. She also complained of neck pain, palpitations. Petitioner informed Dr. Chhabria that she had been markedly depressed, fearful, and was unable to return to work. Dr. Chhabria diagnosed a cerebral concussion, post-concussion headaches, anxiety, post-traumatic stress disorder, and possible hypertension. With respect to treatment, Dr. Chhabria ordered an EEG, psychiatry and psychological evaluations, and a MRI of the brain. Dr. Chhabria recommended that Petitioner return to her office after an evaluation with a psychiatrist (Px C).

On January 5, 2010, petitioner underwent a MRI of the cervical spine. The MRI showed mild broad-based central disc protrusions at the C3-C4 and C4-C5 levels. Moderate degenerative changes throughout the cervical spine had previously been found in 2006 (Px A, p 115). That same day, petitioner underwent a MRI of the brain, which showed several tiny foci of increased T2 signal intensity in the right cerebral white matter. Dr. Kessler and Dr. Allen both testified that said foci are very common, with no neurological significance, and are not evidence of a brain injury.

Petitioner attended a follow up evaluation with Dr. Chhabria on January 8, 2010. Petitioner described night terrors that awoke her following three to four hours of sleep. Dr. Chhabria noted the cervical MRI findings of a disc protrusion at C3-C4 and C4-C5 with an annular bulging disc at C5-C6. Dr. Chhabria recommended continued Xanax for anxiety, melatonin for sleep, a MRI and a CT scan of the brain, and treatment with a psychiatrist for management of post-traumatic stress disorder. With respect to work, Dr. Chhabria wrote, "From a work perspective, she is advised to do work that is away from patient contact within her limitations." Petitioner testified that Dr. Chhabria had recommended that she return to work to a unit other than the psychiatric department. On January 21, 2010, petitioner underwent an X-ray of the right femur. The X-ray yielded normal findings (Px B, p 213). Petitioner underwent an MRI of the right hip at the prescription on Dr. Allen on February 25, 2010. The MRI was normal (Px H, p 226).

Petitioner attended an initial evaluation with Dr. Tylkin on January 27, 2010 (Px K). During the January 27, 2010 visit, Dr. Tylkin diagnosed post-traumatic stress disorder, major depressive disorder, headaches, and asthma. On February 4, 2010 Dr. Tylkin provided a note with the diagnosis of Posttraumatic stress disorder and major depressive disorder. The conditions will require continued pharmacological and psychological treatment. She prescribed anti-depressive and sedative medications and referred Petitioner for individual psychotherapy. She opined that Petitioner was disabled due to the mental disorder (Px H, p 209). Petitioner attended nearly monthly sessions with Dr. Tylkin through March, 2015. Petitioner testified that during her sessions with Dr. Tylkin, she at times discusses relationship problems in addition to the December 19, 2009 event.

Petitioner attended Physical therapy at Vista Health from February 10, 2010 through May 26, 2010 (Px A, p 94). Petitioner received treatment for various complaints of pain including right knee, groin pain and neck pain. Vestibular and Balance Evaluations were requested by Dr. Neil Allen and vestibular therapy was also introduced into the therapy regiment. Petitioner participated in physical therapy at Vista Medical Center East through her discharged from on May 26, 2010 (Px A). From June 2, 2010 through June 30, 2010, Petitioner attended 12 sessions of physical therapy at Gurnee Medical Center for complaints of headaches, dizziness, anxiety, depression, neck pain, low back pain, and right shoulder and right hip pain (Px J). Petitioner reported improvement in her low back and hip complaints. Petitioner was also able to walk more comfortably and overall felt stronger.

Petitioner was examined by Dr. Michael Mercury, a clinical psychologist, on July 21, 2010 on referral from Dr. Allen (Px D). Petitioner informed Dr. Mercury of the attack at work and her treatment and symptoms. She also reported that, in January or February 2010, her daughter had reportedly tried to choke herself with a scarf. Dr. Mercury administered several tests over a two-day period of July 21 and July 23, 2010. In the impressions section of his report, Dr. Mercury noted that Petitioner's performance on tests measuring effort was mixed. On two tests, petitioner's effort was deemed appropriate, but on the third it was outside of the expected range. Dr. Mercury noted that petitioner's scores therefore should be interpreted with caution, as they may be underestimating true ability. Dr. Mercury recommended a sleep evaluation; follow up treatment with Dr. Allen, physical exercise, intellectual stimulation, social connectedness, and consultation with a child psychiatrist for her daughter. Dr. Mercury's plan states that Petitioner should identify a nursing position with less risk (Px D, p 43-50).

On September 30, 2010, Petitioner was transported by ambulance to the Condell Medical Center emergency department following a motor vehicle accident (Px F). When she arrived, Petitioner was restrained on a backboard and was wearing a cervical collar. She reported pain in the neck and low back. A CT scan of the head was described as normal. A CT of the cervical spine showed no evidence of fracture, subluxation or pre-vertebral soft tissue swelling. With a primary diagnosis of a cervical strain, Petitioner was discharged from the emergency department that same day. Petitioner testified that she received a cervical collar at Condell. She has continued to wear this collar. Petitioner was seen at Condell emergency room on December 1, 2011 for complaints of dizziness. She was prescribed morphine and valium and discharged on December 2, 2011 (Px F).

Petitioner testified she has continued to treat with Dr. Bhalala on a near monthly basis through the present (Px B, p 15-137). On October 12, 2012 Dr. Bhalala prepared a disability report stating the injuries Petitioner incurred included a cervical muscle strain, LS strain, headaches, migraines, vertigo, post-traumatic stress syndrome, post cerebral contusion, right knee pain, anxiety and low back syndrome. Dr. Bhalala stated

Petitioner was house confined and on complete bed rest. Dr. Bhalala has continued to diagnose low back pain and cervical disc (herniated) (Px B, Pg. 78). His records document continued prescription of Hydrocodone.
Dr. Bhalala diagnosed her with mild depression. His records include notations that Petitioner denies any memory loss.

Petitioner was first evaluated by Dr. Neil Allen of Consultants in Neurology on February 22, 2010 (Px H). Petitioner was referred to Dr. Allen by a friend (Px H, p 218-219). Dr. Allen authored a narrative report of his treatment and opinions (Px G) on February 17, 2014 summarizing his findings, treatment and opinions and testified by evidence deposition on August 28, 2014 (Px I). Dr. Allen testified that his initial diagnosis was depression, loss of self worth, post traumatic stress disorder, pain localized to her neck, head and back. Her major complaints were right leg, spine, head and neck injury with hip and groin pain (Px I, p 10-11). Dr. Allen was acting as a triage doctor; you listen to the complaints and send the patient off to doctors who can help them (Px I, p 13). He diagnosed cervicogenic headache, post traumatic stress disorder and various myofascial pain syndromes (Px I, p 15). He opined that these conditions were causally connected to the December 19, 2009 incident (Px I, p 16). Dr. Allen testified he does not know if Petitioner could return to work as a nurse based upon her physical abilities. He testified that the medications she is taking will cause drowsiness, dizziness and cognitive difficulty. Dr. Allen testified that he does not think Petitioner has memory problems. She is on medications that can affect her memory (Px I, p 48). She has depression and fearfulness which is an emotional component (Px I, p 18-20). He testified she might be able to return to some administrative nursing. Dr. Allen agreed that it is possible that attempting to return to work could benefit Petitioner (Px I, p 45-46). Petitioner testified she is now seeing Dr. Allen every three months.

Dr. Allen testified that the syrinx had nothing whatsoever to do with her signs and symptoms (Px I, p 12), was probably of a congenital nature (Px G, p 3) and also testified that the incident was enough trauma to cause her to have a syrinx that may have been aggravated (Px I, p 26) and also that the syrinx was not related to this accident (Px I, p 34). Dr. Allen testified he is not a psychiatrist. He would need to rely upon the psychiatrist to make the clinical diagnosis of post traumatic stress disorder (Px I, p 24). He also testified that he is qualified to make the diagnosis (Px I, p 28-31). He testified that the lumbar MRI and MRI of the brain were normal. He opined that Petitioner did not sustain a brain injury or a cerebral concussion (Px I, p 35-36, 39). He did not find give away weakness because Petitioner is not weak (Px I, p 42-43).

Dr. Elen Tylkin testified by evidence deposition on May 9, 2013 and June 20, 2013 (Px L). Post traumatic stress disorder requires four categories: a life threatening situation, severe distress, flashbacks, and avoidance behavior. The diagnosis is arrived at through a standard psychiatric interview (Px L, p 8-10). This examination is the patient's subjective answers to questions and the doctor's objective observation (Px L, p 123). Dr. Tylkin diagnosed Petitioner with post traumatic stress disorder on January 27, 2010. She was suffering with the consequence of psychological trauma as well as physical trauma. Petitioner felt she was unable to work. She has had problems in family. Dr. Tylkin testified that this related back to the trauma (Px L, p 17-18). She prescribed Zoloft and Xanax. Petitioner also received Vicodin from Dr. Bhalala. Dr. Tylkin referred Petitioner for psychotherapy with Dr. Bortnick (Px L, p 18-19). Petitioner had slow motor activity. She was in severe distress. She was very depressed (Px L, p 19-20). The medications will make the patient sluggish, not able to concentrate, sleepy, dizzy. A person could work with the medication but it would be a concern (Px L, p 22). Petitioner reported she had a neurological condition, syringeomelia (Px L, p 27-28). This was a concern. Petitioner continued Lexapro and Xanax (Px L, p 28). Dr. Tylkin testified that Petitioner's complaints were headache, nightmares, anxiety, panic attacks, palpitations, can't breathe. Driving provoked

more anxiety. Lexapro did have some improvement, but not much (Px L, p 30). Dr. Tylkin testified to her monthly sessions through December, 2010. Petitioner was referred to Dr. Bortnick for psychotherapy. On October 23, 2010, Petitioner also discussed her crisis with her boyfriend. Petitioner's condition was causing stress in the relationship. This is not related to the work accident but is related to her depression (Px L, p 42-43. 124-125). A year into the treatment, Petitioner was still unable to return to work (Px L, p 50).

Dr. Tylkin testified that she continued to treat Petitioner. She authored the correspondence dated January 24, 2012 and August 15, 2012 (Px L, Ex 2, 3) addressing Petitioner's diagnosis, treatment and disability status and the causal connection of her condition to the December 19, 2009 incident. Dr. Tylkin opined that Petitioner is still unable to work (Px L, p 77). By February, 2012 there has been no positive change in Petitioner's condition. Dr. Tylkin opined that as of August, 2012, Petitioner is not able to work as a nurse or any other job (Px L, p 87).

Dr. Bortnick provided a report of the Psychological Evaluation dated October 31, 2012. She noted the testing was at the referral of Dr. Tylkin because of Petitioner's growing decline in memory, mood and overall functioning. The behavioral observations record that when tasks got harder, Petitioner appeared somewhat disoriented and distraught. She took longer than average to calm down and return to task. Petitioner undertook a battery of tests. The results appeared to be valid. She performed in the low average for verbal comprehension, borderline in perceptual reasoning, low average in working memory, borderline in processing speed, visual and auditory memory were impaired. The assessment revealed that Petitioner is experiencing severe vegetative and psychological symptoms of depression, severe anxiety. She has a pessimistic outlook towards herself and the future and has a state of hopelessness, isolation and a sense of loss (Px M, p 25-29).

Dr. Tylkin testified that she last saw Petitioner May 25, 2013. Petitioner continued on medications. She cannot work. This is related to the December 19, 2009 accident. Petitioner cannot work because she is not able to focus, to sustain concentration, make independent decisions, deal with routine work related stress, with supervisors, and keep attendance persistently (Px L, 131). Dr. Tylkin is not prescribing narcotic pain medication (Px L, p 132). Dr. Tylkin notes no gross memory or cognitive impairment (Px L, p 164). She testified that she does not think the Petitioner is a malingerer (Px L, p 171). Dr. Tylkin has continued to see Petitioner monthly through at least March 21, 2015 (Px K, p 23).

At Respondent's request, Petitioner attended Section 12 medical evaluation with Dr. Elizabeth Kessler, a neurologist, on June 21, 2010. Dr. Kessler authored a report, containing a summary of Petitioner's medical treatment to date, as well as petitioner's subjective complaints (Rx 4, Ex 2). Dr. Kessler concluded that Petitioner's symptoms and inability to function were grossly out of proportion to the objective evidence of any injury sustained in the December 19, 2009 incident. Dr. Kessler did not see any evidence of an injury sustained by Petitioner in the December 19, 2009 incident that would account for continued complaints of pain in the neck, shoulder, back, or hip. Dr. Kessler found no evidence of a vestibular injury, and there was no objective evidence that would correlate with her reported dizziness or nausea. Dr. Kessler opined that petitioner did not sustain a traumatic brain injury during the December 19, 2009 incident, and noted that Petitioner did not sustain a loss or impairment in consciousness. While Petitioner demonstrated some memory deficits at the time of the June 21, 2010 evaluation, she was able to provide a detailed history from memory and had none of the other cognitive deficits that she reported, including word-finding difficulty or impaired comprehension. With respect to the diagnosis of post-traumatic stress disorder, Dr. Kessler explained that the diagnosis was made in the medical records which she had reviewed in the absence of any

supporting evidence. Dr. Kessler did not find evidence of a physical or brain injury that would prevent Petitioner from returning to all of her usual activities, both at work and at home. She further saw no evidence that would prevent petitioner from driving.

Dr. Kessler testified by evidence deposition on November 20, 2014 (Rx 4). She testified that Petitioner's symptoms were not indicative of a brain injury (Rx 4, p 11). The tiny foci revealed during the brain scan are very common, with no neurological significance, and would not be evidence of a brain injury (Rx 4, p 19). The syringiohydromyelia was seen on the 2006 MRI and is congenital (RX 4, p 21).

Petitioner described having loss of vibratory sensation to one side of her sternum and one side of her forehead, which could not happen physically (Rx 4, p 23). Dr. Kessler testified that for the nightmares and flashbacks to be symptoms of post-traumatic stress disorder, they need to be related to the specific incident that caused the post-traumatic stress disorder. Without more detail within Dr. Tylkin's records that indicates the substance of these events or the frequency with which they occurred, the notes do not support this diagnosis (Rx 4, p 26). Dr. Kessler testified that Petitioner told her that she did not want to continue her job as a psychiatric nurse because it was difficult to also care for her child (Rx 4, p 32). Dr. Kessler did not believe petitioner required a cane (Rx 4, p 38). During a neurological examination, petitioner did not have any consistent abnormalities regarding memory and cognition. Dr. Kessler testified that Petitioner demonstrated reduction of cervical range of motion and tenderness to light touch over the right cervical midline, upper back, shoulder and low back which she opined was not physiological (Rx 4, p 39). Petitioner reported to Dr. Kessler that she had experienced slurred speech for four months, but there was no mention or explanation of this in the medical records (Rx 4, p 44).

Dr. Kessler opined that Petitioner sustained contusions and bruises with a muscle strain. There is no evidence of any injury that would explain headaches, neck pain, back pain, right leg pain, weakness, any numbness or tingling or any other symptoms that persisted for weeks or months after the date of accident (Rx 4, p 42). Dr. Kessler opined that Petitioner did not have a concussion (Rx 4, p 53). The MRI and EMG did not support a finding of cervical radiculopathy (Rx 4, p 54-55). Dr. Kessler opined that Petitioner reported symptoms that were considerably out of proportion to objective evidence of any kind of pathology and did not support a diagnosis of post traumatic stress disorder (Rx 4, p 56). Dr. Kessler opined that petitioner could work in a full time position (Rx 4, p 57).

Petitioner attended a Section 12 medical examination with Dr. David Hartman, a medical and forensic neuropsychologist, on January 26, 2011 (Rx 2). Dr. David Hartman testified by evidence deposition on October 11, 2013 (Rx 3). He testified that Petitioner's responses during the structured inventory for the malingering symptomatology test suggested concern that Petitioner's self-report may be distorted or not credible (Rx 3, p 19-20). During the Green's memory complaints inventory test, Petitioner's findings resembled an extreme pattern of memory symptom admission that was much more similar to people who are malingering memory impairment rather than people with genuine memory impairment (Rx 3, p 21-22). During the medical symptom validity test, Petitioner's scores were lower than children who were given the French version of the test and did not speak French and also worse than children whose mean IQ is in the mentally retarded range or than chronic pain patients, and people with severe brain injury or neurologic disease (Rx 3, p 24-25). During the computerized assessment response bias test, Petitioner's score was so low that there was no real disease or injury that would explain it (Rx 3, p 27). During the Morel emotional numbing test, Petitioner had more errors than real post-traumatic stress disorders, very old people, and schizophrenics (Rx

3, p 28-29). The Health Improvement battery was an extreme presentation which could be somatization, a dramatic presentation or malingering (Px 3, p 32).

Dr. Hartman opined that Petitioner did not have post-concussion syndrome or a credible post-traumatic stress disorder (Rx 3, p 35). From a neuropsychological standpoint, Dr. Hartman opined it was plausible that, as a result of the December 2009 incident, petitioner sustained some degree of pain and discomfort, consistent with a soft tissue injury or headache. He did not diagnose any long-term presentation, and instead diagnosed a malingered presentation (Rx 3, p 38). Dr. Hartman opined that there was no credible evidence that Petitioner required restrictions (Rx 3, p. 40-41). He testified that there is no treatment necessary for someone who is feigning their symptoms (Rx 3, p 40). He opined that since Petitioner reported that her symptoms are exactly the same after two and a half years of treatment that this either is the wrong treatment or she really doesn't have what she says she has (Rx 3, p 50).

Petitioner testified that she suffers daily from the severe pain in her neck, for which she wears a neck brace which had been recommended upon discharge from Condell Medical Center to use on an as-needed basis. She testified to knee pain, for which she uses a cane for balance that had been recommended by a physical therapist. She testified to nausea and dizziness upon movement of the head and a feeling she is going to faint. She testified to the psychological issues that she faces on a daily including night terrors, anxiety and palpitations during the waking hours. Petitioner described her level of cervical pain on the day of trial as 10/10. Petitioner testified that neither injections nor surgery have ever been discussed by any physician who has evaluated petitioner following the December 2009 incident.

Petitioner testified that she possesses a valid driver's license and owns a motor vehicle. She testified that she can drive short distances if she is familiar with the route. Her significant other drives her to the doctor. She owns and operates a computer. She is able to read intermittently for periods ranging from 30 minutes to an hour. Petitioner participates in the care of her daughter, who was 13 years old at the time of trial. Petitioner's daughter is involved in band and tennis. Petitioner testified that she will drive her daughter to and from band practice and attend performances. Petitioner testified that she is capable of grocery shopping if the bags are light. Petitioner eats at a restaurant approximately one time per month. Petitioner last frequented a movie theater in 2014.

Petitioner testified that she has not applied for any employment since the December 19, 2009 incident. She testified that she would not accept a position with the respondent if it were offered. She would not accept a position working for an employer other than the respondent, even if she could work strictly from home. She testified she does not believe she could work due to her symptoms. Petitioner is currently receiving social security disability benefits.

Conclusions of Law

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

Petitioner was involved in an undisputed accident on December 19, 2009 when she was attacked by a psychiatric patient. As a result of this attack, she is claiming multiple physical and psychological injuries.

With respect to the alleged physical injuries, the initial medical records from Vista Medical Center confirm Petitioner suffered the blow to the face resulting in the facial bruising and broken teeth. There is no dispute as to the dental injuries and treatment. She also suffered injuries to the knees and left wrist. Petitioner returned to the emergency room later that morning complaining of dizziness. Vista records do not find any evidence of trauma to the neck or back. On December 21, 2009, Dr. Bhalala diagnosed multiple soft tissue injuries, headache, right knee sprain, cervical sprain, and LS sprain.

Petitioner is currently complaining of myriad symptoms including headaches, dizziness, nausea, cervical and lumbar pain, injuries to her right hip and groin, and right arm pain and weakness. She has undergone multiple diagnostic testing. The EEG and MRI of the brain were negative as were MRI to the right knee, right hip, thoracic and lumbar spine. The cervical MRI noted degenerative changes as did the earlier 2006 MRI of the cervical spine. An EMG was read as showing cervical radiculopathy, but Dr. Kessler disputes the finding and Dr. Allen's primary physical diagnosis is myofascial pain.

Petitioner's medical providers disagree on the diagnosis and possible physical cause of the Petitioner's multiple complaints. Dr. Chhabria diagnosed a concussion, but Dr. Allen specifically testified that there is no evidence of a brain injury, an opinion shared by Dr. Kessler. There is no medical indication of any treatment for a cervical radiculopathy and no recommendation for any further intervention for this condition. The Arbitrator notes that Petitioner had a prior MRI of the cervical spine in 2006 and was treated for the cervical spine following the September 30, 2010 motor vehicle accident.

With respect to Petitioner's physical complaints the Arbitrator has reviewed the medical evidence including the treating records and deposition testimony and finds the opinion of Dr. Kessler more persuasive that those of the Petitioner's treating physicians Dr. Allen, Dr. Chhabria and Dr. Bhalala.

The Arbitrator had the opportunity to observe the Petitioner during her testimony and found her presentation of her complaints to be dramatic, and unconvincing. The Arbitrator notes multiple inconsistencies in the medical opinions and Petitioner's testimony and histories with respect to her symptoms. Petitioner complains of weakness in her arm and giving way of her leg. Dr. Kessler finds give away weakness which she states in not physiologic. Dr. Allen testified he did not find give away weakness because there was no weakness. Dr. Chhabria's diagnosis of a cerebral concussion is specifically refuted by Dr. Allen and Dr. Kessler. The cervical injury was diagnosed as a soft tissue sprain or myofascial pain by Dr. Allen. The doctor does not address the issue of the 2010 motor vehicle accident as related to the neck, but has multiple conflicting opinions with respect to the syrinx in his report and testimony. While Dr. Bhalala includes multiple diagnoses in his records, the Arbitrator notes that he is a primary care physician and appears to be providing the diagnoses based on the other treating experts rather that an opinion based upon his own findings and is not providing any particular treatment other than endless refills of Hydrocodone. His opinion that Petitioner should be on complete bed rest and house confined almost two years after the incident defy the opinions of every other provider, the Petitioner's own testimony as to her activities, and common sense. The Arbitrator also notes that Dr. Allen testified that many of Petitioner's symptoms including dizziness and nausea may be the result of the medications she is taking. Dr. Allen also testified that Petitioner's physical symptoms may be emanating from her psychological injury which he opined was post traumatic stress disorder.

Based upon the medical evidence as to Petitioner's physical injuries the Arbitrator, based upon the opinion of Dr. Kessler, finds that Petitioner suffered multiple contusions and sprains to the neck, knees and left wrist

and the injury to the lip and teeth which condition reached maximum medical improvement as of the date of Dr. Kessler's examination on June 21, 2010.

With respect to Petitioner's claim psychological injury, she has been diagnosed with post traumatic stress disorder, anxiety and depression. Petitioner has presented the testimony of Dr. Tylkin and Dr. Allen as well as medical records from Dr. Bhalala, Dr. Bortnick. Respondent has provided the reports and testimony of Dr. Kessler and Dr. Hartman to refute Petitioner's claim.

The diagnosis of post traumatic stress disorder has been made by Dr. Tylkin, supported by Dr. Allen and disputed by Dr. Kessler and Dr. Hartman. The Arbitrator notes that Dr. Allen testified that this diagnosis should be the province of a psychiatrist and finds his self laudatory pronouncements of his expertise to render the diagnosis unpersuasive. Similarly, the Arbitrator finds Dr. Kessler's rejection of the diagnosis based primarily on her inability to find sufficient documentation of the needed detailed description in Dr. Tylkin's records also unpersuasive. As noted above with respect to Petitioner's physical injuries, the Arbitrator finds the records of Dr. Bhalala unpersuasive based upon his lack of expertise and inclusion of diagnoses based on reporting of other providers and his unreliable recommendations.

Dr. Tylkin testified that post traumatic stress disorder requires four categories: a life threatening situation, severe distress, flashbacks, and avoidance behavior. The diagnosis is arrived at through a standard psychiatric interview. This examination is the patient's subjective answers to questions and the doctor's objective observation. Dr. Tylkin diagnosed Petitioner with post traumatic stress disorder.

Dr. Michael Mercury, a clinical psychologist, administered several tests over a two-day period of July 21 and July 23, 2010. He noted that Petitioner's performance on tests measuring effort was mixed and noted that petitioner's scores therefore should be interpreted with caution, as they may be underestimating true ability. Dr. Bortnick performed a Psychological Evaluation dated October 31, 2012. The behavioral observations record that when tasks got harder, Petitioner appeared somewhat disoriented and distraught. She took longer than average to calm down and return to task. Petitioner undertook a battery of tests. The results appeared to be valid. She performed in the low average for verbal comprehension, borderline in perceptual reasoning, low average in working memory, borderline in processing speed, visual and auditory memory were impaired. The assessment revealed that Petitioner is experiencing severe vegetative and psychological symptoms of depression, severe anxiety. She has a pessimistic outlook towards herself and the future and has a state of hopelessness, isolation and a sense of loss.

Dr. David Hartman, a medical and forensic neuropsychologist, testified that Petitioner's responses during the structured inventory for the malingering symptomatology test suggested concern that Petitioner's self-report may be distorted or not credible. Dr. Hartman opined it was plausible that, as a result of the December 2009 incident, petitioner sustained some degree of pain and discomfort, consistent with a soft tissue injury or headache. He did not diagnose any long-term presentation, and instead diagnosed a malingered presentation.

The Arbitrator's observation of Petitioner's testimony and physical presentation support the opinions of Dr. Mercury and Dr. Hartman that Petitioner's overall presentation is not consistent with her reported activity and may underestimate her true abilities. The Arbitrator finds the Petitioner's use of the cervical collar and cane, neither of which were prescribed by a medical doctor for ongoing use as a result of the accident support the finding that Petitioner is embellishing the extent of her disability.

However, given the severity of the attack on December 19, 2009 and the onset of Petitioner's complaints beginning immediately thereafter, the Arbitrator finds that, while Petitioner may not fit the clinical diagnosis of post traumatic stress disorder do to the lack of consistent credible presentation of her symptoms, the Petitioner has suffered a psychological trauma as a result of the incident in addition to the physical injuries. The psychological trauma has resulted in depression and anxiety as diagnosed by Dr. Bortnick. Dr. Hartman's opinions seem to attribute all of the positive test results to his initial finding that the self reporting may be distorted and not credible. Dr. Bortnick's behavior observations, that when tasks got harder, Petitioner appeared somewhat disoriented and distraught, took longer than average to calm down and return to task, could also contribute to inconsistent results.

Based upon the record as a whole, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that, as a result of the accidental injuries sustained on December 19, 2009 she sustained physical injuries consisting of multiple contusions and sprains to the neck, knees and left wrist and the injury to the lip and teeth, and psychological injuries of anxiety and depression.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Petitioner has claimed bills with respect to the treatment rendered to Petitioner as a result of the alleged injuries sustained as a result of the accidental injuries sustained on December 19, 2009. Bills have been included in the medical record exhibits submitted by Petitioner.

With respect to the treatment for the physical injuries the Arbitrator adopts his finding as detailed above with respect to causal connection, that the opinions of Dr. Kessler are more persuasive as to the Petitioner's physical injuries. With respect to the treatment provided by Dr. Bhalala, Dr. Chhabria, Dr. Allen and Vista and Condell, the Arbitrator notes that reasonable, necessary and causally related treatment would be only through the finding of maximum medical improvement by Dr. Kessler on June 21, 2010. The Arbitrator finds no bills for treatment by these providers unpaid through that date and therefore awards no medical costs to these providers. The Arbitrator further notes that the charges from Condell Medical Center for September 30, 2010 are directly related to the motor vehicle accident rather than the work related accident on December 19, 2009.

With respect to the psychological treatment rendered to Petitioner, the Arbitrator finds the treatment of Dr. Mercury reasonable, necessary and causally related. The bills submitted in Petitioner's Exhibits D do not reflect any unpaid balance and therefore no additional medical is awarded to this provider. With respect to Dr. Tylkin's and Dr. Bortnick's treatment, the Arbitrator finds the testimony of Dr. Hartman persuasive that "since Petitioner reported that her symptoms are exactly the same after two and a half years of treatment that this either is the wrong treatment or she really doesn't have what she says she has." The Arbitrator finds additional treatment by Dr. Tylkin's and Dr. Bortnick after the date of this opinion expressed on October 11, 2013, is not reasonable, necessary or causally connected to the accidental injuries sustained on December 19, 2009. Petitioner's Exhibit K includes unpaid bills to Dr. Tylkin prior to this date for services rendered from September 16, 2010 through February 26, 2011 totaling $950.00. Petitioner's Exhibit M does not reflect any unpaid bills to Dr. Bortnick prior to October 11, 2013 and therefore no additional medical is awarded to her.

17IWCC0383

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to medical of $950.00 pursuant to the provisions of Sections 8(a) and 8.2 of the Act. Treatment for physical conditions after June 21, 2010 and psychological treatment after October 11, 2013 is no longer reasonable, necessary or causally connected to the accidental injuries sustained on December 19, 2009.

In support of the Arbitrator's decision with respect to (K) Temporary Compensation, the Arbitrator finds as follows:

Petitioner was paid temporary total compensation from December 19, 2009 through February 2, 2011 when benefits were terminated based upon receipt of Dr. Hartman's report and opinions. The medical opinions submitted range from Petitioner being unable to perform any gainful employment to those recommending return to work with out restrictions.

Dr. Bhalala has authored reports that Petitioner should be confined to her home and on complete bedrest. Dr. Tylkin has testified that Petitioner cannot return to gainful employment because she is not able to focus, to sustain concentration, make independent decisions, deal with routine work related stress, with supervisors, and keep attendance persistently.

Yet Petitioner was advised by Dr. Chhabria to return to work to a unit other than the psychiatric department on January 8, 2010. Dr. Mercury's plan in his July 21, 2010 evaluation states that Petitioner should identify a nursing position with less risk. Dr. Allen conceded that Petitioner might be able to return to some administrative nursing. Dr. Allen agreed that it is possible that attempting to return to work could benefit Petitioner.

Dr. Kessler and Dr. Hartman have opined that Petitioner could return to full unrestricted duty.

Based upon the testimony of the Petitioner and the medical records provided, the Arbitrator finds the opinions that Petitioner can return to work, but should avoid a return to psychiatric nursing most persuasive. The Arbitrator, as previously outlined, does not find Dr. Bhalala's opinions persuasive and Dr. Tylkin's explanation of her opinion of total disability is similarly unpersuasive. When asked to explain the basis for her opinion that petitioner is unable to work, Dr. Tylkin states that petitioner is unsure of herself, has low self-esteem, a feeling of worthlessness, and is very desperate and miserable. Dr. Tylkin's records reflect a referral to Dr. Bortnick for memory issues, but Dr. Allen testified Petitioner has no memory issues. Dr. Tylkin testified in response to return to work questions that this was outside of her expertise. Her opinion of Petitioner's inability to return to work are based upon acceptance of the Petitioner's subjective complaints, which the Arbitrator finds embellished, and Petitioners firmly expressed belief in the medical records and her testimony that she is unable work.

However as noted in the Arbitrator's findings with respect to causal connection, Petitioner has suffered a psychological injury resulting in anxiety and depression and finds the Dr. Kessler's and Dr. Hartman's opinions that Petitioner could return to her prior unrestricted employment in the psychiatric ward similarly unpersuasive based upon the psychological impact of the attack on the Petitioner.

The Arbitrator finds the opinions of Dr. Mercury and Dr. Chhabria and the concession of Dr. Allen that Petitioner can return to work as an administrative nurse or in nursing in a less stressful area more persuasive and supported by the Arbitrator's observation that the Petitioner's testimony and presentation included her

embellished subjective complaints. Given Petitioner's prior employment history including working in nursing homes and in telemetry with Vista, the record supports her ability to perform these modified tasks.

Based upon the finding that Petitioner was able to perform modified duty, but not return to her prior regular employment with Respondent, Petitioner would be entitled to temporary compensation through the date of a finding of maximum medical improvement. Based upon the Arbitrator's findings with respect to causal connection and medical, Petitioner was at maximum medical improvement for her physical injuries as of the date of Dr. Kessler's examination on June 21, 2010 but not at maximum medical improvement with respect to her psychological injuries until Dr. Hartman's opinion with respect to the reasonableness of additional psychological treatment rendered at his deposition on October 11, 2013.

Based upon the record as a whole, the Arbitrator finds that Petitioner is entitled to temporary total disability from December 19, 2009 through October 11, 2013 a period of 198 6/7 weeks. Respondent shall receive credit for benefits paid through February 2, 2011 of $44,221.48.

In support of the Arbitrator's decision with respect to (L) Nature and Extent, the Arbitrator finds as follows:

Petitioner is claiming to be permanently and totally disabled. Petitioner can demonstrate permanent and total disability: by preponderance of the medical evidence; by showing a diligent but unsuccessful job search; or by showing that, because of age, training, education, experience, and condition, no jobs are available to a person in the petitioner's circumstances. Petitioner presented no evidence presented of a diligent but unsuccessful job search. Petitioner testified that she has not submitted a single job application since the December 19, 2009 incident. Petitioner is 48 years old, has a nursing degree, and has worked as a registered nurse for 15-plus years. Petitioner speaks fluent English, and possesses a valid driver's license. She testified that she is able to read as well as operate a computer. It follows that petitioner did not establish that there are no jobs available to a person in her circumstances. Petitioner must therefore prove that she is permanently and totally disabled by a preponderance of the medical evidence.

The medical claim that Petitioner is unable to perform any employment must be based on the opinions of Dr. Tylkin and Dr. Bhalala. As discussed above in the Arbitrator's findings with respect to temporary compensation, the Arbitrator finds these opinions unpersuasive. The Arbitrator further notes that Dr. Tylkin testified that she was not stating Petitioner could never return to work. The Arbitrator finds the opinions of Dr. Chhabria and Dr. Mercury that Petitioner could return to work in a less stressful nursing position persuasive. Dr. Allen conceded that Petitioner may be able to perform administrative nursing. Dr. Kessler and Dr. Hartman found Petitioner could do unrestricted work. Petitioner's prior employment history including working in nursing homes and in telemetry with Vista, the record supports her ability to perform these modified tasks. Her current driver's license and ability to perform certain household tasks would support her ability to perform these functions or home care nursing as raised in the cross examination of Petitioner and her medical witnesses.

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she is permanently totally disabled.

Petitioner has also failed to present evidence that she is entitled to a wage differential award under Section 8(d)1. Based upon the Arbitrator's finding with respect to temporary compensation and the above finding with

respect to Petitioner's claim for permanent total disability, the Arbitrator finds Petitioner capable of employment in various less stressful nursing positions. While the stipulated average weekly wage may provide a basis for determining Petitioner's earnings in her prior full duty capacity, Petitioner has failed to provide any effort at a job search or any evidence whatsoever to support the Petitioner's earning capacity in the modified duty position. Petitioner has failed to establish by a preponderance of the evidence, or indeed by any evidence whatsoever, a claim for a wage differential award.

The Petitioner had undisputed injuries including the dental injuries described by Dr. Galvez and the multiple bruises, contusions and sprains to the left wrist and both knees. Based upon the mechanism of injury and the medical testimony, Petitioner has also suffered soft tissue injuries to the cervical spine. Petitioner has also suffered psychological trauma as a result of the attack that has at least contributed to her anxiety and depression. While the Arbitrator notes Petitioner's other life issues which have also contributed and the stress caused by the financial pressure and the family and social tensions and conflict discussed with Dr. Tylkin which resulted from Petitioner not working, the persuasive medical opinions find that Petitioner should not return to her former employment as a psychiatric nurse. Based upon the multiple injuries sustained and the loss of Petitioner's regular occupation, the Arbitrator finds that Petitioner has suffered a loss of use of the person as a whole to the extent of 50%.

Based upon the record as a whole, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that she is either permanently totally disabled or entitled to a wage differential award pursuant to Section 8(d)1. The Arbitrator finds that the Petitioner is entitled to permanent partial disability benefits of $664.72 per week for 250 weeks, because the injuries sustained caused the 50% loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

Bridget Ellett,

Petitioner,

vs.

NO: 10 WC 32933

17IWCC0392

Southern Illinois Adult
Transition 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 March 28, 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.

17IWCC0392

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: JUN 27 2017
TJT:yl
o 6/20/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ELLETT, BRIDGET
Employee/Petitioner

Case# **10WC032933**

SOUTHERN ILLINOIS ADULT TRANSITION CENTER
Employer/Respondent

17IWCC0392

On 3/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% 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:

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

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

MAR 28 2016

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

17IWCC0392

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

Bridget Ellett
Employee/Petitioner

v.

Southern Illinois Adult Transition Center
Employer/Respondent

Case # **10** WC **32933**

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 **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. ☒ Did an accident occur that arose out of and in the course of 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 _____

17IWCC0392

FINDINGS

On **August 18, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$62,354.00**; the average weekly wage was **$1,199.12**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$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 $86,803.22, 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 permanent partial disability benefits of $669.64/week for 101.525 weeks, because the injuries sustained caused the 15% loss of the right arm (37.95 weeks), 15% loss of the left arm (37.95 weeks) and the 12.5% loss of the left hand (25.625 weeks), 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.

Michael K. Nowak, Arbitrator

3/23/16
Date

MAR 28 2016

FINDINGS OF FACT

Petitioner began her career with Respondent in 1999 as a correctional food service supervisor I at Southern Illinois Adult Transition Center. After one year she was promoted to a correctional food service supervisor II. She continued in this position until the facility closed in 2013. Since January of 2013, she has been employed in the same capacity at Pinckneyville Correctional Center. Petitioner testified that there was no difference between the job duties performed by a food service supervisor I and II at the Adult Transition Center.

As a food service supervisor at the Adult Transition Center, Petitioner was involved in food preparation, which consisted of supervising and working alongside inmate workers teaching them how to cook. Petitioner performed activities such as chopping and preparing vegetables, opening cans, mixing items, stirring pots, and baking and cutting cakes. Every ingredient, utensil, refrigerator and freezer in the facility's kitchen was kept under lock and key, and it was Petitioner's responsibility to lock and unlock each cabinet. Petitioner was involved in food preparation for three hours out of an eight hour shift, as there were two meals to prepare during each shift. She would be required to prepare three meals per day if she worked overtime. Petitioner testified that she would use her hands continuously throughout the food preparation process, because everything was kept under lock and key. The facility was supposed to be staffed with three food service supervisors, but for several years, there were only two individuals employed in this position. Petitioner testified that she worked eight extra full shifts per month of overtime due to the short staffing at the facility. Petitioner indicated that there were fourteen (14) locks in the dietary department.

When not actively involved in food preparation Petitioner performed other tasks. She performed a significant amount of driving. She would drive inmates to their places of employment from approximately 5:30 to 8:30 AM. This was done using vans which Petitioner described as older with significantly high mileage, ranging from 250,000 to 400,000 miles. She stated that due to the age of the vehicles they often vibrated significantly. Lifting was also a part of Petitioner's job duties at the Southern Illinois Adult Transition Center. Petitioner testified that during several years of her employment, the facility did not employ a food service supervisor III or dietary manager therefore she was required to perform those duties as well, including shopping for food. She described shopping at Walmart twice a week and purchasing twenty cases of bottled water during each trip, which required her to lift thirty-two bottle cases of water weighing approximately thirty-three pounds each. Petitioner also performed cleaning at the facility and testified that she would wipe down stainless steel refrigerators in order to ensure that this was performed adequately and properly. Data entry was also required Petitioner testified that she was required to place all food bills into her employer's computer system and generate reports for same. She performed this activity for one hour at a time on several occasions throughout the week.

The record contains an extensive amount of evidence regarding Petitioner's job duties: a CorVel Job Site Analysis (JSA) procured at Respondent's request (PX11, RX5); a DVD produced at Respondent's direction which depicts the job duties of a food service supervisor (RX6); a CMS Demands of the Job (RX2); a job description prepared by Petitioner (PX8); a deposition of Melanie Welch (PX10, RX7); and a list of additional duties applicable to Petitioner. (PX12)

Petitioner reviewed the Job Site Analysis and demands of the job form prepared by Respondent. With regard to the Job Site Analysis, Petitioner testified that neither she nor any food service supervisors were

interviewed by the individuals who prepared the report. She disagreed with the JSA's assessment that she was only required to perform wrist turning, grasping, pinching and finger manipulation occasionally, or up to 2.5 hours per day, and indicated that she would use her upper extremities for these types of activities on a more frequent basis. Petitioner also testified that she disagreed with the demands of the job form, which indicated that she was only required to lift 1-10 pounds less than three times per month and would never lift anything weighing more than eleven pounds. She described retrieving ground beef weighing fifty pounds out of the facility's refrigerator and carrying cases of bottled water weighing in excess of thirty pounds. Petitioner also disagreed with the demands of the job form's characterization that she would use her hands for fine manipulation, typing, and good finger dexterity for 0-2 hours per day.

Respondent called Scott Prince to testify as a witness on its behalf. Mr. Prince testified that he was currently employed at Menard Correctional Center as a correctional supply supervisor II, and worked at Southern Illinois Adult Transition Center from April 2010 to January 2012 as a corrections residence counselor I. He indicated that he worked in the food service department when overtime was available and had occasionally worked with Petitioner. Mr. Prince corroborated Petitioner's testimony. He confirmed that he has witnessed Petitioner preparing meals in the kitchen and that her testimony with regard to the amount of driving required and the condition of the vans was accurate.

Respondent had a Job Site Analysis prepared by Melanie Welch. (RX5). The Job Site Analysis indicates that Petitioner's position would require strength demands of performing lifting of up to twenty (20) pounds maximum with frequent lifting and/or carrying up to ten (10) pounds (frequent being defined as up to 5 ½ hours per day), but under the physical demands second of the Job Site Analysis it is indicated that Petitioner would only be occasionally required to lift from floor to waist, waist to shoulder, or shoulder to overhead (occasionally being defined as up to 2 ½ hours per day). The Job Site Analysis also quantifies Petitioner's level of grasping, pinching, finger manipulation and carrying as occasional, or up to 2 ½ hours per day. (RX5).

Melanie Welch testified by deposition on July 22, 2011. She is employed by CorVel as a vocational rehabilitation counselor. She visited the Southern Illinois Adult Transition Center at the request of the State of Illinois. (RX7, p. 9). She testified that when she toured the facility, she did so with Yolanda Harrington and Connie Halliday. *Id.* at 9-10. She testified that she took video footage of the facility. (*Id.* at 10). Ms. Welch indicated that breakfast at the facility served 35-40 people, and lunched served 30-35. (*Id.* at 14-15). She believed that the inmates prepared and cooked meals and was told by Yolanda Harrington that food service supervisors did not cook, but only supervised inmate workers. *Id.* at 15-16. Ms. Welch acknowledged that she did not know what Petitioner's job title was from March 2001 to February 2008. *Id.* at 29-30. She was unaware that there were only two (2) food service supervisors employed at the facility during that time frame, or that Petitioner performed the lead position, which involved ordering, inventorying supplies, and cleaning. *Id.* at 30-31. She was unaware that Petitioner performed data entry or that Petitioner worked overtime. *Id.* at 31. Ms. Welch did not know the number of locks in the facility's dietary area. *Id.* at 32.

Respondent also had a Demands of the Job form signed by Patricia Barone. (RX2). The Demands of the Job form indicated that Petitioner was required to perform lifting 1-10 pounds less than three (3) times per month, and would never be required to lift more than eleven (11) pounds. (RX2). The Demands of the Job form also indicated that Petitioner would never be required to drive automotive equipment, and that Petitioner would use her hands for gross manipulation (grasping, twisting, handling) less than three (3) times per week,

and that Petitioner would use her hands for fine manipulation (typing, good finger dexterity) for 0-2 hours per day. The Arbitrator notes that this information is inconsistent with the testimony of both Petitioner and Respondent's live witness, Mr. Prince.

During the course of her employment at the Southern Illinois Adult Transition Center, Petitioner began developing symptoms of pain and numbness in her elbows and wrists. Petitioner testified that she had developed carpal tunnel syndrome in her dominant right hand in 2000, but that she did not know the cause of this condition when she was diagnosed. That condition was treated and improved. Later she began experiencing symptoms in her left hand and both arms.

Petitioner sought treatment with Dr. David Brown on referral from her attorney on August 18, 2010. Dr. Brown's records indicate that Petitioner was a thirty-six (36) year old, right-hand dominant female with a two (2) year history of intermittent numbness in both hands, worse on the left than right associated with medial elbow pain. Dr. Brown also noted that Petitioner had been employed with the Department of Corrections since 1999 and that her job involved food prep, turning keys repeatedly throughout the day, and performing data entry on a computer. On examination, Dr. Brown noted symptoms and findings consistent with bilateral cubital tunnel syndrome as well as left carpal tunnel syndrome and recommended nerve conduction studies of both upper extremities. Following review of the nerve conduction studies, which were performed by Dr. Daniel Phillips on that same day, Dr. Brown diagnosed bilateral cubital tunnel syndrome as well as moderate left carpal tunnel syndrome. Dr. Brown recommended continued conservative treatment and advised Petitioner to follow up for a reevaluation in 4-6 weeks. He indicated that based on Petitioner's job description, he believed her employment to be an aggravating factor in the need for further evaluation and treatment for cubital tunnel syndrome and carpal tunnel syndrome.

Petitioner subsequently filled out an incident report while at work on August 24, 2010 indicating that her condition was work-related. (PX7). She testified that August 18, 2010 was the first date she received a diagnosis and was informed that her condition was work-related.

After failing conservative treatment, Dr. Brown ultimately performed a left carpal tunnel release and left cubital tunnel release on December 7, 2010, followed by a right cubital tunnel release on with an anterior submuscular transposition of the ulnar nerve with myofascial lengthening of the flexor-pronator tendon origin on January 4, 2011. (PX5) Petitioner continued to follow up post surgically with Dr. Brown, and she was ultimately released on May 16, 2011. At that time, Dr. Brown noted that Petitioner continued to suffer from some residual numbness in the left little and ring fingers, and recommended repeat nerve conduction studies. Following the repeat studies, which were again performed by Dr. Daniel Phillips, he noted that the new studies revealed improvement in both the left median and ulnar nerve values consistent with decompression. He recommended continued observation and a reevaluation in three to six months if her symptoms failed to improve. *Id.*

Respondent had Petitioner's records reviewed by Dr. Anthony Sudekum, but no Section 12 examination took place. Dr. Sudekum authored a report dated July 7, 2012. It was Dr. Sudekum's opinion that Petitioner "would have developed her bilateral upper extremity peripheral neuropathies due to nonwork-related comorbid conditions and risk factors, regardless of her employment activities..." and that Petitioner's "job activities...did

not cause or aggravate carpal tunnel syndrome, cubital tunnel syndrome, and/or lateral epicondylitis..." nor did her job duties "contribute to her need to undergo treatment for those conditions." (RX8, p.33)

Dr. Brown testified by deposition on July 29, 2014. Dr. Brown testified consistently with his medical records that he believed Petitioner's bilateral cubital tunnel syndrome and left carpal tunnel syndrome were aggravated by her cumulative employment at the Southern Illinois Adult Transition Center since 1999. (PX9, p. 22). He also confirmed that Petitioner had informed him of her prior right sided carpal tunnel diagnosis. *Id.* at 19-20. Dr. Brown testified that he reviewed two JSAs with regard to Southern Illinois Adult Transition Center, a DVD purportedly showing the job duties of a food service supervisor at the Adult Transition Center, a deposition of Melenie Welch, the individual who performed the JSA, a records review report from Dr. Sudekum, as well as comments from Petitioner with regard to the JSA. *Id.* at 34. He testified that performing food preparation on a frequent basis over a prolonged period of time, as well as cleaning can contribute to carpal and cubital tunnel syndromes. *Id.* at 39-40. He also testified that while JSAs and video analyses can be helpful in giving an assessment of an employee's job duties, the best and most detailed information should come from the actual employee herself. *Id.* at 40. In support of his opinion, Dr. Brown stated:

> I think the supplemental information she provided—she talked about a little bit more detail, that she would have to unlock and lock these padlocks. She described it on a continuous basis—to get the tools and utensils and food inventory out. She would have to do food prep and the cooking and she would have to clean, and none of that's mentioned in the JSA. So there's clearly a discrepancy between what she described and a complete lack of information in the JSA regarding the job duties of a correctional food service supervisor. *Id.* at 42.

Dr. Brown also testified that driving three (3) hours per day could be a potential aggravating factor for Petitioner's carpal and cubital due to vibration exposure. *Id.* at 72. Dr. Brown disagreed with several statements contained in Dr. Sudekum's report. He disagreed that Petitioner's diagnosis of Sjogren's syndrome could cause or contribute to carpal or cubital tunnel syndrome, and indicated that Sjogren's is an autoimmune condition which attacks the lacrimal and salivary glands and causes dry mouth and dry eyes. *Id.* at 52. He likewise indicated that Petitioner presented with no history of psoriasis or psoriatic arthritis. *Id.*

Dr. Sudekum testified by deposition on September 11, 2014. Dr. Sudekum testified that he was neither able to agree or disagree with Dr. Brown's diagnosis in this case as he did not have an opportunity to examine Petitioner. (RX9, p. 22) He acknowledged that if Petitioner was in fact suffering from carpal and cubital tunnel syndromes, that the surgeries performed by Dr. Brown would be reasonable and necessary to cure or relieve the effects of those injuries. *Id.* at 23. With regard to causation, Dr. Sudekum testified that he did not feel that Petitioner's left carpal tunnel syndrome or bilateral cubital tunnel syndrome was aggravated by her job duties as a correctional food service supervisor at Southern Illinois Adult Transition Center. *Id.* at 23-24, 28. He instead attributed any peripheral compression neuropathy to Petitioner's gender, age, hypothyroidism, and Sjogren's syndrome. *Id.* at 25. He also testified that Petitioner's hobby of dog breeding could cause or contribute to the development of peripheral compression neuropathies. *Id.* at 41-42. He further indicated that it was his opinion that Petitioner would have developed carpal and cubital tunnel syndrome regardless of her employment activities, but acknowledged that there was no way to know that information with certainty. *Id.* at 68-69. Dr. Sudekum acknowledged that he did not produce any literature to support his opinion that Sjogren's syndrome can be a predisposing factor to peripheral compression neuropathies. *Id.* at 71-72.

Petitioner believed that Dr. Brown had an accurate understanding of her job duties at the Adult Transition Center. She acknowledged that her family owns and operates a dog breeding business and she performs occasional clerical tasks associated with this business. She testified to no other hobbies.

Despite improvement following surgery, Petitioner testified that she still experiences lack of strength in her upper extremities and notices pain and aching with changes in the weather. She has trouble opening several refrigerators at work and asks for help when opening freezers. She also notices pain in her wrist after scrubbing for a prolonged period of time.

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?

The Arbitrator finds that Petitioner was a credible witness. Petitioner testified that she spent three hours during each shift preparing food alongside inmate workers. She also credibly testified that each ingredient or utensil was under lock and key, and because inmates did not have access to the keys or locks, it was her responsibility to lock and unlock each cabinet, refrigerator, or freezer when materials were needed. She also credibly testified that for a number of years, she was required to drive a van three hours per day, which vibrated through the steering wheel. She also testified to use of her hands for cleaning, lifting, and data entry. The Arbitrator finds it significant that Respondent's witness, Scott Prince, completely corroborated Petitioner's testimony concerning her job duties, and verified that he observed Petitioner preparing food alongside the inmates. He also confirmed that driving a van for three hours per shift was a job requirement for Petitioner.

The Arbitrator further finds Respondent's evidence regarding Petitioner's job duties to be at best incomplete and unpersuasive. Specifically, Respondent's Demands of the Job form indicates that Petitioner would never be required to drive automotive equipment. This is refuted by both Petitioner and Mr. Prince. It claims that Petitioner would lift 1-10 pounds less than three (3) times per month, would never be required to lift more than eleven (11) pounds. This would be exceeded any time bottled water was purchased. It asserts that Petitioner would use her hands for gross manipulation (grasping, twisting, handling) less than three (3) times per week, and would use her hands for fine manipulation (typing, good finger dexterity) for 0-2 hours per day. However, the JSA commissioned by Respondent indicates that Petitioner would use her upper extremities for grasping, pinching, finger manipulation, carrying, and lifting on an occasional basis, or up to 2.5 hours per day. (RX5).

Furthermore, it is clear that the author of the JSA, Melanie Welch, was not fully informed regarding Petitioner's job duties. Specifically, she testified that she was informed that food service supervisors did not cook, but only supervised inmate workers. *Id.* at 15-16. She did not know what Petitioner's job title was from March 2001 to February 2008. *Id.* at 29-30. She indicated that she was unaware that there were only two (2) food service supervisors employed at the facility during that time frame, or that Petitioner performed the lead position, which involved ordering, inventorying supplies, and cleaning. *Id.* at 30-31. She was unaware that Petitioner performed data entry or that Petitioner worked overtime, and did not know the number of locks in the facility's dietary area. *Id.* at 32.

The Arbitrator finds the testimony and opinions of Dr. Brown more persuasive than those of Dr. Sudekum. Dr. Brown was of the opinion that Petitioner's job duties would serve as an aggravating factor in the development and progression of her conditions. Dr. Sudekum opined that Petitioner's age, gender, hypothyroidism, and Sjogren's syndrome were the sole causes of her upper extremity conditions, but that her eleven year employment with Respondent played no role whatsoever in the development of those conditions.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has met her burden of establishing that she sustained accidental injuries which arose out of and in the course of her employment with Respondent, and that her 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 claimed her injuries manifested on August 18, 2010, the date she saw Dr. Brown, was provided a diagnosis and was advised that she had a work-related condition. The Arbitrator finds that August 18, 2010 is an appropriate manifestation date under the Act.

It is undisputed that Petitioner notified Respondent through an incident report dated August 24, 2010. (RX3). 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?

Respondent disputed liability for medical expenses based upon issues C-F above. Respondent does not dispute the reasonableness or necessity of Petitioner's medical care.

Based upon the above findings regarding issues C-F, Respondent shall pay reasonable and necessary medical services of $86,803.22, as set forth in Petitioner's group exhibit 1, pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Petitioner's injuries occurred before the effective date of the Amendment of §8.1b of the Act.

As a result of her injuries, Petitioner underwent a left carpal tunnel release and left cubital tunnel release on December 7, 2010, followed by a right cubital tunnel release on with an anterior submuscular transposition of the ulnar nerve with myofascial lengthening of the flexor-pronator tendon origin on January 4, 2011. Despite improvement following surgery, Petitioner testified to residual symptoms in her upper extremities. Specifically, she indicated that she experiences lack of strength in her upper extremities and notices pain and aching with changes in the weather. She indicated that she has trouble opening several refrigerators at work and asks for help when opening freezers. She also notices pain in her wrist after scrubbing for a prolonged period of time.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has sustained serious and permanent injuries that resulted in the 15% loss of the right arm, 15% loss of the left arm, and 12.5% loss of the left hand, as provided in Section 8(e) of the Act.

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

ROBERTO ALVARENGA FLORES,

Petitioner,

vs.

NO: 11 WC 2348

17IWCC0396

CHICAGO DRYER COMPANY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of reinstatement and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator.

The Commission notes that Petitioner alleged injury as the result of a work-related accident on January 10, 2011. An Application for Adjustment of Claim was filed on January 20, 2011 by Petitioner's prior attorney, the law office of Katz, Friedman, Eagle, Eisenstein, Johnson & Bareck. Petitioner's claim has since been dismissed for want of prosecution not once, but twice.

This claim was originally dismissed for want of prosecution on April 17, 2014. Nearly one year later, Petitioner, now represented by James Ellis Gumbiner & Associates ("Petitioner's attorney"), filed a Petition to Reinstate the claim on April 14, 2015. In the Petition, Petitioner's attorney claimed that their office was attorney of record on April 17, 2014, but was not listed as such on the Illinois Workers' Compensation Commission ("IWCC") website. Petitioner's attorney noted in the Petition that as of April 9, 2015, their office was still not listed as attorney of record. Petitioner's attorney argued in the Petition that their office never received notice of the April 17, 2014 hearing; it was not until 2015, when the Gumbiner attorney formerly assigned to

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Petitioner's case left the Petitioner's attorney's firm, did their office learn of the dismissal. (October 5, 2015 transcript, T.5; T.8; Arbitrator's Exhibit 1).

A hearing on Petitioner's Petition to Reinstate was set on October 5, 2015 before Arbitrator Jeffrey Huebsch. (T.5-6). Petitioner's attorney reiterated the arguments made in the Petition for Reinstatement at the October 5, 2015 hearing; and stated that their office contacted Petitioner who also confirmed that he had not received any notice of the dismissal. Immediately upon receiving notice in April 2015, Petitioner's attorney filed the Petition to Reinstate and argued that the request was timely. (T.8-9).

Respondent argued that Petitioner did not act with due diligence. Petitioner took no action to move the matter forward. Prior to dismissal, the claim had been "sitting at the Commission" for three years. (T.12). Respondent argued, "[T]o now cause the defendant four years after the accident to come in and defend it, I just – we do not feel is proper." (T.13). Respondent also claimed that this matter was not timely filed as Respondent received its notice of the dismissal on May 2, 2014, and noted the Commission mailed a copy to Petitioner. However, Respondent conceded that it was not sure Petitioner was still at the mailing address used by the Commission. (T.10-11). Respondent further argued that Petitioner's attorney's office filed an improper appearance. (T.11-12).

Arbitrator Huebsch ultimately found Petitioner's Petition to Reinstate timely and granted the reinstatement as there was no evidence that Petitioner had received notice of the dismissal until April 2015. The IWCC Rules do provide that a Petition to Reinstate must be filed within 60 days from receipt of a dismissal order. §9020.90.

The Arbitrator did agree with Respondent that Petitioner's attorney filed an improper appearance and the appearance form should have been rejected. "[T]he rejection should have been sent to everybody so they would know, and then they could do something. And apparently that didn't happen. So we'll reinstate the case and I'll give you guys a trial date in December." (T.15).

The agreed-upon trial date was set for December 7, 2015. On that date, the parties did not proceed to trial; and, Arbitrator Huebsch dismissed the claim for want of prosecution for a second time.

On April 7, 2016, the parties appeared before Arbitrator Huebsch on Petitioner's second Petition to Reinstate. The Arbitrator noted that Petitioner initially filed his Petition to Reinstate on February 2, 2016. However, the caption on the Petition provided was not correct. It had the wrong Petitioner, wrong Respondent, and wrong case number listed. It was attached to a Notice of Motion form with the correct information. Petitioner amended the caption on April 7, 2016, the hearing date. (April 7, 2016 transcript, T.4).

In the body of the Petition, Petitioner notes that prior to the December 7, 2015 dismissal, he had reached out to Respondent regarding a possible settlement. He requested that this matter be reinstated so that the parties could resolve the matter either by settlement or trial. (April 7, 2016 transcript, Arbitrator's Exhibits 1 and 3). At the April 7, 2016 hearing, Petitioner's attorney explained what occurred on December 7, 2015:

> [T]he Petitioner was present. Although, the petitioner's attorney was running late. There was a scheduling conflict within the office and the new attorney that was assigned the file for that date. He was unable to make it on a timely basis, but did show up to object to any kind of dismissal to this claim. (T.8).

Petitioner's attorney stated that since the October 5, 2015 reinstatement (attorney incorrectly stated December 5, 2015), Petitioner had provided Respondent with all known medical billing information and "is currently today ready to proceed on all matters of this claim." (T.8).

Respondent conceded that Petitioner's initial Petition to Reinstate may have been properly filed on February 2, 2016. (T.9). Respondent noted that the notice was properly captioned and Respondent could ascertain what claim the Petition pertained to through the contents of the motion. (T.9). Respondent stated that on December 7, 2015:

> Respondent appeared. I searched for petitioner's attorney for quite sometime. Whether petitioner was here or not, I don't know. I am not available to talk to the petitioner without his attorney present. So I didn't even look for him. At the Arbitrator's request, I called petitioner's attorney's office. An attorney came over after I called and objected to our motion to dismiss. You dismissed the case because it had been specially set for hearing, at that time, over our prior objection to reinstating the case. The only thing inequitable here is the fact that my client over five years now has had to continually pay someone to defend this case for them. The petitioner's attorney just today provided us with copies of medical records and bills for them to proceed to trial. (T.11).

The Arbitrator denied Petitioner's Petition to Reinstate. He also noted that Petitioner's attorney had not been prepared to proceed to trial on December 7, 2015 as he was in Geneva on another claim. (T.12-14).

On a Petition to Reinstate, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks v. Indus. Comm'n*, 345 Ill. App. 3d 1138, 1140 (5th Dist. 2004). The decision to grant or deny a timely Petition to Reinstate is a matter which rests within the sound discretion of the Commission, and its determination will not be disturbed on review absent an abuse of that discretion. *Id.*; *See also Conley v. Indus. Comm'n*, 229 Ill. App. 3d 925,

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930 (4th Dist. 1992). Here, Petitioner had the burden of justifying reinstatement of his claim after the Arbitrator had dismissed it for a second time.

When the matter was first dismissed on April 17, 2014, the Respondent objected to its reinstatement, arguing that Petitioner did not act with due diligence in moving the claim forward and that it had been properly dismissed after "sitting at the Commission" for three years. (T.12). Section 16 of the Act asserts that the process and procedure before the Commission shall be simple and summary. 820 ILCS 305/16. Petitioner's attorney offered no justification for the lack of movement in said claim other than to say that the case had been handled by another attorney who had since left their firm. (October 5, 2015 transcript, T.5; T.8; Arbitrator's Exhibit 1). Nonetheless, the Arbitrator reinstated the claim on October 5, 2015, simply on the basis that Petitioner had filed a timely Petition to Reinstate; the Arbitrator also set the matter for a date certain for trial on December 7, 2015. (T.15).

On December 7, 2015, the Arbitrator dismissed the claim a second time when Petitioner's attorney appeared late and showed no indication that he was ready to proceed with trial. No one appeared on behalf of Petitioner on December 7, 2015, until Respondent called Petitioner's attorney's office. (T.11). Petitioner's attorney alleged a scheduling conflict and that a new attorney were to blame. (T.8). The Arbitrator noted that Petitioner's attorney was not prepared to proceed as he was in Geneva on another claim. (T.12-14). Finally, it should be noted that it was not until the April 7, 2016 hearing on Petitioner's Petition to Reinstate, did Petitioner's attorney tender the medical records and bills necessary for the parties to proceed to trial. (T.11).

In addition, it was not until April 28, 2017, four days prior to oral arguments in this matter, that the Commission received Petitioner's Statement of Exceptions and Supporting Brief. Respondent acknowledged at oral arguments that it too never received a copy of Petitioner's Statement of Exceptions and Supporting Brief.

Here, the record shows a pattern of obfuscation and delay for a period of five years, rationalized by dubious excuses and no real justification. The Supreme Court in *Bromberg v. Indus. Comm'n* made it a point to note the following, citing the Decision of the Circuit Court, in its opinion in support of denying reinstatement in that claim:

> The endless delays, the endless failures of attorneys to appear without excuse, either real or apparent, to inform a hearing officer as to the reasons for delay has reflected for years adversely upon the effective administration of justice and continues to do so and will continue to do so until the Appellate Courts start acting to see to it that lawyers fulfill their responsibilities to their clients and appear on the days and dates set for hearing that move hearings to a proper conclusion. 97 Ill. 2d 395, 400 (1983).

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The Commission finds that Petitioner and Petitioner's attorney failed to credibly justify the reinstatement of this claim.

More than 30 years have passed since the entry of the Supreme Court's Decision in *Bromberg*. Yet, practitioners continue to believe that they are entitled to continue matters endlessly and without justification. Time and again, Arbitrators and the Commission refuse to reinstate claims and time and again, practitioners engage in the same pattern of conduct.

As in the case at bar, the plea of the Petitioner's attorney in each case is the same: "It's not my fault; the Commission made a mistake; the Respondent wasn't harmed and the arbitrator didn't understand." None of these excuses merit the reinstatement of a claim. None of the above excuses has anything to do with the reasons for which a claim has been dismissed. None will be favorably looked upon by any tribunal. They are not favorably looked upon because the attorney praying for reinstatement never takes ownership of his own failure to act.

An attorney is responsible for the preparation of the evidence and its presentation before the tribunal. If the preparation or the presentation is deficient, it is not the client's fault, it is the attorney's. So too, when the attorney fails to act, it is not just the client's fault, it is also the attorney's.

Matters are dismissed for want of prosecution for many reasons, but ultimately, just one: the Petitioner's case was not presented to the arbitrator within three (3) years after filing. When a claim is dismissed for want of prosecution it is not the Commission's fault; it is not the Arbitrator's fault; it is not the Respondent's fault. It is the Petitioner's and his attorney's fault.

In the future, please refrain from arguing to the contrary. Rather, please explain the reasons for your own deficiencies or those of your client and posit a valid reason for reinstatement. Excuses will not be accepted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is hereby affirmed and adopted; and, the Petition for Reinstatement of the above-referenced claim is denied.

17IWCC0396

The party commencing 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: JUN 27 2017

Michael J. Brennan

MJB/pm
O: 5-2-17
052

Kevin W. Lamborn

Thomas J. Tyrrell

3rd Amended

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed.
Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

FILED
2016 APR -7 AM 10:15
2016 APR -7 AM 11:29
COMMISSION

Roberto Alvarenga Flores
mployee/Petitioner

Case # **11** WC **2348**

Chicago – Huebsch

Chicago Dryer Company
mployer/Respondent

17IWCC0396

O: Nyhan Bambrick Kinzie & Lowry
20 North Clark Street, Suite 1000
Chicago, Illinois 60602

On **04/1/2016**, at **2:00** PM, or as soon thereafter as possible, I shall appear before the Honorable **HUEBSCH** or any arbitrator or commissioner appearing in his or her place at **100 West Randolph 8th Floor Chicago**, Illinois, and present the attached motion for:

- ☐ Change of venue (#3072)
- ☐ Consolidation of cases (#3071) (list case#)
- ☐ Dismissal of attorney (#3052)
- ☐ Dismissal of review (#3085)
- ☐ Fees under Section 16 (#1600)
- ☐ Fees under Section 16a (#1645)
- ☐ Hearing under Sect.19(b) (#1902)
- ☐ Penalties under Sect. 19(k) (#1911)
- ☐ Penalties under Sect. 19(l) (#1912)
- ☒ Reinstatement of case (#3074)
- ☐ Request for hearing (#R33)
- ☐ Withdrawal of attorney (#3073)
- ☐ Other (explain)

ature Petitioner ☒ Respondent ☐

180 North Michigan Avenue, Ste. 2100
Street address

uardo C. Salgado - #815
ey's name and IC code # (please print)

Chicago, Illinois 60601
City, State, Zip code

MES ELLIS GUMBINER & ASSOCIATES
of law firm, if applicable

(312) 236-9751 **esalgado@jegumbinerlaw.com**
Telephone number E-mail address

ORDER

motion is set for hearing on _____

ure of arbitrator or commissioner

Date

DENIED

ORDER HEARING HELD

motion is ___ Granted ___ Withdrawn ___ Continued to _____

___ Denied ___ Dismissed ___ Set for trial (date certain) on _____

ure of arbitrator or commissioner

Date 4/7/2016

PROOF OF SERVICE

If the person who signed the *Proof of Service* is not an attorney, this form must be notarized.

17IWCC0396

Eduardo C. Salgado, affirm that I delivered ☐ mailed with proper postage ☒ in the city of **Chicago**

copy of this form at **5:00 PM** on ~~02/02/2016~~ 9/7/16 to each party at the address(es) listed below.

Nyhan Bambrick Kinzie & Lowry
20 North Clark Street, Suite 1000
Chicago, Illinois 60602

Signature of person completing *Proof of Service*

ned and sworn to before me on _____

ıry Public

Workers' Compensation Commission assigns code numbers to attorneys who regularly practice before it. To obtain or look up a code er, contact the Information Unit in Chicago or any of the downstate offices at the telephone numbers listed on this form.

AMENDED

ILLINOIS WORKERS' COMPENSATION COMMISSION
PETITION TO REINSTATE CASE

ATTENTION: This petition must be filed within 60 days of receipt of the dismissal order.

Herminia Alvarez
Employee/Petitioner

v.

~~Village Discount Outlet~~ Chicago Dryer Co.
Employer/Respondent

Case # ~~13~~ WC ~~29265~~ 11 2348

Chicago - Williams

17IWCC0396

FILED
2016 APR -7 AM 11:29
ILLINOIS WORKERS' COMPENSATION COMMISSION

On 12/07/2015, this case was dismissed for want of prosecution. I received the dismissal order on 02/01/2016. On 04/1/2016, I will present this petition to reinstate the case before Arbitrator Huebsch for the following reason:

On the date Petitioner's claim was dismissed it had been on the Arbitrator's call for only 63 days since the claims first reinstatement and less than a single trial cycle. On December 7, 2015 all parties were present including a representative from James Ellis Gumbiner & Associates, but Petitioner's claim was unfortunately dismissed. Prior to the date of dismissal James Ellis Gumbiner & Associates spoke with Respondent's counsel via telephone and provided counsel a verbal settlement demand on a disputed basis to resolve Petitioner's claim for benefits. Despite having a settlement demand in place and prior to receiving a rejections or even a counter offer Petitioner's claim was dismissed. At this time Petitioner is ready for trial and requests that this claim be reinstated so that it may be immediately resolved by way of settlement or trial. Petitioner request that special attention be noted to the fact that this is only the second reinstatement of his claim as well as the fact that the claim was not dismissed on Respondent's petition to dismiss but rather a special set date to discuss status of the claim. Given the fact that Petitioner's reinstatement is timely filed and comports with all requirements under the Act, we hereby request that Petitioner's reinstatement be granted.

Signature

James Ellis Gumbiner & Associates
Name (please print; attorneys, please include IC code #)

312 236-9751
Telephone number

2/1/16

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

KIMBERLY JACKSON,

Petitioner,

17IWCC0421

vs.

NO: 11 WC 06608

SALVATION ARMY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue the denial of Petitioner's Motion for Reinstatement of Case and being advised of the facts and law, finds it does not have the jurisdiction to entertain Petitioner's Petition for Review.

Pursuant to Respondent's Motion for a Date Certain or Dismissal, a hearing was held on December 1, 2015, with Arbitrator Williams presiding. He granted Respondent's motion and dismissed Petitioner's claim on that date and, also on that date, provided a copy of his dismissal order to counsel representing the respective parties. Subsequently, on January 4, 2016, counsel for Petitioner received a copy of Arbitrator Williams' December 1, 2015, dismissal order in the mail. On February 2, 2016, counsel for Petitioner filed a Motion for Reinstatement of Case. This motion was argued before Arbitrator Williams on June 30, 2016. Arbitrator Williams denied the motion on that date. Petitioner filed a Petition for Review of Arbitration Hearing the same day.

The basis for the Petition for Review of Arbitration Hearing is the same claim counsel for Petitioner made before Arbitrator Williams on June 30, 2016, namely that the Motion for Reinstatement of Case filed on February 2, 2016, was timely filed as it was filed within 60 days of receipt of the mailed copy of Arbitrator Williams' December 1, 2015, dismissal order and

17IWCC0421

should have been granted. The Commission disagrees with the assertion that the Motion for Reinstatement of Case was timely filed.

Petitioner acknowledged that an associate attorney was present and accepted the dismissal order on Petitioner's behalf from Arbitrator Williams on December 1, 2015. The Commission notes Rule 9020.90 in the State of Illinois' Rules Governing the Practice Before the Commission indicates that the party seeking reinstatement of a claim following a dismissal for want of prosecution "shall have 60 days from receipt of the dismissal order to file a Petition to Reinstate the cause onto Arbitration Call." 50 Ill. Adm. Code 9020.90 (2016). Noted further is that Rule 9020.90 differs from the language in Section 19(b) of the Act as Section 19(b) states that a petition for review of an arbitration decision must be filed within 30 days after receipt of the arbitration decision. 820 ILCS 305/19(b) (2013).

Rule 9020.90 specifically addresses motions seeking reinstatement of a claim after that claim has been dismissed for want of prosecution. Section 19(b) specifically addresses petitions to appeal an arbitration decision. In this particular case, the former, not the latter, applies as Petitioner is seeking reinstatement of her claim. The Commission finds Petitioner had 60 days from December 1, 2015, to file a Petition for Reinstatement of Case as Arbitrator Williams' dismissal order was personally tendered to Petitioner's counsel on December 1, 2015. Petitioner's counsel, therefore, had until January 30, 2016, to file a Petition for Reinstatement of Case. Petitioner's Petition for Reinstatement of Case was filed on February 2, 2016.

"[A] claimant's failure to timely file a petition for reinstatement following a dismissal for want of prosecution results in a final judgment with respect to the claimant's rights to recover workers' compensation benefits arising from the claim." *TTC Illinois, Inc./Tom Via Trucking v. Illinois Workers' Compensation Commission*, 396 Ill. App. 3d 344, 354, 918 N.E.2d 570, 579, 335 Ill. Dec. 225 (2009). The Commission notes this Court found the timeframe to reinstate a case to be jurisdictional in nature. *TTC Illinois, Inc./Tom Via Trucking*, 396 Ill. App. 3d 344 at 354.

The Commission, by virtue of Petitioner's failure to file her Petition for Reinstatement of Case within 60 days of receipt of the Arbitrator's dismissal Order, leaves the Commission without the jurisdiction to entertain said Petition for Review.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 30, 2016 is hereby affirmed and adopted.

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

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

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

17IWCC0421

DATED: JUN 29 2017
KWL/mav
O: 06/06/17

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michelle Brooks,

Petitioner,

vs. NO: 11 WC 12905

Regional Elite Airlines Service,

Respondent,

17IWCC0405

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, penalties, fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 22, 2016, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

17IWCC0405

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: JUN 27 2017
o060817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

BROOKS, MICHELLE
Employee/Petitioner

Case# **11WC012905**

REGIONAL ELITE AIRLINE SERVICES
Employer/Respondent

17IWCC0405

On 7/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0696 RITTENBERG BUFFEN GULBRANDSEN
IVAN M RITTENBERG
309 W WASHINGTON ST SUITE 900
CHICAGO, IL 60606

2904 HENNESSY & ROACH PC
EMILIE A MILLER
2501 OLD CHATHAM RD
SPRINGFIELD, IL 62704

17IWCC0405

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

- [ ] 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)

Michelle Brooks
Employee/Petitioner

v.

Regional Elite Airline Services
Employer/Respondent

Case # **11 WC 12905**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Urbana**, on **April 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 [x] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Vocational rehabilitation**

FINDINGS

On the date of accident, **5/12/2010**, 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 not* causally related to the accident.

In the year preceding the injury, Petitioner earned **$9,888.00**; the average weekly wage was **$190.00**.

On the date of accident, Petitioner was **42** 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 **$10,437.60** for TTD, **$0** for TPD, **$4,266.56** for maintenance, and **$0** for other benefits, for a total credit of **$14,704.16**.

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

ORDER

Prospective medical treatment is denied as Petitioner's current conditions of ill-being are not causally related to her work accident.

TTD and maintenance beyond that already paid by Respondent, or stipulated to be paid at the time of hearing is denied.

Vocational rehabilitation is denied.

Penalties and fees pursuant to Section 16, Section 19(k) and Section 19(l) are denied.

Respondent shall pay reasonable and necessary medical services incurred through March 27, 2013, pursuant to the fee scheduled as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit for any medical benefits paid.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Edward Lee
Signature of Arbitrator

7/22/16
Date

ICArbDec19(b)

JUL 22 2016

FINDINGS OF FACT

Petitioner worked for Respondent as a customer service agent and ground service worker. (T. 17). Petitioner was hired in March of 2010 and worked part-time earning $8.25 per hour. (T. 18). Petitioner testified that her job duties included loading and unloading baggage and freight from planes, hooking up ground power units, running the jet bridge, checking passengers in, cleaning the planes, stocking the planes, taking out the trash, running the deicer and marshaling in planes. Petitioner testified that the baggage she handled weight up to 70 pounds and that she would classify her job as heavy duty. (T. 26).

On May 12, 2010 Petitioner was helping a co-worker bring a jet bridge into a plane when she was struck by the plane's door. Petitioner testified that she was warned by her co-worker that the door was opening and in response turned her back to the door, put her hands behind her head with her hands interlocked and bent forward protecting her head with her shoulders up and her neck bent. (T. 33). Petitioner testified that when the door struck her it hit her upper back, neck, head, shoulders and elbows. (T. 31). Petitioner testified that when the door struck her it knocked her to her knees and she rolled over. (T. 33). Petitioner testified that the door that struck her was approximately three feet wide and weighed 600 pounds. (T. 31 and 34).

Petitioner was transported from the scene of her accident to Carle Foundation Hospital by ambulance. A CT scan of her neck and head were performed but were reported as normal. Petitioner was diagnosed with a head contusion and cervical strain and prescribed medication and light duty restrictions of no overhead work and no twisting with her neck. Petitioner was referred to Carle Clinic for follow up with Dr. Thomas Sutter. (Px's 6).

Petitioner first presented to Dr. Sutter on May 14, 2010. Based on Dr. Sutter's recommendation, Petitioner underwent multiple diagnostic tests of her cervical spine. Other than evidence of mild degenerative changes, Dr. Sutter noted Petitioner's diagnostic tests were normal. Dr. Sutter diagnosed Petitioner with chronic neck pain and recommended physical therapy and use of a TENS unit. He also continued Petitioner on light duty restrictions of no overhead work and no twisting her neck. After Petitioner's complaints worsened, Dr. Sutter recommended a second opinion. (Px's 6).

Petitioner was seen by Dr. David Fletcher on May 17, 2011. Dr. Fletcher diagnosed Petitioner with cervical myofascial pain syndrome superimposed on degenerative disc disease, but confirmed right shoulder impingement needed to be ruled out. Dr. Fletcher restricted Petitioner to light duty work involving no overhead activities and prescribed ongoing physical therapy and use of a TENS unit. He also recommended an MRI arthrogram of Petitioner's right shoulder. The MRI arthrogram of Petitioner's right shoulder completed on July 18, 2011 revealed a partial tear of the supraspinatus tendon and AC joint arthritis. (Px's 7 and 7a).

Subsequently, Petitioner came under the care of Dr. Lawrence Li for her right shoulder. Dr. Li initially administered a steroid injection into Petitioner' shoulder; however, when conservative treatment did not resolve her symptomology Dr. Li recommended arthroscopic rotator cuff repair and subacromial decompression. (Px's 3). That surgery was authorized following an Independent Medical Examination at Respondent's request with Dr. Richard Kube. Dr. Kube felt that if someone was struck from behind "very soundly with a large object" it was reasonable that could have resulted in the condition of Petitioner' right shoulder. (Px's 12).

On November 4, 2011, Petitioner underwent a right shoulder arthroscopic rotator cuff repair and subacromial decompression and distal clavicle excision with Dr. Li. Postoperatively Petitioner was sent for physical therapy and continued to treat with Dr. Li and Dr. Fletcher. (Px's 2). Shortly after her surgery Petitioner began to experience numbness in her lower right arm near the elbow and extending towards the hand. Dr. Li diagnosed Petitioner with right cubital tunnel syndrome and recommended a release and transposition of the ulnar nerve. However, EMG/NCV testing completed did not confirm cubital tunnel syndrome. . (Px's 3). Petitioner has a documented history of right cubital tunnel syndrome and release in 2006

Based on Dr. Li's new surgical recommendation, Respondent submitted Petitioner for an Independent Medical Examination with Dr. Thomas Kiesler on April 9, 2012. Based on Dr. Kiesler's opinion that Petitioner did not have cubital tunnel syndrome, but rather ulnar neuritis and that her symptoms of pain were not related to her work injury on May 12, 2010, surgery as recommended by Dr. Li was denied. (Rx's 5).

Petitioner also continued to complain of pain and popping in her right shoulder. Another injection was attempted by Dr. Li; however, after a bone scan revealed moderate radionuclide uptake in the right acromion in the area of the right AC joint Dr. Li recommended revision right shoulder arthroscopy with excision of the distal clavicle and debridement of scar tissue. That surgery was done on June 1, 2012 and revealed right shoulder AC joint dysfunction and scar tissue formation. (Px's 3).

Following her second surgery Petitioner did well; however, she continued to report symptoms in her right elbow and neck, as well as headaches. On August 7, 2012, Dr. Fletcher recommended a home exercise program and functional capacity evaluation. Petitioner submitted for a FCE at Safeworks Illinois on August 27, 2012. (Px's 7 and 7a). Petitioner was also submitted for updated EMG/NCV testing by Dr. Li on June 26, 2012. Petitioner's updated testing confirmed ulnar neuropathy at the right elbow. (Px's 3).

Based on the results of her FCE Dr. Fletcher placed Petitioner at maximum medical improvement effective September 4, 2012, with the exception of her right cubital tunnel, and released her with permanent restrictions per the FCE of no lifting more than 5 pounds floor to waist, 5 pounds waist to crown, and 5 pounds front carry on an occasional basis. However, Dr. Fletcher also referred Petitioner for a neurology consult due to her report of ongoing cervicogenic headaches. Dr. Fletcher's diagnosis for Petitioner as of September 4, 2012 included cervical myofascial pain syndrome imposed on degenerative disc disease, recurrent right ulnar neuropathy and cervicogenic headaches. (Px's 7 and 7a).

Petitioner was seen by neurologist Dr. Barry Riskin on September 20, 2012 for her headaches. After reviewing the results of an updated MRI of Petitioner's cervical spine completed on September 14, 2012, Dr. Riskin noted no cervical radiculopathy and recommended she work on her guarding behaviors, including elevation of the shoulders and forward thrusting of the chin to prevent a cycle of spasms and pain, and advised her to stop smoking. Dr. Riskin noted that smoking has been reported to intensify pain sensitivity. (Rx's 5).

After seeing Dr. Riskin Petitioner returned to Dr. Fletcher on September 24, 2012. Due to Petitioner's ongoing reports of cervicogenic headaches Dr. Fletcher

referred her back to Dr. Thatcher for pain management treatment and cervical epidural steroid injections. (Px's 7 and 7a).

Medical records from Dr. Thatcher confirm that Petitioner underwent a series of three epidural steroid injections on October 10, 2012, November 14, 2012 and December 11, 2012. (Px's 5). Petitioner testified that the injections helped a lot. (T. 78).

After her first injection Petitioner returned to Dr. Fletcher on November 8, 2012 and reported improvement in her cervicogenic headaches and neck pain. On examination Dr. Fletcher noted improved range of motion in Petitioner's cervical spine and right shoulder. Range of motion in Petitioner's right shoulder was noted to be normal. Dr. Fletcher noted Petitioner's cervical spine was definitely improved. Due to Petitioner's response to the first injection, Dr. Fletcher recommended a second injection. (Px's 7 and 7a).

After her second injection on November 14, 2012 Petitioner returned to Dr. Fletcher on November 29, 2012. Despite her exam findings and noted improvement, Petitioner reported right shoulder pain and swelling and swelling in her neck with pressure in her head. However, Dr. Fletcher continued to note improvement in Petitioner's cervicogenic headaches and range of motion. (Px's 7 and 7a).

Petitioner again returned to Dr. Fletcher on December 31, 2012 with reports of popping in her neck with headaches. After noting that Petitioner had been seen for 35 visits for two years, Dr. Fletcher again confirmed Petitioner was a maximum medical improvement and noted that aside from her right ulnar nerve issue she would not benefit for any further medical treatment. (Px's 7 and 7a).

Despite confirming again that Petitioner was at maximum medical improvement and required no further treatment as of December 31, 2012, Dr. Fletcher saw Petitioner again on January 28th, February 28th and March 27th, 2013. As of March 27, 2013 Petitioner reported that her condition was worse. However, again Dr. Fletcher confirmed Petitioner was at maximum medical improvement. (Px's 7 and 7a).

After March 27, 2013 there is no record of treatment of Petitioner again until March 10, 2014. On March 10, 2014 Petitioner presented to the emergency room at Carle Foundation Hospital with complaints of a headache, neck pain and right shoulder

pain after falling on ice and hitting the right side of her face on the bumper of a car and then falling to the ground. (Px's 6).

Thereafter, on April 17, 2014 Petitioner presented to Dr. Patrick Sweeney with complaints of ongoing popping and grinding to the back right side of her neck, headaches, neck pain radiating into both shoulder blades, and burning, numbness, and tingling in her right elbow down to her right fourth and fifth fingers related to her work injury on May 12, 2010. Petitioner testified that her examination with Dr. Sweeney was arranged by her attorney. Petitioner did not report her March 10, 2014 fall to Dr. Sweeney. (Px's 8).

After examining Petitioner and reviewing her medical records Dr. Sweeney diagnosed Petitioner with cervical facet syndrome and suboccipital neuritis. For treatment Dr. Sweeney recommended referral for a facet block trial and suboccipital injections. (Px's 8).

Dr. Sweeney was deposed on October 2, 2015 and testified that in his opinion Petitioner's neck problems were causally related to her work accident. On cross examination Dr. Sweeney explained that in his opinion Petitioner's facet joints were chronically injured at the time of her accident due to the fact that her accident involved a complex whiplash type injury. Dr. Sweeney explained that a whiplash type injury involves a sudden acceleration and deceleration that results in injuries to the ligaments, the tendons, the facet joint capsules and the muscles. However, on cross examination, Dr. Sweeney admitted that Petitioner's ongoing problems as of April of 2014 could be related to her falling and hitting her head on the bumper of a car rather than her work accident, especially if there were no medical records between the end of 2012 or beginning of 2013 and March 10, 2014 showing ongoing complains by Petitioner related to her work accident. (Px's 10).

After seeing Dr. Sweeney, Petitioner was submitted for an Independent Medical Examination with Dr. Timothy VanFleet to address her need for ongoing treatment related to her work accident. Dr. VanFleet examined Petitioner on October 22, 2014 and was deposed on December 9, 2015. Dr. VanFleet testified that after examining Petitioner and reviewing all of her medical records he diagnosed her with chronic cervicalgia and cervical spondylosis. Dr. VanFleet testified that in his opinion Petitioner's current condition was not casually related to her work accident. Dr.

VanFleet explained that given the period of time between Petitioner's accident and her intervening injury of March 10, 2014, her current condition is related to her intervening injury and not her work accident. Dr. VanFleet also testified that in his opinion Petitioner did not require ongoing work restrictions. (Rx's 4).

Dr. Kube was also deposed by Petitioner's attorney related to his examinations of Petitioner. Dr. Kube's deposition took place on October 19, 2015. Dr. Kube examined Petitioner at Respondent's request on July 1, 2011 and February 24, 2012 in regard to both her neck and right shoulder. Dr. Kube testified that after examining Petitioner on July 1, 2011 he diagnosed her with a crush injury to her shoulder and neck. Dr. Kube testified he felt Petitioner's conditions were causally related to her work accident and recommended ongoing treatment for her right shoulder as of July 1, 2011 in the form of an MRI and physical therapy and TENS unit for her neck. Petitioner ultimately had that treatment and more upon authorization by Respondent. Dr. Kube testified that after conducting an updated examination of Petitioner on February 24, 2012, it was his opinion that she required ongoing treatment of her right shoulder with Dr. Li, but had reached maximum medical improvement for her neck absent work conditioning and possibility an FCE. Dr. Kube had no opinion as to Petitioner's status after February 24, 2012. (Px's 12).

Petitioner ultimately underwent an FCE as recommended by Dr. Fletcher; however, Dr. Fletcher never ordered work conditioning for Petitioner. Instead, Dr. Fletcher imposed permanent restrictions as noted based on the FCE and discharged Petitioner at maximum medical improvement effective September 4, 2012. (Px's 7 and 7a).

In addition to seeking ongoing treatment related to her neck as recommended by Dr. Sweeney, Petitioner is also seeking ongoing treatment of her right arm related to her right cubital tunnel syndrome. Dr. Li, who initially diagnosed Petitioner's right cubital tunnel syndrome in 2011 testified via deposition on December 7, 2015. Dr. Li testified that in his opinion Petitioner has recurrent right cubital tunnel syndrome that resulted from her being placed in a sling for six weeks following her first shoulder surgery on November 4, 2011. Dr. Li testified that cubital tunnel sometimes occurs in these cases as a result of swelling from the shoulder pooling in the elbow. However, Dr. Li testified that this only occurs in 5 out of 150 cases, or less than 0.04% of the time. (Px's 11).

As noted, Petitioner was previously diagnosed with right cubital tunnel syndrome in 2006 and underwent surgery. Records from that surgery were not admitted into evidence. However, EMG/NCV testing completed in December of 2011, right after Petitioner was taken out of the sling, showed no evidence of right ulnar neuropathy. In fact, Dr. Li testified that the EMG/NCV results from December of 2011 were within normal limits and could have been residuals from her prior surgery. (Px's 11).

Dr. Li testified that Petitioner did not begin complaining of pain in her elbow or numbness and ringing until after her first surgery. However, Petitioner testified to pain in her elbow since the time of her accident. Petitioner also reported to Dr. Kiesler, Respondent's IME doctor, ongoing swelling in her right elbow since her surgery in 2006. (Rx's 5).

Dr. Kiesler was deposed on November 3, 2015and testified that Petitioner did not have recurrent right cubital tunnel syndrome, but rather ulnar neuritis unrelated to her work accident. (Rx's 5).

While Petitioner ultimately had an updated EMG/NCV study of her right upper extremity in June of 2012 that showed right ulnar neuropathy, Dr. Li noted in his review of the results of that testing on July 10, 2012 that Petitioner's condition was related to a work injury she suffered in 2006 and the fact that the previous surgeon had not performed transportation of the ulnar nerve (Px's 3).

Dr. Sweeney also provided an opinion related to Petitioner's right cubital tunnel at Petitioner's attorney's request. Dr. Sweeney opined that in his opinion Petitioner's ulnar neuropathy was not causally related to her work injury. (Px's 10, Exh. 1).

Petitioner returned to Dr. Li for treatment on October 28, 2015. Prior to October 28th Petitioner had not been seen by Dr. Li since July 10, 2012. As of October 28th Dr. Li ordered an updated MRI of Petitioner's right shoulder and EMG/NCV study. Petitioner's MRI was completed on October 30, 2015 and was negative for any recurrent tear but showed residual tendinopathy consistent with Petitioner's surgery. Petitioner's EMG/NCV was completed on November 17, 2014 and confirmed right ulnar neuropathy. After both tests Petitioner followed up with Dr. Li on November 24, 2015 Dr. Li again recommended Petitioner proceed with a right cubital tunnel release and ulnar nerve transposition. Dr. Li recommended no ongoing treatment related to Petitioner's right shoulder. (Px's 11, Exh. 1-8).

Despite initially returning to work light duty for Respondent after her accident, Petitioner's employment with Respondent ended effective August 31, 2010 when Respondent went out of business. (T. 47). Petitioner remained off work until released at maximum medical improvement effective September 4, 2012. Respondent has paid and/or stipulated to paying Petitioner TTD from August 31, 2010 through September 4, 2012 and maintenance from September 5, 2012 through March 10, 2013. Petitioner's maintenance benefits were terminated effective March 10, 2013 for failure to conduct a job search.

Petitioner testified that she looked for work after being laid off by Respondent. Petitioner testified that she looked at 30 to 40 places but no one would accommodate her restrictions. (T. 48). No documentation of job searches was admitted into evidence by Petitioner.

Petitioner testified that she has continued to experience pain in her head, neck, shoulders and elbows since her accident. Petitioner testified that she became subsequently employed in April of 2014 as a cashier at a gas station. (T. 57). Petitioner testified that she found the job through her fiancé's uncle who was the manager. (T. 58). Petitioner testified she was original hired in the kitchen but that the kitchen never opened so they moved her to a cashier. (T. 70). Petitioner testified that she earned $9.00 an hour when initially hired but received a raise to $9.25. Petitioner testified that she worked full time 40 hours a week and worked within her restrictions. (T. 57 and 75).

Respondent admitted a copy of Petitioner's employment file from her employer, Gilman OPCO, into evidence. Those records confirm Petitioner's employment beginning April 21, 2014. At the time Petitioner's position was changed to a cashier she signed a job description confirmed her acknowledgement of her job duties. Within the job description is a section entitled "Requirement of the Job" that outlines the "essential functions" of the job of a cashier. Included in those functions is the following: (Rx's 3).

1. Can lift up to 50 pounds, and carry cases of milk cartons and soft drinks, beer, and juice containers;
2. Stands and walks 8-10 hours a day without breaks on a tile or concrete surface while completing job duties.

3. Lifts and carries stock weighing up to twenty-five (25) pounds while stocking shelves and cooler.
4. Pulls and pushes up to twenty0five (25) pounds to move stock.
5. Bends and stoops to stock low shelves in store, cooler and to clean.
6. Frequently reaches in order to stock and clean store. *Id.*

All of these essential functions exceed Petitioner's restrictions as imposed by Dr. Fletcher. Petitioner acknowledged signing the job description, but testified that she did not perform these functions. (T. 72 and 78).

Petitioner testified that she remained employed with Gilman OPCO until October 4, 2015 when they went out of business. After October 4, 2015 Petitioner testified she was unemployed until April 12, 2016 when she found employment as a cashier at Casey's gas station. (T. 73-74).

CONCLUSIONS OF LAW

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

The current conditions of Petitioner's neck and right arm are not causally related to her work accident on May 10, 2010. After last seeking active treatment for her neck in 2012 Petitioner sustained an intervening injury that severed the chain of causation between her condition and work accident. Petitioner had a significant accident on March 10, 2014 requiring emergency room treatment after she fell on ice and hit her face on the bumper of a car. Upon presenting to the emergency room Petitioner complained of a headache, neck pain and right shoulder pain, since her fall. Petitioner did not report a history of ongoing headaches, neck pain or right shoulder pain related to her work accident. While Petitioner testified that she had ongoing headaches, neck pain, right shoulder pain and right elbow pain since her work accident, Petitioner did not seek treatment for these complaints after the end of 2012 beginning of 2013.

Petitioner testified that the reason she did not seek treatment was that Respondent's insurance carrier was denying her treatment. However, it is noted from records admitted into evidence by Petitioner that she did in fact seek medical treatment between the end of beginning of 2013 and March 10, 2014 at Carle Clinic for conditions unrelated to her work accident. During those visits Petitioner did not report any

complaints of headaches, neck pain, right shoulder pain or elbow pain. It is also noted that Petitioner failed to report her intervening injury to Dr. Sweeney even though it occurred only one month prior to her visit with him.

These facts when taken together with Dr. VanFleet's and Dr. Sweeney's testimony, supports that the current condition of Petitioner's neck is not causally related to her work accident. Both Dr. VanFleet and Dr. Sweeney testified that Petitioner's ongoing neck problems could solely be related to her intervening injury in March of 2014. This Arbitrator believes that if Petitioner's neck continued to be a problem after the beginning of 2013 she would have sought treatment as she did for problems unrelated to her work injury.

With regard to Petitioner's cubital tunnel, Dr. Li's opinion that Petitioner's recurrent cubital tunnel syndrome is causally related to her work accident is not credible. Dr. Li testified that Petitioner's problems with her cubital tunnel only began after her first surgery. However, Petitioner reported ongoing problems with her right elbow following her first surgery in 2006. Also, the EMG/NCV testing conducted in December of 2011, most contemporaneously with the time Petitioner was in a sling, was normal. It was not until June of 2012 that Petitioner's EMG/NCV testing showed a right ulnar neuropathy. Furthermore, Dr. Li testified that Petitioner's findings on EMG/NCV could have been consistent with a residual from her surgery in 2006. Also, Dr. Sweeney opined that Petitioner cubital tunnel was unrelated to her work accident.

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

Petitioner is seeking payment of medical bills incurred from the date of her accident to the present. Respondent is ordered to pay Petitioner's related medical bills incurred through March 27, 2013, Petitioner's last visit with Dr. Fletcher. Respondent is also given a credit for any bills already paid. Respondent is not responsible for Petitioner's unpaid medical bills incurred after March 27, 2013.

K. Is Petitioner entitled to prospective medical care?

As a finding has been made that Petitioner's current conditions of ill-being are not causally related to her work injury, Petitioner's request for prospective medial treatment is denied.

L. Is Petitioner entitled to TTD and/or maintenance benefits?

Petitioner is seeking payment of TTD or maintenance from March 11, 2013 through April 21, 2014 and October 4, 2015 through April 12, 2016. The Arbitrator finds Petitioner is not entitled to TTD or maintenance for these periods. First, maintenance and TTD are separate and distinct benefits. *Freeman United Coal Mining Co. v. Industrial Commission*, 318 Ill.App.3d 170, 741 N.E.2d 1144,251 Ill.Dec. 966 (5th Dist. 2000). Once the petitioner has reached maximum medical improvement, he or she is no longer temporarily and totally disabled, and entitlement to TTD benefits ceases.

Taking the first period alleged by Petitioner from March 11, 2013 through April 21, 2014, Petitioner's condition had stabilized as of September 4, 2012 when she was placed a maximum medical improvement by Dr. Fletcher. Therefore, all benefits paid after September 4, 2012 are classified as maintenance. Section 8(a) provides that the employer shall pay for the "physical, mental and vocational rehabilitation of the employee, *including all maintenance costs and expenses incidental thereto.*" Therefore, payment of maintenance benefits is incidental to vocational rehabilitation and Petitioner is only entitled to maintenance where there is proof of participation in a vocational rehabilitation program. There is no proof in this case from testimony or records that Petitioner participated in a vocational rehabilitation program.

While Petitioner testified to a self-direct job search beginning after she was placed at maximum medical improvement, no evidence of such job search, via job logs or applications was provided. Petitioner testified that she kept records and provided those records to her prior attorney, Kevin Markes; however, again, those records were not admitted into evidence to support Petitioner's testimony. In fact, Petitioner provided no specific testimony related to any jobs she applied for after she was placed at maximum medical improvement. While Petitioner testified that she ultimately became subsequently employed in April, 2014 with Gilman OPCO, she testified that that job was offered to her by a family friend and was not part of any active job search. (T. 58).

With regard to the second period claimed by Petitioner from October 4, 2015 through April 12, 2016, Petitioner is not entitled to TTD for this period as she was at maximum medical improvement for her work injury. She is also not entitled to maintenance benefits there is no proof of participation in a vocational rehabilitation program.

M. Should penalties and fees be imposed upon Respondent?

Petitioner argues that she is entitled to penalties and attorney's fees pursuant to Section 19(k), 19(l) and 16 due to Respondent's failure to provide her vocational rehabilitation and TTD or maintenance benefits after March 10, 2013. As a finding has been made (see findings with regard to issue O) that Petitioner was not entitled to vocational rehabilitation and Petitioner failed to provide evidence of participation in a job search, Petitioner's petition for penalties and fee is denied.

O. Is Petitioner entitled to vocational rehabilitation?

Petitioner argues that she was entitled to vocational rehabilitation at Respondent's expense after her employment with Respondent ended on August 31, 2013 (Px's 16). The Arbitrator finds Petitioner was not entitled to vocational rehabilitation then or now.

It is undisputed that Petitioner's employment with Respondent ended as of August 31, 2010 due to Respondent going out of business. After Respondent went our of business and Petitioner was laid off Respondent continued to pay Petitioner TTD until she was discharged at maximum medical improvement by Dr. Fletcher effective September 4, 2012 with permanent restrictions. Thereafter, Petitioner's benefits were continued as maintenance benefits until March 10, 2013 when her benefits were terminated for failure to provided evidence of a job search. (Rx's 2). While Petitioner testified that she looked for a job after August 31, 2010, she offered no proof of a job search at hearing.

Petitioner's argument appears to be that Respondent had a statutory right to provide her vocational assistance under Section 8(a) after she was prescribed

permanent restrictions by Dr. Fletcher; however, the Supreme Court in *Hunter Corp.* v. *Industrial Commission* has confirmed that it is the petitioner that has the burden of proving the necessity for any rehabilitative efforts, as well as the actual benefit that would flow from them. 86 Ill.2d 489, 427 N.E.2d 1247,56 Ill.Dec. 701 (1981). The Arbitrator finds that Petitioner has not met her burden of proof in this regard.

The Supreme Court set forth guidelines in *National Tea Co.* v. *Industrial Commission*, 97 Ill.2d 424, 454 N.E.2d 672, 73 Ill.Dec. 575 (1983), to help determine when an award of vocational rehabilitation is necessary. Those factors include:

Factors favoring rehabilitation:

a. The employee has sustained an injury that caused a reduction in earning power, and there is evidence rehabilitation will increase his or her earning capacity.

b. The employee is likely to lose job security due to the injury.

c. The employee is likely to obtain employment upon completion of rehabilitation training.

Mitigating factors against rehabilitation:

a. The employee has unsuccessfully undergone similar treatment in the past.

b. The employee has received training under a prior rehabilitation program that would enable him or her to resume employment.

c. The employee is not trainable due to age, education, prior training, and occupation.

d. The employee has sufficient skills to obtain employment without further training or education. *Id. at 432*

Other appropriate factors to consider are (a) the relative costs and benefits to be derived from the program, (b) the employee's work-life expectancy, (c) the employee's ability and motivation to undertake the program, and (d) the employee's prospects for recovering work capacity through medical rehabilitation or other means. *Id. at 433.*

There are no factors here favoring the need for vocational rehabilitation. Petitioner was an unskilled part-time employee earning minimum wage. Petitioner had sufficient skills to obtain employment without further training or education within her restrictions. This is evidenced by the fact that Petitioner found two subsequent jobs without assistance earning more than she was earning when employed by Respondent.

Furthermore, the cost of vocational assistance in this case would have been outweighed by any benefits. Therefore, no benefit would have flowed from vocational rehabilitation.

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

Veronica Sanchez,

Petitioner,

vs.

NO: 11 WC 13983

Yoli Inc., d/b/a Mi Costanita

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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 causation, medical expenses, temporary total disability and res judicata, reverses the Decision of the Arbitrator, for the reasons stated below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Comm'n*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

I. HISTORY OF THE CASE

A) 6/26/12 §19b Arbitration Decision

In a prior §19(b) decision dated 6/26/12, and involving claims 11 WC 13982, 11 WC 13983 and 11 WC 144476, Arbitrator Kelmanson found that Petitioner proved she sustained accidental injuries arising out of and in the course of her employment on 12/15/09 [11 WC 13982], 2/24/11 [11 WC 13983] and 6/1/09 [11 WC 13983] and that Petitioner's current conditions of ill-being are causally related to said accidents. In addition, the Arbitrator found that Petitioner was temporarily totally disabled from 3/3/11 through 5/25/11, for a period of 12 weeks, and that with respect to Petitioner's "...putative claim for repetitive trauma to the left elbow and arm" Respondent was to pay further TTD from 5/26/11 through 2/15/12 "...provided Petitioner timely files an application for adjustment of claim." Furthermore, the Arbitrator found

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that Petitioner was entitled to bills from MercyWorks for services rendered on 12/30/09, 1/6/10 and 1/15/10 as well as the "...related medical bills in evidence that are associated with Petitioner's back condition and were incurred prior to May 25, 2011." Finally, the Arbitrator found that with respect to Petitioner's "...putative claim for repetitive trauma to the left elbow and arm" Respondent shall pay the related medical bills incurred on or before 2/13/12 "provided Petitioner timely files an application for adjustment of claim." (6/26/12 Arb.Dec.).

B) 4/13/13 Corrected Commission Decision and Opinion on Review

In a Corrected Decision and Opinion on Review dated 4/11/13, involving claims 11 WC 13982, 11 WC 13983 and 11 WC 144476, the Commission struck the "conditional phrases" and the "qualification" language used by the Arbitrator to the effect that Petitioner was to file a timely application with respect to her "putative" claim concerning her left elbow and arm. The Commission also clarified the Arbitrator's decision by noting that "... all transportation charges, whether they were non-emergency or not, are denied." (13 IWWC 348).

C) 3/8/16 §19(b) Arbitration Decision

With respect to the present §19(b) decision currently on review, involving only claim 11 WC 13983, Arbitrator Kane found that "[r]es judicata applies in this case" and that "... Petitioner was essentially found at MMI as of 2/15/12 for the left arm at the prior hearing. As such, the issue cannot be contested again." (3/8/16 Arb.Dec.[Addendum], pp.5-6). In addition, the Arbitrator found "... the records of Marque Medicos are not credible. The Arbitrator adopts the opinion of Dr. Caroll [sic] that Petitioner was at MMI for her elbow prior to the date of the previous hearing." (Id., p.6).

Furthermore, the Arbitrator found that "Petitioner has failed to prove that her extensive medical treatment was reasonable and necessary", noting that "... the treatment rendered by Marque Medicos and Medicos Pain & Surgical Specialists is not unlike an annuity plan. Further, as she was found at MMI at the prior hearing, her decision to continue to treat in contravention of the Arbitrator's findings should not be Respondent's responsibility." (Id., pp.6-7). The Arbitrator also "explicitly denied" all bills after 5/25/11 for the back, given the prior arbitration decision finding of MMI on that date. (Id., p.7). Likewise, the Arbitrator denied the transportation charges that appear on the bill from Medicos Pain & Surgical Specialists, noting that "... these charges are inherently unreasonable and exorbitant by any standard. Moreover, there is nothing in the record to show that these charges were necessary as Petitioner never testified that she required transportation as a result of her condition. In fact, Petitioner testified that she drives." (Id.).

Finally, the Arbitrator denied further TTD after 2/15/12 based on the Commission's prior determination of MMI and the records of Dr. Nam. (Id., p.8). The Arbitrator also denied maintenance benefits after that date, noting that "Petitioner failed to meet her burden of establishing that she conducted a diligent but unsuccessful search for employment..." (Id.). As a result, the Arbitrator found that "Petitioner was previously found at maximum medical improvement for the left elbow as of 2/15/12. She was previously found at MMI for the back as of 5/25/11. Subsequent benefits are denied, respectively." (Id., pp.5,9).

II. FINDINGS OF FACT

A. *Discussion on the Record* (2/23/16) 17IWCC0382

A hearing was held with respect to the present §19b petition on 2/23/16. At the commencement of said hearing, the Arbitrator noted that "... it's agreed by both parties the other three cases (11 WC 13982, 11 WC 14476 & 12 WC 23822) are not relevant for purposes of this 19(b), that we're only talking about the left elbow. And one of those cases (12 WC 23822) was a second filing related to the left elbow..." (T.6). After further discussion, the Arbitrator noted that "... I think it could be stated for the record that that filing (12 WC 23822) made subsequent to the hearing, the Commission declared it as a nullity, essentially." (T.7). Both attorneys agreed that this was a fair statement. (T.7).

In addition, counsel for Respondent represented that "[w]ith respect to accident, Respondent is not disputing that there was an accident on 2/24/11 with regard to the left elbow. However, we are disputing that the accident is related or relevant to any treatment subsequent to the prior date of trial." (T.11).

B. Testimony of Petitioner (2/23/16)

At the hearing held on 2/23/16, Petitioner testified through an interpreter that she last testified at arbitration on 5/14/12. (T.17). She agreed that she hurt her left elbow, among other things, on 2/24/11, while working for Respondent. (T.18). She also agreed that Dr. Nam had essentially discharged her for her left elbow on 4/16/12 after having performed a left cubital tunnel release with anterior transposition of the ulnar nerve on 9/20/11. (T.20; PX15).

Petitioner testified that at the time of Dr. Nam's discharge in April of 2012 her symptoms were "better", noting that presently her "... fingers don't hurt anymore, but [her] elbow does swell up." (T.20-21). She noted that at the time of her release "... it was better; but with constant movement it will start forming again." (T.22).

Petitioner indicated that she did not go back to work for Respondent or any other company from 2/24/11 through the date of trial, noting that "[t]hey didn't give [her] work anymore." (T.22). She noted that in August of 2012, or after the last hearing, Dr. Engel sent her for work conditioning at Elite Physical Therapy. (T.22). She indicated that work conditioning was four hours a day and that it involved "... moving [her] arm with a ball and an elastic band and weights to see how much [she] could lift." (T.22-23). She stated that during the initial days of work conditioning "[i]t would bother [her]. It would hurt [her]. Then [she] had to wear a hot patch [on her left arm around the elbow area] so that the swelling would go down." (T.23). She indicated that lifting the weight and pulling the elastic band caused her to experience increased pain. (T.23). She agreed that this was the most strenuous activity she had done since leaving work. (T.23-24).

Petitioner agreed that in August of 2012 Dr. Engel sent her to a different surgeon, Dr. Sclamberg, for a consultation. (T.24). She noted that her symptoms were the same when she saw Dr. Sclamberg as at the time of the last trial. (T.24). She agreed that Dr. Sclamberg

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recommended surgery for her elbow, and that she underwent said surgery on 9/25/12. (T.24). She agreed that she underwent physical therapy afterwards at Marque Medicos and work conditioning with Elite Physical Therapy. (T.24-25). She noted that she improved "[s]omewhat" after surgery in that she "... can lift a little heavier weight." (T.25). She indicated that she also underwent a functional capacity evaluation at the end of her treatment at Elite, and that Dr. Sclamberg subsequently released her with permanent restrictions on 5/21/13 based on the FCE. (T.25). She also noted that following her surgery she used a continuous passive motion machine to move her elbow that Dr. Sclamberg recommended. (T.26).

Petitioner testified that since her discharge with restrictions she has not been offered work by Respondent, noting that she asked to return "... but they won't give [her] any." (T.26). She indicated that she has not worked anywhere else for pay since, although she did volunteer work cleaning at a church about half a year ago. (T.26-27). She noted that she was only there about three months "... because when [she] would mop [her] elbow would swell up." (T.27). She stated that this was her church and that Public Aid would send her there to do community service. (T.27). She indicated that other than that, she has not done anything else. (T.28).

Petitioner agreed that she was seen for a vocational rehabilitation assessment by Kari Stafseth at Vocamotive on 3/11/14. (T.28). She noted that she has not received the services recommended by Ms. Stafseth, but that she wants Vocamotive's help in finding a new job. (T.28). When asked if she's "... not currently as we sit here today actively looking for work...", Petitioner responded: "[w]ell, yeah. But they won't give me any with the restrictions I'm under." (T.29).

Petitioner agreed that she is not currently in treatment with Dr. Sclamberg for her elbow, and that she has not suffered any other intervening accidents or injuries involving her left arm or elbow since February of 2011. (T.29). Petitioner indicated that she never met with a vocational expert for Respondent named Samantha Allen and that she never personally met with Dr. Charles Carroll regarding her elbow. (T.29).

On cross, Petitioner agreed that she was released from treatment by Dr. Nam for her left elbow on 2/13/12 and that she continued to treat for her back with Dr. Engel after that. (T.30). She likewise agreed that she saw Dr. Nam next on 3/12/12 and was released again for her left elbow. (T.30-31). She indicated that she last saw Dr. Nam on 4/16/12 at which time she was once more released with respect to her left elbow. (T.31). She agreed that Dr. Nam had ordered work conditioning while she was actively treating with him and not after he released her. (T.31). Petitioner agreed "more or less" with the records if they show there was an approximately four-month gap in treatment between the date Dr. Nam released her until she started treating with Dr. Schlamberg in August of 2012. (T.32). She also noted that no one ever restricted her from driving during the course of her treatment. (T.32). Petitioner indicated that she does drive but that she does not have a car. (T.32-33).

Petitioner agreed that Dr. Engel treated her only for her back, and that Dr. Sclamberg ordered the second round of work conditioning. (T.33). She noted that when she performed community service at the church approximately six months ago she was compensated with "... some kind of monetary assistance for [her] kids", known as TANF, which she was apparently

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required to do in order to receive Public Aid. (T.33-34). Petitioner indicated that she was not paid for this work. (T.34). She stated that she applied for work about two months ago and completed about six applications at "[p]izza places, Dollar Tree Stores, stores that are close to where [she] live[s]." (T.35). Petitioner agreed that between March of 2014 and December of 2015 she did not seek any employment. (T.36). However, when asked whether she has sought employment in the last two months she responded: "... [y]es, I did, because since I could no longer do this community service they took away the Public Aid." (T.36).

On re-direct, Petitioner agreed that on the day of the surgery with Dr. Sclamberg she was provided transportation by her doctors back and forth and that she was given a sedative for the surgery. (T.36-37).

C. *Selected Medical Records*

An MRI of the left elbow performed on 3/16/11 was interpreted as revealing 1) mild thickening at the origin of the common flexor tendon, correlate for clinical findings of medial epicondylitis; 2) superficial edema along the posterior aspect of the medial epicondyle extending to the region of the cubital tunnel, the ulnar nerve appears slightly prominent in this region, correlate for clinical findings of a post-traumatic ulnar neuropathy. (PX1).

An EMG performed on 3/25/11 reflects the following impression: 1) there is electrophysiologic evidence of a neuropraxic lesion of the left ulnar nerve at or about the elbow (cubital tunnel) resulting in decreased conduction velocities of the motor and sensory fibers through this region; 2) there is also a neuropraxic lesion of the left median nerve at or about the wrist (carpal tunnel) resulting in decreased conduction velocities of the sensory fibers through this region. (PX1).

In a progress note dated 4/25/11, Dr. Nam noted Petitioner was still having pain in her left elbow with numbness along her fourth and fifth digits of the left hand. (PX1). Dr. Nam's impression at that time was 1) left elbow pain with medial epicondylitis, 2) left cubital tunnel syndrome. (PX1). Dr. Nam noted that it appeared Petitioner's left elbow pain was more symptomatic than her numbness at that time and administered a cortisone injection. (PX1). Dr. Nam also indicated that Petitioner was to remain off work and continue with therapy. (PX1).

In a progress note dated 5/9/11, Dr. Nam noted that the cortisone injection did not provide significant relief of pain, and that Petitioner was to continue with her physical therapy exercises. (PX1). Dr. Nam also indicated that Petitioner could return to work at a desk job with no lifting with the left arm; otherwise, she was to remain off work. (PX1).

In a progress note dated 8/8/11, Dr. Nam noted that Petitioner was experiencing persistent numbness in the fourth and fifth digits with left elbow pain on the medial side. (PX1). Dr. Nam indicated that since it appeared Petitioner's "... left cubital tunnel syndrome is the most symptomatic and the medial epicondylitis is a mild issue at this time" the plan was to proceed with the left cubital tunnel release with an anterior transposition of the ulnar nerve. (PX1).

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In an operative report dated 9/20/11, Dr. Nam noted a pre and postoperative diagnosis of left elbow cubital tunnel syndrome. (PX15). The procedure performed was left cubital tunnel release with anterior transposition of ulnar nerve. (PX15).

In a progress note dated 12/12/11, Dr. Nam noted that Petitioner had "... markedly improved, with minimal numbness at times along her fourth and fifth digits and some mild left elbow pain." (PX1). Dr. Nam indicated that "[h]er work restrictions are no lifting with the left arm. We will transition her to a work-conditioning program." (PX1).

In a progress note dated 2/13/12, Dr. Nam noted that the numbness in Petitioner's left arm was gone and that "[t]he patient states she experiences occasional pain in her left elbow." (RX7). Dr. Nam concluded that "[i]n terms of her left elbow and left upper extremity, I am going to release her to work without restrictions in regards to her left elbow. We will hold off on physical therapy and work conditioning in regards to her left upper extremity as she appears to be functioning well. I feel that she will be at MMI in terms of her left upper extremity at approximately six months post-op. The patient is discharged from my care for the left elbow." (PX1;RX7).

In a progress note dated 3/12/12, Dr. Nam noted that Petitioner's "... left elbow is overall doing well. She does have some pain along the medial aspect of her left elbow. No numbness in her hands. Surgery resolved the numbness in her fingers. She is apparently still being treated for her back condition as she is complaining of pain in her back region." (PX1). Dr. Nam indicated that "[r]egarding her left elbow, I am going to release her to work without restrictions. We will hold off on physical therapy as well as work conditioning for her left upper extremity. I am going to discharge her from my care." (PX1). A separate work status form by Dr. Nam dated 3/12/12 also shows that Petitioner was discharged to full duty at that time. (RX8).

In a progress note dated 4/16/12 Dr. Nam recorded that "[o]verall, she states that the numbness in her fingers has gone. She does have some pain along the medial aspect of her left elbow at times. (PX15). Dr. Nam's impression was 1) status post left elbow cubital tunnel release with anterior transposition of the ulnar nerve and 2) left elbow medial epicondylitis. (PX15). Dr. Nam noted that he had reviewed the IME report of Dr. Lamberti who "... feels that her cubital tunnel syndrome and her medial epicondylitis is most likely secondary to her work-related activities. He has some concern that her medial epicondylitis was not addressed surgically." (PX15). In conclusion, Dr. Nam noted that "Veronica states that she has not been released to work because she has back issues at this time also. When the patient goes back to work without restrictions in regards to her left upper extremity, if she develops significant pain along her medial epicondyle region she will return to my clinic, and we will address that further at that time. Her treatment has been medically reasonable and necessary." (PX1;PX15;RX4).

In an Initial Office Visit note dated 8/14/12, Dr. Sclamberg recorded that Petitioner had been experiencing residual medial epicondylitis since the left ulnar nerve transposition by Dr. Nam. (PX1). He noted that she was currently off work and seeing Dr. Engel for her back, and that she was not doing physical therapy at that time. (PX1). Following his examination and review of the 3/16/11 MRI, Dr. Sclamberg's impression was left elbow medial epicondylitis status post left ulnar nerve transposition. (PX1). Dr. Sclamberg noted that he would continue

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Petitioner off work and referred her to undergo physical therapy. (PX1). Dr. Sclamberg also indicated that he was of the opinion that Petitioner's "... current condition of ill being is related to her work-related injury and subsequent surgeries described." (PX1).

In a progress note dated 9/11/12, Dr. Engel recorded that Petitioner returned with left elbow and back pain and that "... [p]hysical therapy exercises increased her pain. Using her left arm makes her elbow pain worse." (PX1). Dr. Engel's assessment was 1) thoracic spine pain, 2) lumbar facet syndrome, and 3) elbow pain. (PX1). Dr. Engel noted that he "... stopped [Petitioner's] physical therapy exercises because she was not improving" and that the patient was to follow-up with Dr. Sclamberg. (PX1). Dr. Engel also indicated that "[t]he patient was taken out of work since her pain has increased." (PX1).

In an Office Visit note dated 9/18/12, Dr. Sclamberg recorded that Petitioner was having quite a bit of pain in the left elbow, especially with lifting things in pronation and supination. (PX1). Dr. Sclamberg indicated that Petitioner had failed conservative management and recommended a flexor pronator release for her refractory epicondylitis. (PX1).

In an operative report dated 9/25/12, Dr. Sclamberg noted a pre and postoperative diagnosis of refractory left medial epicondylitis, status post ulnar nerve transposition. (PX2). The procedure performed on that date was flexor pronator slide with medial epicondylectomy on the left. (PX1).

In an Office Visit note dated 10/16/12, Dr. Sclamberg indicated that Petitioner was three-weeks post-op and was doing very well. (PX1). Dr. Sclamberg noted that Petitioner was to begin a physical therapy program at that time. (PX1).

In an Office Visit note dated 2/7/13, Dr. Sclamberg indicated that the patient was doing well, was off work and was not undergoing physical therapy for her left elbow. (PX1). Dr. Sclamberg noted that Petitioner was to return in six weeks for "a possible final visit from an elbow standpoint only" and could "lift 5 pounds, however, no repetitive work duty." (PX1).

In a progress report dated 2/13/13, Dr. Engel stated that Petitioner was given a prescription for a work conditioning program per her valid FCE and that she was to "remain out of work for her work conditioning program. I appreciate she is ready to go back to work for her elbow, but she is not ready to go back to work for her thoracic spine since she will be in a work conditioning program." (PX1).

In a progress report dated 3/6/13, Dr. Engel noted that "[t]he patient will stop her work conditioning program as she is not making any improvement. The patient will be discharged with permanent restrictions as per the work condition progress report... The patient will follow-up with Dr. Sclamberg." (PX1).

In an Office Visit note dated 3/21/13, Dr. Sclamberg recorded that "[t]he patient has been in a work conditioning program for the last two weeks, and unfortunately the left elbow has gotten a little bit inflamed at the medial epicondyle region." (PX1).

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In an Office Visit note dated 4/23/13, Dr. Sclamberg recorded that Petitioner was finishing her work-conditioning program and "is responding fairly well." (PX1). Dr. Sclamberg ordered an FCE of her left elbow and instructed the patient to return upon completion of same. (PX1).

In an Office Visit note dated 5/21/13, Dr. Sclamberg indicated that the FCE was valid and demonstrated the ability to function at a sedentary light physical demand level, equating to two-handed occasional lifting of 15 pounds, floor-to-chest level. (PX1). Dr. Sclamberg stated that he would release Petitioner from further care per these restrictions. (PX1).

In an Initial Evaluation Report dated 3/24/14, certified rehabilitation counselor Kari Stafseth opined that Petitioner "... has lost access to her usual and customary job and line of occupation of a Packager ... [and] with restrictions as depicted by the FCE, it is the opinion of this consultant that Ms. Sanchez is prospectively employable." (PX12). Ms. Stafseth noted that "[s]econdary to her education, work history and physical capacity, job targets most probably available would include Cashier, Fast-Foods Worker and light assembly positions." (PX12). Ms. Stafseth recommended that Petitioner "... undergo vocational testing in order to determine the likelihood of her succeeding in additional education to include English as a Second Language classes, a GED and/or computer training." (PX12). In addition, Ms. Stafseth indicated that "... it is the opinion of this consultant that Ms. Sanchez would have a most probable wage earning potential of $8.25 to 9.00 per hour ... [and] that Vocational Rehabilitation would be necessary in order to provide Ms. Sanchez with the skills necessary to seek stable employment in the above noted positions." (PX12). Ms. Stafseth noted that "[r]ehabilitation activity would include comprehensive vocational testing by a Certified Vocational Evaluator in order to complete the most thorough assessment of aptitude, interest, temperament and additional training opportunities", as well as English as a second language and computer courses, facilitation of on-the-job training, assistance with letter development, completion of mock interviews and participation in a self-directed and supervised job search. (PX12). Ms. Stafseth also outlined the same recommendations in a separate "Rehabilitation Plan." (PX12).

In a Labor Market Survey dated 9/24/14, case manager Samantha Allen noted that "[b]ased on Ms. Sanchez's work history, she would qualify for positions which will utilize her transferable skills as well as entry level opportunities available to persons with her employment and educational background. Ms. Sanchez has a solid work history and should be able to find employment within her restrictions." (RX13). Ms. Allen then identified roughly seven (7) positions paying from $8.25 to $11.00 per hour. (RX13).

D. *§12 report of Dr. Paul Lamberti* (10/4/11)

At the request of Respondent, Petitioner visited Dr. Lamberti on 10/4/11 for purposes of a §12 examination. (RX6 & PX11). In a report on that date, and following his examination and review of the medical records, Dr. Lamberti's impression was that Petitioner was "... postop from an anterior subcutaneous transposition of the ulnar nerve. She has had a diagnosis leading up to this of cubital tunnel syndrome, as well as medical epicondylitis. The cubital tunnel syndrome was treated appropriately, both conservatively and operatively, with good surgical technique. However, the medial epicondylitis as diagnosed was not officially treated surgically. It is immediately difficult to examine her, as she is so recently postoperative, but as it should be,

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she already feels a relief of the compression of her ulnar nerve." (RX6, pp.4-5). Dr. Lamberti's diagnosis was "... cubital tunnel syndrome and medial epicondylitis. As stated, the medial epicondylitis was not treated surgically, only the cubital tunnel syndrome." (RX6, p.5).

Dr. Lamberti also noted that "... there is no evidence that she had any preexisting cubital tunnel syndrome prior to her complaint in March, but more specifically, she states that the very beginning of this was likely at least a couple of months earlier, per her admission. The mechanism of lifting boxes from pallet to floor level to a table and then manipulating several hundred small objects during the day, along with intermittent heavy lifting, can very well be the associated cause of her cubital tunnel syndrome. This started out as most likely medial epicondylitis and then progressed to cubital tunnel syndrome. One-third of documented medial epicondylitis cases lead to cubital tunnel syndrome. Medial epicondylitis is due to exertion, such as lifting repeatedly. Cubital tunnel syndrome is related to repeated flexion/extension, even without exertion, and can just be related to associated swelling from medial epicondylitis. Of course, this is within the constraints of the history given to me and any more information would need to be in the form of 1) a job description and 2) a video of her actual job process." (RX6, p.5).

Dr. Lamberti went on to state that there was "... nothing inconsistent with what she states that would give evidence that this is not related to her work." (RX6, p.5). Dr. Lamberti believed that her surgical management was appropriate and that "[h]er postoperative course will most likely take a total of three months with progressive allowance of activities. Right now she should be on a no use of the left arm restriction. At six weeks, I would have her at partial use of no lifting over 15 pounds, two hand lifting, and then by three months she would be unrestricted. I do not think any other further surgery or testing is necessary. It does concern me that she did have medial epicondylitis preoperatively and this was not addressed surgically. This could be an issue during her rehabilitation. This will remain a question through her postoperative recovery." (RX6, p.5). Dr. Lamberti concluded by noting that "[h]er MMI should be at about three months if everything goes well." (RX6, p.5).

E. *Testimony of Dr. Steven Sclamberg* (4/1/13)

Board certified orthopedic surgeon Dr. Sclamberg testified that he first saw Petitioner on 8/14/12 per the referral of pain management physician Dr. Engle at Medicos Pain and Surgical Specialists. (PX10, p.7). When asked whether he is affiliated with that group, Dr. Sclamberg simply indicated that he sees "... a fair number of their patients." (PX10, p.7). Dr. Sclamberg noted that he was "pretty sure" that he looked at the MRI films, and not just the report dated 3/16/11, and that his interpretation was medial epicondylitis on the left. (PX10, p.10). Following his examination, and based on Petitioner's history, physical and MRI findings, Dr. Sclamberg's assessment was left medial epicondylitis of the elbow after a left ulnar nerve transposition. (PX10, p.11). Dr. Sclamberg noted that Petitioner was currently off work per Dr. Engle for her back, but he believed that "... she could have worked a light duty with respect to the elbow at that time." (PX10, p.12). He indicated that he "... would have had her at no lifting more than 5 pounds, no repetitive work, no overhead work." (PX10, p.12). Dr. Sclamberg prescribed an anti-inflammatory, and Petitioner began physical therapy at that time. (PX10, p.11).

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At the time of his next examination on 9/18/12, Dr. Sclamberg recommended a flexor pronator release or medial epicondyler release given that that Petitioner had failed conservative management. (PX10, p.13-14). Dr. Sclamberg subsequently performed this procedure on 9/25/12 at Ambulatory Surgical Center. (PX10, p.14). Dr. Sclamberg testified that he believed "... six to 12 weeks post-operatively is – would be reasonable for her to be doing light duty, very light duty... just assist only with that hand or – but certainly no lifting, no repetitive, no overhead work." (PX10, p.20). He then went on to state that "... at about 12 weeks, she could have worked light duty" but no work, "not even light duty" before then. (PX10, p.21).

Dr. Sclamberg testified that he saw Petitioner most recently on 3/21/13 at which time he noted that "[h]er exam actually looked pretty good with the exception of some mild tenderness of the medial epicondyle", which he wasn't that concerned about given that "...it's common to see patients when they go to work conditioning get a little bit inflamed..." (PX10, p.22). Dr. Sclamberg indicated that Petitioner was "... status post medial flexor pronator slide ... [with] some increased pain secondary to work-conditioning activities." (PX10, p.22). Dr. Sclamberg stated that his plan going forward was to have Petitioner be on an anti-inflammatory, that he was "fine with her staying in work conditioning" and that he would consider an FCE "[p]otentially down the road." (PX10, pp.22-23). He noted that Petitioner's prognosis was good. (PX10, p.23).

Dr. Sclamberg testified that he was of the opinion that a causal relationship existed between Petitioner's left medial epicondylitis and her work activities in February and March of 2011. (PX10, pp.23-24). He indicated that this would be based on "... the fact that she had no symptoms prior, she underwent surgery by ... Dr. Nam, which was, in my opinion, a very well-performed surgery... [W]e see some patients that do get medial epicondylitis, either after the surgery, or totally independent of the cubital tunnel surgery that then go on to require further surgery as she did, but it's part of the process." (PX10, p.24). Dr. Sclamberg also stated that it would not affect his opinions to learn that Petitioner's left elbow complaints were minimal in June and July of 2012 "[b]ecause she began work conditioning ... [and] it's pretty – you know, rigorous, and I wouldn't be surprised at all if it flared it up." (PX10, pp.25-26). In addition, Dr. Sclamberg indicated that the treatment he offered was reasonable and necessary. (PX10, pp.26-27).

On cross, Dr. Sclamberg indicated that he sees patients once a week at Marque Medicos that are referred to him by their doctors. (PX10, p.28). He stated that he has been seeing patients at Marque Medicos "[p]robably for the last six or eight months... [m]aybe longer." (PX10, p.28). He also agreed that the majority of the patients he sees at Marque Medicos are being treated for workers' compensation injuries. (PX10, pp.28-29). Dr. Sclamberg indicated that an interpreter was present at the time of Petitioner's visit on 8/14/12. (PX10, p.29). He also noted that he "[p]retty much" is fluent in Spanish himself. (PX10, p.29).

Dr. Sclamberg agreed that he saw Petitioner approximately six months after she had been discharged from treatment by Dr. Nam at MMI, and that to his knowledge she had not returned to work in any capacity in those six months. (PX10, pp.29-30). He also agreed that other than tenderness of the epicondylar region he did not note any other positive objective findings at his exam on 8/14/12. (PX10, p.30). He stated that the findings demonstrated on the MRI performed before Dr. Nam's surgery would "[n]ot necessarily" have resolved following said surgery.

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(PX10, p.30). Dr. Sclamberg was equally noncommittal when asked whether he would have expected Petitioner's symptoms to have resolved after Dr. Nam discharged her at MMI, noting that Dr. Nam "... definitely got rid of her nerve symptoms for sure, but she has this persistent flexor pain." (PX10, p.30).

Dr. Sclamberg indicated that other than tenderness he also did not note any positive findings on physical examination at the time of his follow up exam on 9/18/12. (PX10, p.31). He noted that the basis for his recommendation for surgery at that time was the fact that "... she had this refractory medial epicondylitis." (PX10, p.32). When asked whether it was based on her subjective pain complaints, Dr. Sclamberg responded: "[t]hat's partially based on it. It's based on her history; her surgery; her exam; her failure of conservative management." (PX10, p.32). He conceded, however, that there were no objective findings to support his position that she had failed conservative treatment other than her pain complaints. (PX10, p.32).

When asked if it would change his opinion as to whether the elbow condition was related to the original work injury if Petitioner had not been doing any repetitive activities from February 2012 through March 2013, Dr. Sclamberg responded: "[t]he original work injury and subsequent treatment, no." (PX10, pp.36-37). He also noted that from an elbow perspective he expected Petitioner to be able to return to work full duty. (PX10, p.37). Dr. Sclamberg indicated that he did not believe that he restricted Petitioner from driving. (PX10, p.38). When asked about the reference in his 3/21/13 office note of providing "ground round-trip, and non-emergency transportation" to Petitioner, Dr. Sclamberg stated: "I'm not part of the transportation. I don't know. She could have brought herself there... I did not have any driving restrictions for her." (PX10, pp.38-39).

On re-direct, Dr. Sclamberg indicated that on the date of the surgery itself, 9/25/12, Petitioner was anesthetized "to a large degree", and that as far as he knew driving under those circumstances is "... against the law. And if it isn't, it should be against the law..." (PX10, p.39). Thus, he felt it would have been appropriate to provide transportation on the date of surgery. (PX10, p.39). He also noted that "... for [Petitioner's] first postoperative visit, because she's in a splint. She's in a long-arm splint at 90 degrees of flexion. I don't think she should be driving in that... So for, at least, the surgery and one or two subsequent visits I think that it's – I would definitely not want her driving." (PX10, pp.39-40).

F. *Testimony of Dr. Charles Carroll IV* (12/15/14)

Dr. Carroll testified that he is board certified in orthopedic surgery with an added qualification in hand surgery. (RX2, p.5). He indicated that at the request of Respondent he performed a record review and authored a report on or about 9/12/14. (RX2, p.5; RX1). Following his review of those records, Dr. Carroll was of the opinion that Petitioner "... received appropriate treatment prior to April 1st [2012] and that she'd come to maximum medical improvement, though she needed, perhaps, further care down the road, beyond April 1st or whatever the date she came to see Dr. Sclamberg. I was unable to relate it to the injury of February 24th of 2011, based on review of the records, the fact that she'd come to maximum medical improvement by a qualified surgeon, and improvement had been noted." (RX2, pp.9-10).

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Dr. Carroll went on to state that "I would opine that care after April 1, 2012 or the like, when she came to maximum medical improvement, relates to a different phenomena or different set of cause, perhaps. I did not relate the care that she received or the need for restrictions or anything after April 1st to the injury of February 24, 2011." (RX2, p.10). When asked if he agreed with the full-duty release with respect to her upper extremity by her treating physician as of 2/14/12, Dr. Carroll stated: "I felt it was reasonable and appropriate to release her at that time, based on the findings of the qualified surgeon." (RX2, p.11).

When asked whether any subsequent restrictions were necessary and related to the work accident of 2/24/11, Dr. Carroll noted that Petitioner "... ultimately did require restrictions, which placed her on 15-pound lifting restriction, based on a second functional capacity evaluation... I would go on to state that I would not relate that need for restrictions to the injury of February 24th of 2011. I would look for alternative reasons or sources for that need for restrictions, as she had none when she was discharged by Dr. Nam... but had significant restrictions after being released by Dr. Sclamberg." (RX2, pp.11-12). Dr. Carroll did not indicate what those alternative reasons or sources might be.

On cross, Dr. Carroll conceded that he never met Petitioner and that he only reviewed the MRI report dated 3/16/11, not the films. (RX2, pp.13,15-16). When asked whether he had reviewed the 10/4/11 IME report of Dr. Lamberti, Dr. Carroll stated: "[i]f I did not refer to it, I most likely have not seen it." (RX2, p.14). He also indicated that pain would typically be present with medial epicondylitis and numbness would not necessarily be a component. (RX2, pp.14-15). He also agreed that the MRI findings appeared to be consistent with a diagnosis of medial epicondylitis. (RX2, p.16). Dr. Carroll was also asked to review the 9/20/11 operative report and noted that most of the work done was on the ulnar nerve. (RX2, p.17). With respect to the 9/25/12 procedure, Dr. Carrol indicated that "... Dr. Sclamberg did a much more extensive procedure of, as he called it, 'a flexor pronator swab with medial epicondylectomy.'" (RX2, p.17). When asked to what extent the procedure performed by Dr. Nam in 2011 would have addressed a possible epicondylitis, Dr. Carroll noted that "... when you move the nerve and you take the tissue down, you often have to change the environment and sometimes work in the area of the muscles and the anterior medial aspect of the elbow, so you'd have to look at Dr. Nam's testimony to see what he did... [However,] [a]s I mentioned in the discussion about medial epicondylitis, some component of that can be ulnar nerve-related pain. In her presentation [prior to Dr. Nam's surgery], it appeared to be more ulnar nerve-related pain than anything else." (RX2, p.18).

When asked whether he was aware that Dr. Lamberti's diagnosis had included epicondylitis, and that he had stated that another procedure might be necessary to address that condition, Dr. Carroll stated: "I don't have any thoughts or knowledge of Dr. Lamberti's opinions." (RX2, pp.18-19). When asked about his understanding as to Petitioner's symptomology or physical examination findings related to epicondylitis prior to February of 2012, Dr. Carroll testified that "Dr. Nam makes mention, in his February visit, of some residual medial elbow pain. He did not specifically diagnose epicondylitis, and given he'd been treating her, I believe he might have been looking for it, but, again, I would defer to his testimony... But the residual pain that she had, in his mind, did not require treatment at that point." (RX2, p.19).

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When asked whether it would change his analysis if Dr. Nam diagnosed Petitioner with epicondylitis prior to his release in February of 2012, Dr. Carroll stated: "[n]o, because that point of it was, she improved. An epicondylistis, whether it's diagnosed or not, if it improves, it doesn't always necessitate surgery. (RX2, pp.19-20). In addition, Dr. Carroll conceded that he was not aware that Petitioner was in work conditioning immediately preceding her referral to Dr. Sclamberg in August of 2012, after having completed care for her low back. (RX2, p.20). When asked whether the work conditioning program could potentially cause the existing condition to become symptomatic, requiring surgery, given that she had not been working prior thereto, Dr. Carroll testified: "[t]hat type of thing is theoretically possible, you know, a possible type of thing, theoretically, but I'd have to review the records and know more about it, to offer an opinion to the Arbitrator to a reasonable degree." (RX2, p.21). Dr. Carroll also stated that he has seen epicondylitis wax and wane, and that it was "theoretically possible" that an increase in activity could cause the symptomology to increase, "...but that's not been my opinion today." (RX2, pp.21-22).

III. CONCLUSIONS OF LAW

Under the doctrine of res judicata, "a final judgment rendered by a court of competent jurisdiction on the merits is conclusive as to the rights of the parties and their privies, and, as to them, constitutes an absolute bar to a subsequent action involving the same claim, demand, or cause of action." *J & R Carrozza Plumbing Co. v. Industrial Commission*, 307 Ill.App.3d 220, 223, 717 N.E.2d 438, 240 Ill.Dec. 345 (1999).

"Collateral estoppel prohibits the relitigation of an issue essential to and actually decided in an earlier proceeding by the same parties or their privies." *McCulla v. Industrial Commission*, 232 Ill.App.3d 517, 520, 597 N.E.2d 875, 173 Ill.Dec. 901 (1992). Administrative agency decisions made in adjudicatory, judicial, or quasi-judicial proceedings may have collateral estoppel effect. *Id.* Collateral estoppel may be asserted when: (1) the issue decided in the prior adjudication is identical to the issue in the current action; (2) the issue was "necessarily determined" in the prior adjudication; (3) the party against whom estoppel is asserted was a party or in privity with a party in the prior action; (4) the party had a full and fair opportunity to contest the issue in the prior adjudication; and (5) the prior adjudication must have resulted in a final judgment on the merits. *Mabie v. Village of Schaumberg*, 364 Ill.App.3d 756, 758, 847 N.E.2d 796, 301 Ill.Dec. 786 (2006); *McCulla*, 232 Ill.App.3d at 520.

The Arbitrator found that "[r]es judicata applies in this case" and that "... Petitioner was essentially found at MMI as of 2/15/12 for the left arm at the prior hearing. As such, the issue cannot be contested again." (3/8/16 Arb.Dec.[Addendum], pp.5-6). The Commission notes that since the doctrine of res judicata is more commonly associated with "claim preclusion," the question here is more aptly described as one of "issue preclusion" or collateral estoppel. In either case, the Commission finds that neither doctrine applies.

More to the point, the Commission finds that the issue of MMI with respect to the left elbow/arm was not "necessarily determined" in the prior adjudication. In fact, in the initial §19(b) decision, Arb. Kelmanson only found that Petitioner reached MMI with respect to her ***back injuries*** (DOA=2/24/11) as of 5/25/11, and that "[w]ith respect to the putative claim for

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repetitive trauma to the left elbow and arm, the Arbitrator finds that no intervening event has occurred that would sever the chain of causation." (6/26/12 Arb.Dec., p.7). The Commission subsequently "...affirmed and adopted the Arbitrator's findings with respect to the repetitive trauma claim for Petitioner's left elbow and arm; however, we strike the Arbitrator's qualification of 'provided Petitioner timely files an application for adjustment of claim.'" (13 IWWC 348). Thus, the need for a separate "putative" filing was eliminated, and the Arbitrator's finding of causation -- in addition to her finding of a manifestation date of 3/28/11 -- ***without*** any express determination of MMI for the left elbow/arm, was affirmed. And while the Arbitrator did award medical bills that were incurred with respect to this injury on or before 2/13/12, or the date Dr. Nam first released Petitioner with respect to her left elbow/arm condition, this finding is in no way the equivalent of a determination of MMI.

Instead, the Commission finds that Petitioner reached MMI as of 5/21/13, or the date of Dr. Sclamberg's release with permanent restrictions, as set forth in the FCE. Along these lines, the record shows Petitioner had been diagnosed with both left medial epicondylitis and left cubital tunnel syndrome as early as March of 2011, and that Dr. Nam had elected to focus his treatment on the more symptomatic of the two issues – namely, the cubital tunnel syndrome. Following a left cubital tunnel release on 9/20/11, Dr. Nam discharged Petitioner from his care with respect to the left elbow on 2/13/12 and again on 3/12/12. (PX1). At the time of her next visit on 4/16/12, Dr. Nam noted that "[o]verall, she states that the numbness in her fingers has gone. She does have some pain along the medial aspect of her left elbow at times." (PX1). Dr. Nam went on to note that Petitioner had not been released to work because of her separate back issues, but that "[w]hen the patient goes back to work without restrictions in regards to her left upper extremity, if she develops significant pain along her medial epicondyle region she will return to my clinic, and we will address that further at that time." (PX1).

Petitioner testified that at the time of her release by Dr. Nam her symptoms were better, particularly with respect to the pain in her fingers, but that her elbow would still swell up. (T.20-21). Petitioner also noted that while participating in work conditioning in August of 2012 she experienced increased pain and swelling of her left elbow/arm and was referred to Dr. Sclamberg, whom she saw for the first time on 8/14/12. (T.22-23). She testified that her symptoms when she saw Dr. Sclamberg were the same as at the time of the previous hearing on 5/14/12. (T.24).

For his part, Dr. Sclamberg diagnosed refractory left medial epicondylitis and eventually performed a left medial epicondylectomy on 9/25/12. (PX1). Dr. Sclamberg later testified that he was of the opinion that a causal relationship existed between Petitioner's left medial epicondylitis and her work activities in February and March of 2011. (PX10, pp.23-24). He indicated that this would be based on "... the fact that she had no symptoms prior, she underwent surgery by ... Dr. Nam [for cubital tunnel syndrome], which was, in my opinion, a very well-performed surgery... [W]e see some patients that do get medial epicondylitis, either after the surgery, or totally independent of the cubital tunnel surgery that then go on to require further surgery as she did, but it's part of the process." (PX10, p.24). Dr. Sclamberg also stated that it would not affect his opinions to learn that Petitioner's left elbow complaints were minimal in June and July of 2012 "[b]ecause she began work conditioning ... [and] it's pretty – you know, rigorous, and I wouldn't be surprised at all if it flared it up." (PX10, pp.25-26).

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Interestingly enough, Respondent's own §12 examining physician, Dr. Lamberti, had expressed earlier concerns about the lack of treatment relative to Petitioner's medial epicondylitis well before Dr. Nam's discharges in February and March of 2012, and prior to Arb. Kelmanson's decision in June of 2012. To wit, in a report dated 10/4/11, Dr. Lamberti pointed out that Petitioner's condition "...started out as most likely medial epicondylitis and then progressed to cubital tunnel syndrome" and that "[i]t does concern me that she did have medial epicondylitis preoperatively and this was not addressed surgically. This could be an issue during her rehabilitation. This will remain a question through her postoperative recovery." (RX6, p.5). Needless to say, as it turns out, her nascent condition of medial epicondylitis did indeed become an issue following cubital tunnel surgery and work conditioning.

As a result, the Commission reverses the Arbitrator's decision and finds that Petitioner's current condition of ill-being relative to her left elbow/arm is causally related to the repetitive trauma type injuries which were previously found to have manifested itself on 3/28/11.

Furthermore, the Commission finds that Petitioner was temporarily totally disabled from 9/25/12, the date of surgery by Dr. Sclamberg, through 5/21/13, or the date Petitioner was released by Dr. Sclamberg and found to be at MMI, for a period of 34-1/7 weeks.

The Commission also finds that Petitioner is entitled to reasonable and necessary medical expenses associated with the care and treatment provided by Dr. Sclamberg with respect to the left elbow/arm, pursuant to §8(a) and the fee schedule provisions of §8.2. However, the Commission specifically denies any and all claimed transportation charges associated with this treatment on the grounds that said charges were unreasonable, unnecessary and not prescribed by any physician.

In addition, the Commission finds that Petitioner failed to prove her entitlement to vocational rehabilitation services given her admitted failure to seek employment within her restrictions. Indeed, Petitioner testified at arbitration that since her release with permanent restrictions she had performed community service at her church six months earlier, in order to receive Public Aid, and had completed about six applications about two months ago. (T.33-36). She also agreed that between March of 2014 and December of 2015 she did not seek employment. (T.36). The Commission finds this job search effort wholly insufficient.

Finally, the Commission dismisses, sua sponte, claim 12 WC 23822, the duplicate filing concerning the left arm made by Petitioner subsequent to the initial §19(b) decision of Arb. Kelmanson . As previously noted, the parties agreed at the commencement of the present proceedings that it was their understanding the case had been found to be a "nullity" by the Commission. (T.7). Since the case is still showing as pending at arbitration on the Commission's mainframe computer, the Commission hereby dismisses claim 12 WC 23822 outright to avoid any further confusion.

All else is otherwise affirmed and adopted.

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IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.67 per week for a period of 34-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses associated with the care and treatment provided by Dr. Sclamberg with respect to Petitioner's left arm/elbow, with the exception of transportation fees, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's request for vocational rehabilitation is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that this case (11 WC 13983) be remanded to the Arbitrator for further proceedings consistent with this Decision, specifically with respect to permanent partial disability, 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.

IT IS FURTHER ORDERED BY THE COMMISSION that claim number 12 WC 23822 is hereby dismissed.

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: JUN 26 2017
o:5/2/17
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

SANCHEZ, VERONICA
Employee/Petitioner

Case# **11WC013983**

YOLI INC D/B/A MI COSTANITA
Employer/Respondent

17IWCC0382

On 3/8/2016, 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 0.47% 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:

2553 McHARGUE, JAMES P LAW OFFICES
MATTHEW C JONES
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

2837 LAW OFFICES JOSEPH MARCINIAK
MICHELLE POWELL
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

TATE 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)

Veronica Sanchez
Employee/Petitioner
v.
Yoli, Inc., d/b/a Mi Constenita
Employer/Respondent

Case # **11 WC 13983**

17IWCC0382

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David Kane**, Arbitrator of the Commission, in the city of **Chicago** on **2/23/16**. 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

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On the date of accident 2/24/11, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $ 24,934.52; the average weekly wage was $ 479.51.

On the date of accident, Petitioner was 39 years of age, ***single*** with 4 dependent children.

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

Respondent shall be given a credit of $ 15,983.50 for TTD, $ 0 for TPD, $ 0 for maintenance, and $ 0 for other benefits, for a total credit of $ 15,983.50.

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

ORDER

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

March 7, 2016
Date

David A. Kane
ICArbDec19(b)

MAR 8 - 2016

17IWCC0382

13 WC 13983
VERONICA SANCHEZ V. MI COSTANITA

ATTACHMENT TO ARBITRATOR'S DECISION

SUMMARY OF PRIOR PROCEEDINGS AND NATURE OF THE CASE

Petitioner in this case has four filings for four dates of dates of accident: 6/1/09, 12/15/09, 2/24/11 and 3/28/11. The cases have been consolidated. Case 11 WC 13983, at issue in the instant hearing, involves claims of injury to the back and left arm. The left arm is specifically at issue for purposes of this 19(b) hearing.

The first 19(b) hearing in this case took place on 5/14/12 before Arbitrator Kelmanson. The issues in that hearing were accident, causation, medical benefits, and TTD. The Arbitrator found accident and causation for the back and left arm. The Arbitrator found that Petitioner sustained a thoracic strain on 6/1/09 and reached MMI for that injury on 6/17/09. The Arbitrator found that Petitioner sustained a thoracic strain on 12/15/09 and reached MMI for that injury on 1/15/10. The Arbitrator found that Petitioner sustained a thoracolumbar strain on 2/24/11 and reached MMI for that injury on 5/25/11. With regard to the repetitive trauma claim to the left arm, the Arbitrator found that the date of manifestation was 3/28/11 and ordered Petitioner to file an Application for Adjustment of Claim for that date.

With regard to medical benefits, the Arbitrator noted that "on February 12, 2012, Dr. Nam released Petitioner to return to work full duty and discharged her from care. Although Petitioner returned to Dr. Nam on 3/12/12 and 4/16/12, she reported no material change in her condition, and Dr. Nam did not change his recommendation." (Comm. Dec., p.13). As such, the Arbitrator awarded medical bills incurred for the left

arm on or before 2/13/12 and denied bills for subsequent treatment to the left arm. (Comm. Dec., p.13). The Arbitrator awarded bills for the back through the date of MMI of 5/25/11 and denied other bills for the back.

With regard to TTD benefits, Petitioner was seeking additional TTD from 2/16/12 through the date of hearing of 5/14/12. With regard to the left arm, TTD was ordered to be paid through 2/15/12. Subsequent TTD was denied. (Comm. Dec., p. 14).

The Commission upheld the Arbitrator's decision, though it struck the Arbitrator's order that Petitioner had to file another Application for Adjustment of Claim for accident date 3/28/11.

Respondent's position is that Petitioner was found to be at MMI for the left elbow at the prior hearing and the principle of *res judicata* should govern for two reasons:

1. The Commission upheld the Arbitrator's decision denying TTD and medical benefits for the left elbow subsequent to 2/15/12, and
2. Petitioner claims that her current condition of ill-being regarding the left arm is due to work conditioning ordered by Dr. Engel in August 2012. However, Dr. Engel was treating Petitioner for her back and the Arbitrator found Petitioner at MMI for her back as of 5/25/11 in the prior hearing.

FINDINGS OF FACT

Petitioner in this case testified that she worked as a packer for Respondent for approximately 14 years. She testified that she hurt her elbow at work on 2/24/11. She testified that on 4/16/12, Dr. Nam discharged her from care for her left elbow, which was prior to the previous trial date of 5/14/12. On cross-examination, Petitioner

acknowledged that Dr. Nam first released her from care for the left elbow on 2/13/12. She testified that he again released her on 3/12/12 and 4/16/12. Petitioner testified that when Dr. Nam discharged her in April 2012, her left arm and fingers were better.

Petitioner testified that in August 2012, Dr. Engel sent her for work conditioning. Dr. Engel was treating Petitioner for her back. Petitioner testified that in work conditioning, she moved her arms, used a ball, a band and lifted weights. She attended 4 hours per day. Petitioner testified that she felt pain from work conditioning and wore a hot patch on her elbow.

Petitioner testified that Dr. Engel referred her to Dr. Sclamberg. She testified that Dr. Sclamberg recommended elbow surgery. She testified that she underwent surgery and physical therapy. She testified that she is not currently treating with Dr. Sclamberg.

Petitioner testified that in the fall on 2015, she performed community service cleaning at a church for 3 months. She would perform mopping. She testified her elbow would swell.

Petitioner testified that she underwent a vocational assessment on 3/11/4 and that she would like help finding a job. Petitioenr testified that in December 2015, she completed 6 job applications at various businesses near where she lives.

Petitioner testified that other than when she received injections she was not restricted from driving, and that she does drive.

CONCLUSIONS OF LAW

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

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of the credible evidence. Illinois Bell Tel. Co. v. Industrial Comm'n., 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. Id. A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. Caterpillar Tractor Co. v. Industrial Comm'n., 83 Ill. 2d 213; 414 N.E. 2d 740 (1980).

Petitioner alleges her current condition of the left arm is the result of repetitive trauma with a date of manifestation of 2/24/11.

Petitioner had reached MMI for her back and left arm as of the date of the prior hearing

Petitioner reached MMI and was been discharged from care by Dr. Nam, on several occasions, despite Dr. Engel's repeated referrals back to him. Dr. Nam treated Petitioner for both her hands and left elbow. (PX1) He released Petitioner to full duty work and discharged her from care on 2/13/12 for the left elbow. (RX7). He released her again to full duty work and discharged her from care again on 3/12/12. (RX3) Dr. Nam reexamined Petitioner on 4/16/12. These there dates of service were all prior to the previous 19b hearing in this case. In the prior decision, the Arbitrator noted that "on

February 12, 2012, Dr. Nam released Petitioner to return to work full duty and discharged her from care. Although Petitioner returned to Dr. Nam on 3/12/12 and 4/16/12, she reported no material change in her condition, and Dr. Nam did not change his recommendation." The Commission upheld this decision. (Comm. Dec., p.13).

Further, Petitioner claims that her current condition of ill-being regarding the left arm is due to work conditioning ordered in August 2012 by Dr. Engel. However, Dr. Engel was treating Petitioner for her back and the Arbitrator found Petitioner at MMI for her back as of 5/25/11 in the prior hearing. The Commission upheld this decision. (Comm. Dec., p.13).

Res judicata

Res judicata applies in this case. "Once a lawsuit is decided, the same issue or an issue arising from the first issue cannot be contested again." (Black's Law Dictionary, 2nd Ed.) Petitioner claims that her current condition of ill-being regarding the left arm is due to work conditioning ordered in August 2012 by Dr. Engel for her back. However, it is clear that Petitioner was already found at MMI for her back in the prior 19b hearing as of 5/25/11. As such, the issue cannot be contested again.

Also, Petitioner reached MMI and was been discharged from care by Dr. Nam, on several occasions, despite Dr. Engel's repeated referrals back to him. Dr. Nam treated Petitioner for both her hands and left elbow. (PX1) He released Petitioner to full duty work and discharged her from care on 2/13/12 for the left elbow. (RX7). He released her again to full duty work and discharged her from care again on 3/12/12. (RX3) Dr. Nam reexamined Petitioner on 4/16/12. These there dates of service were all prior to the previous 19b hearing in this case. In the prior decision, the Arbitrator noted that "on

February 12, 2012, Dr. Nam released Petitioner to return to work full duty and discharged her from care. Although Petitioner returned to Dr. Nam on 3/12/12 and 4/16/12, she reported no material change in her condition, and Dr. Nam did not change his recommendation." The medical bills for 3/12/12 and 4/16/12, as well as the claimed TD benefits for the left arm, were denied after 2/13/12. The Commission upheld this decision. (Comm. Dec., p.13) Therefore, Petitioner was essentially found at MMI as of 2/15/12 for the left arm at the prior hearing. As such, the issue cannot be contested again.

Further, the Arbitrator finds the records of Marque Medicos are not credible. The Arbitrator adopts the opinion of Dr. Caroll that Petitioner was at MMI for her elbow prior to the date of the previous hearing. (RX1,2)

The Arbitrator finds that Petitioner reached MMI for her left arm as of 2/15/12.

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

Section 8(a) of the Illinois Workers' Compensation Act states, "[t]he employer shall pay for *necessary* medical, surgical, and hospital services, limited, however to that which is *reasonably* required to cure or relieve from the effects of the accidental injury..." 820 ILCS 305/8(a) (emphasis added). The Act thus provides for a clear requirement that all medical care be reasonable and necessary in order for the employer to be responsible for such costs. In this case, Petitioner has failed to prove that her extensive medical treatment was reasonable and necessary.

A review of the medical records makes it clear that the treatment rendered by Marque Medicos and Medicos Pain & Surgical Specialists is not unlike an annuity plan. Further, as she was found at MMI at the prior hearing, her decision to continue to treat in contravention of the Arbitrator's findings should not be Respondent's responsibility.

The arbitrator concludes that all charges for medical services to the left arm subsequent to 2/15/12 are denied as Petitioner was at MMI. Further, the Arbitrator notes that Petitioner was also found at MMI for the back in the prior hearing as of 5/25/11. The bills for the back are an issue because of Petitioner's claim that she aggravated her left arm while performing work conditioning for her back. Given the foregoing, all bills after 5/25/11 for the back are explicitly denied.

The Arbitrator also specifically denies the transportation charges that appear on the bill from Medicos Pain & Surgical Specialists. (PX2). The Arbitrator finds that these charges are inherently unreasonable and exorbitant by any standard. Moreover, there is nothing in the record to show that these charges were necessary as Petitioner never testified that she required transportation as a result of her condition. In fact, Petitioner testified that she drives. (Tr. p. 149).

Issue L: What temporary benefits are in dispute?

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of the credible evidence. Illinois Bell Tel. Co. v. Industrial Comm'n., 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). The period of temporary total disability encompasses the time from when an injury incapacitates a claimant until it stabilizes. Gallentine v. Industrial Comm'n., 201 Ill. App. 3d 880 (1990). A claimant must show both that he did not work, *and* that he was

unable to work to be entitled to temporary total disability compensation. Id. (emphasis added).

Petitioner alleges she is due TTD from 3/3/11 to 2/15/12, and from 8/14/12 to 5/21/13, representing 102 6/7 weeks. Respondent alleges TTD is due only through 2/15/12, and states that TTD was paid through said date, totaling $15,983.50. Further, this period was previously adjudicated in the prior 19(b) hearing.

Petitioner is not entitled to temporary total disability compensation after 2/15/12 because she was not temporarily and totally disabled after this date, based on the medical records of Dr. Nam (RX 7).

The Arbitrator notes from the prior record in this case that Dr. Engel had released Petitioner to light duty work as of 4/21/11, and kept her on light duty restrictions for nearly 10 months, but then took her off work on 2/14/12 for the thoracic spine, just *one day* after Dr. Nam released her to full duty work.

Petitioner alleges she is due maintenance benefits from 5/22/13 to 1/28/16, representing 140 2/7 weeks. The Arbitrator finds that as Petitioner reached MMI on 2/15/12 with a full duty release, she is not entitled to maintenance benefits. Further, the Arbitrator finds that Petitioner did not meet the standard for establishing entitlement to maintenance benefits. Petitioner testified that in December 2015, she completed 6 job applications at various businesses near where she lives. She offered no job search logs into evidence. Petitioner failed to meet her burden of establishing that she conducted a diligent but unsuccessful search for employment. Valley Mould & Iron Co. v. Industrial Com., 84 Ill. 2d 538 (Ill. 1981).

Temporary total disability benefits after 2/15/12 are therefore denied. Maintenance benefits are denied. Respondent shall receive any applicable credit for benefits already paid.

17IWCC0382

CONCLUSION

Petitioner was previously found at maximum medical improvement for the left elbow as of 2/15/12. She was previously found at MMI for the back as of 5/25/11. Subsequent benefits are denied, respectively.

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

John Costello,
Petitioner,

vs.

NO: 11 WC 28248

Continental Tire of The Americas,
Respondent,

17IWCC0404

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, causal connection, medical, 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 11, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $43,900.00. 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: JUN 27 2017
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DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COSTELLO, JOHN
Employee/Petitioner

Case# **11WC028248**

CONTINENTAL TIRE OF THE AMERICAS
Employer/Respondent

17IWCC0404

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:

1167 WOMICK LAW FIRM CHTD
CASEY VAN WINKLE
501 RUSHING DR
HERRIN, IL 62948

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

17IWCC0404

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

John Costello
Employee/Petitioner

v.

Continental Tire of The Americas
Employer/Respondent

Case # **11** WC **28248**

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 **Mt. Vernon**, on **September 3, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 21, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,720.44**; the average weekly wage was **$898.47**.

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

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

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

Respondent shall be given a credit of **$8,143.72** for TTD, $- for TPD, $- for maintenance, and **$18,991.53** for short term disability benefits, for a total credit of **$27,135.25**.

Respondent is entitled to a credit of **$30,332.54** under Section 8(j) of the Act for medical payments.

ORDER

Respondent shall pay reasonable and necessary medical bills incurred prior to 11/7/12, as submitted in Petitioner's Exhibit 7, except those charges of Pinckneyville Family Medical Center and Pinckneyville Community Hospital, 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 $598.98/week for 16 6/7 weeks, commencing 7/4/11 through 7/10/11 (1weeks), and 3/19/12 through 7/7/12 (15 6/7 weeks), as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability and/or short term disability benefits that have been paid corresponding to the periods of temporary total disability set forth above.

Respondent shall pay Petitioner permanent partial disability benefits of $539.08/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act. Respondent shall be given credit for $26,954.00 for permanent partial disability benefits paid under Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

8/9/16
Date

ICArbDec p. 2

AUG 11 2016

FINDINGS OF FACT

Petitioner, John Costello, was an employee of Respondent, Continental Tire of The Americas. On June 21, 2011 he was operating a motorized buggy and while pulling on a bar and hitch pin with his right hand, felt a pop in his right shoulder.

He first came under the care of Dr. Michael Milne who began treating him on July 5, 2011 and ordered an MRI arthrogram. (Px4) On August 9, 2011 Dr. Milne reviewed the MRI and found it to be negative. Dr. Milne noted that Petitioner's subjective complaints on this date outweighed his objective findings considering he had full passive range of motion. Petitioner complained of a lipoma that was 4cm in diameter as being a pain generator and developed as a result of the alleged injury on June 21, 2011, but Dr. Milne was of the opinion that a lipoma of this size would have taken months or years to develop. At this time a cortisone injection was offered which Petitioner refused reportedly because it would cause him paralysis. He was instructed to cease using a sling and to move his shoulder as well as continue physical therapy. Dr. Milne stated that the lipoma was not work related. Petitioner was seen again on August 30, 2011 and then again on September 27, 2011, at which point Petitioner reported improvement. Petitioner was on restrictions but requested a crossbow permit so as to deer hunt. Following injections, Petitioner returned on October 13, 2011 stating that the injections did not help, so additional conservative treatment was provided. Petitioner last saw Dr. Milne on November 15, 2011 and the doctor noted that Petitioner "perseverates about his shoulder pain and appears to have a lipoma under his skin." Dr. Milne reported hypersensitivity to the touch and that his subjective complaints outweigh his objective findings. Before Dr. Milne would continue to treat Petitioner, a second opinion was requested by the doctor. (Px4)

Petitioner was then examined by Dr. Richard Howard on December 19, 2011. (Rx1) He recorded Petitioner's subjective complaints of having no improvement with treatment and noted Petitioner's clinical picture as inconsistent. Examples of this were that Petitioner was in such severe pain he could not shake hands with that arm, but had full passive range of motion and a normal MRI. He was described as a symptom magnifier to a significant degree that did not require surgical intervention and could return to work full duty. (Rx1)

Petitioner was offered work by Respondent in the full duty capacity as this point and he initially accepted it. Ms. Cravens testified that Respondent consistently offers light duty and full duty accommodations as part of their plant policy. Petitioner and his counsel had a meeting with Respondent in early 2012 and Petitioner refused the offer of employment.

Petitioner then sought treatment at Southern Illinois Orthopedic Center where he had previously treated for a right knee injury in 2004 which was involved in the Illinois workers' compensation case of 05 WC 8392. Because of subjective complaints of extreme sensitivity to simple gentle touch, Dr. David Wood voiced concerns of possible RSD on July 15, 2004. (Rx3) This was eventually discounted and he was released to return to work without restrictions on August 26, 2004.

With regard to the right shoulder, Petitioner first sought treatment at the facility with Dr. Brett Miller on March 19, 2012 complaining that any movement caused shoulder pain. Petitioner admitted to fishing, hunting, golfing, and bowling and was diagnosed with impingement. Dr. Miller described him as "histrionic" at this point and in his deposition he defined this as a person who had emotional responses that were greater than what

would be expected which is similar to a symptom magnifier. (Px6 at 26) Petitioner was again examined on March 29, 2012 and a potential diagnosis of arthrofibrosis, commonly referred to as frozen shoulder, was made for which a manipulation under anesthesia was recommended along with a diagnostic arthroscopy. A manipulation under anesthesia was performed on April 9, 2012 by Dr. Miller and a SLAP lesion was repaired at the same time. The lipoma previously complained of was noted in the operative report and was stable. (Rx 3) Petitioner was put on restrictions and followed up with Dr. Miller post-operatively. As evidenced by the office note of Dr. Miller dated July 11, 2012, Petitioner continued to complain of symptoms around a lipoma in his shoulder region which Dr. Miller repeatedly indicated was not work related and predated the injury despite Petitioner's objections to the contrary. (Px6 at 12, Px2)

On May 14, 2012 Dr. Howard reviewed the operative records and indicated that Petitioner did develop adhesive capsulitis as a result of the disuse of the arm by Petitioner which over time would cause the frozen shoulder. (Rx1) Dr. Howard also opinioned that the SLAP tear was likely a result of the manipulation under anesthesia since it clearly was not present pre-operatively.

Petitioner was then examined by Dr. Howard on September 27, 2012 reporting pain in the lipoma and was requesting surgery to have it removed which Dr. Howard clearly stated was not work related and if it was causing pain would still not have been caused or aggravated by the work event. (Rx1) There were also complaints of numbness in the right ulnar region which could not be correlated to any anatomic condition and all together Dr. Howard found no reason why Petitioner should not be released to full duty work. (Rx1)

After the first surgery, Petitioner developed pain in the anterior aspect of the arm which he did not have previously. (Px6 at 23) Petitioner continued to treat with Dr. Miller who felt he might have a cervical condition and referred him to Dr. Clint Hill, an orthopedic spine specialist on October 24, 2012. (Px3) Dr. Hill ordered MRI and nerve conduction tests and ultimately opined that he did not have a cervical problem. (Rx4) In the meantime on November 7, 2012, Dr. Miller examined Petitioner noting that he had full range of motion with some discomfort when he lifted his arm despite the fact that he could do this without restriction and passive range of motion was full. Dr. Miller felt he had full recovery from the shoulder surgery and he was released to return to work full duty without restrictions on November 7, 2012. (Rx4)

Petitioner had additional treatment including an additional surgery on June 17, 2013 which he described at trial as being for removal of the lipoma and a biceps procedure. (Px2 & 3). Dr. Miller again placed him at maximum medical improvement and full duty on April 14, 2015. (Px3) At that time, Dr. Miller noted that Petitioner was doing really well with no pain or problems. He was able to lift 95 pounds without difficulty. Despite admitting to not doing stretching exercises, Petitioner only had what was described as a little bit of restricted range of motion with his arm fully extended going in to abduct. (Px3)

Despite Petitioner's full duty release he has not found new employment because subjectively he cannot reach overhead, directly in contradiction to Dr. Miller's last office notes. Nevertheless, Petitioner stated he helped family members carry 80 pound bags of cement, shovel rock, and received a crossbow archery permit from his family doctor.

CONCLUSIONS

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

Petitioner did have a compensable injury when he was pulling on a lever with his left arm on June 21, 2011. He had appropriate treatment including surgery on March 19, 2012 with Dr. Bret Miller. Petitioner has failed to prove a causal relationship for his condition of ill-being after being placed at maximum medical improvement on November 7, 2012 by Dr. Miller.

Treatment after this date was for complaints of cervical radiculopathy which the orthopedic spine physician Dr. Hill could not identify and continued complaints of a lipoma on Petitioner's shoulder. Petitioner complained first to Dr. Michael Milne of this on August 9, 2011 and he was advised that the lipoma would have taken months if not years to form and continued to complain of this to Dr. Milne on November 15, 2011 when Dr. Milne noted that his subjective complaints outweighed his objective findings and suggested he get a second opinion.

Petitioner complained to Dr. Richard Howard on December 19, 2011 about the lipoma causing pain and it was noted again that Petitioner was having subjective complaints that outweighed his objective findings to the point of being labeled a symptom magnifier. When Petitioner first saw Dr. Brett Miller, the doctor noted he was histrionic, which he later defined in his deposition as being overly emotional regarding his pain. (Px6 at 26) Dr. Miller also testified that he tried to explain to Petitioner that the lipoma was benign and not related to the work injury. (Px6 at 12)

Petitioner complained of the lipoma to Dr. Howard in his second examination of September 27, 2012 and the doctor was very clear there was no causal relationship between the lipoma and his injury. (Rx1) Dr. Howard has the most credible opinion concerning causal connection to the complaints Petitioner voiced. In his September 27, 2012 report he concisely opined that Petitioner had reasonable treatment to this point and that complaints at this point, including the lipoma, were not objectively supported and that there was no reason he could not return to work full duty. Dr. Miller essentially concurred with this when he released him from care and placed him at full duty six weeks later on November 7, 2012. The Arbitrator finds that Petitioner in fact reached maximum medical treatment under the law on November 7, 2012.

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

Based upon the foregoing, Respondent shall be responsible for the medical treatment provided prior to November 7, 2012 as submitted in Petitioner's Exhibit 7 except Pinckneyville Family Medical Center and Pinckneyville Community Hospital. Upon review of Petitioner's Exhibit 7, the Arbitrator notes that there are supporting medical records for all of the providers rendering treatment before November 7, 2012, except those two providers. The record does not contain any evidence to support that these charges were for related and necessary medical treatment. Those specific charges and any charges listed for "Date of Service" after November 7, 2012 are denied.

Respondent shall pay reasonable and necessary medical bills incurred prior to 11/7/12, as submitted in Petitioner's Exhibit 7, except those charges of Pinckneyville Family Medical Center and Pinckneyville Community Hospital, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for

medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

Petitioner has proven entitlement to Temporary Total Disability benefits from July 4, 2011 to July 10, 2011 (1 week) and from the date of Dr. Miller's first surgery, March 19, 2012 to July 7, 2012 (15-6/7 weeks) when he returned to work.

Petitioner has failed to prove entitlement to Temporary Total Disability benefits from January 25, 2012 to March 19, 2012 as he was placed at full duty and offered employment pursuant to the credible opinions of Dr. Richard Howard and the additional testimony of Ms. Cravens regarding Respondent's offers of employment. Petitioner has failed to prove entitlement to Temporary Total Disability for any other dates.

Respondent shall pay Petitioner temporary total disability benefits of $598.98/week for 16 6/7 weeks, commencing 7/4/11 through 7/10/11 (1weeks), and 3/19/12 through 7/7/12 (15 6/7 weeks), as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability and/or short term disability benefits that have been paid corresponding to the periods of temporary total disability set forth above.

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

Petitioner suffered an injury to his right shoulder and developed adhesive capsulitis. He underwent a manipulation of the frozen shoulder under anesthesia on March 19, 2012 by Dr. Brett Miller. He was placed at maximum medical improvement and full duty from that procedure according Dr. Miller on November 7, 2012.

At trial Petitioner complained of not being able to handle 80 pound bags of cement despite Dr. Miller noting on April 14, 2015 that he could lift 95 pounds without difficulty. Petitioner complained at trial of not being able to lift his right arm above his head. Dr. Miller placed Petitioner at full duty on April 14, 2015.

Petitioner testified he has been able to find subsequent employment. He noted that he has certificates in electrical and HVAC, the job areas he was hired into by Respondent but failed to qualify for. Notwithstanding Petitioner's complaints, Dr. Miller released Petitioner for full unrestricted duty and noted Petitioner's ability to safely lift 95 pounds.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has suffered 12.5% loss of use of the body as a whole.

Respondent shall pay Petitioner permanent partial disability benefits of $539.08/week for 62.5 weeks, because the injuries sustained caused the 12.5% loss of the person as a whole, as provided in Section 8(d)2 of the Act. Respondent shall be given credit for $26,954.00 for permanent partial disability benefits paid under Section 8(d)2 of the Act.

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

FRANK A. CIPOLLA,

Petitioner,

vs. NO: 11 WC 28888

17IWCC0398

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of reinstatement and being advised of the facts and applicable law, hereby reverses the Decision of the Arbitrator, and reinstates and remands this claim back to the Arbitrator for further proceedings.

Having reviewed the record, the Commission notes that a Petition for Fees pursuant to Section 16 of the Act was heard before Arbitrator Bocanegra on March 27, 2015. Arbitrator Bocanegra continued the matter to the disposition of the case. That same day, the matter was subsequently dismissed for want of prosecution by Arbitrator Bocanegra, despite no Notice of Motion and Order for Dismissal for Want of Prosecution having been presented by the parties to the Arbitrator.

The Commission finds it inconceivable that the Arbitrator would continue the issue of penalties to the disposition of the case only then to subsequently dismiss the action later that day for want of prosecution. Further, no record was made when this case was dismissed by the Arbitrator. Without more, the Commission is left without sufficient evidence to judge the merits of the dismissal. The Commission can only surmise that the dismissal was a clerical error.

17IWCC0398

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is hereby reversed; and, the above-referenced claim is reinstated and remanded back to the Arbitrator for further proceedings.

The party commencing 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: JUN 27 2017

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB/pm
O: 5-16-17
052

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
DECISION

Frank Cipolla
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **11** WC **28888**

17IWCC0398

The ***petitioner*** filed a petition or motion for **Reinstatement of Case** on **7/20/16** , and properly served all parties. The matter came before me on **8/26/16** in the city of **Chicago** . After hearing the parties' arguments and due deliberations, I hereby ***deny*** the petition. A record of the hearing ***was*** made.

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Arbitrator finds that the claim was dismissed on 3/27/15. The Petition to Reinstate was not filed until July 20, 2016, well past the 60 day requirement for reinstatement. The Petitioner claims that he never received notice of the dismissal. However, the Arbitrator finds that the Petitioner's attorney failed in his due diligence to monitor his claim and that a year is well beyond the appropriate time to realize that a 2011 was not coming up on the call before the Arbitrator and had been dismissed. Therefore, the Arbitrator denies the Petition to Reinstate.

Unless a *Petition for Review* is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

David A. Kane
Signature of arbitrator

August 29, 2016
Date

AUG 29 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THORLAN BUCHANAN,

Petitioner,

vs.

NO: 11 WC 42542

UCAN,

17IWCC0399

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, and being advised of the facts and applicable law, modifies 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.

In her Decision, the Arbitrator awarded $321,423.91 in medical bills. They are as follows:

1. Center for Minimally Invasive Surgery	$107,008.90
2. Dr. Gregory Primus	$140,007.01
3. Network Durable Equipment	$14,375.00
4. Advocate South Suburban Hospital	$18,940.00

17IWCC0399

5. North Chicago Medical	$41,093.00
	$321,423.91

Respondent argued that the Arbitrator erred in awarding the alleged outstanding balances for Network Durable Equipment and North Chicago Medical as Petitioner offered no evidence at arbitration to support such charges. Respondent further claimed that it offered evidence of payments made toward said outstanding charges, none of which were reflected on the medical bills submitted by Petitioner. Additionally, Respondent stated the award did not reflect allowable reductions pursuant to the Illinois Workers' Compensation Commission medical fee schedule.

The Commission finds that Petitioner failed to offer the medical bills for Network Durable Equipment and North Chicago Medical into evidence. Section 16 of the Act requires that bills from a treating provider be certified as true and correct by the treating provider in order for said bills to be admissible. The proponent of such evidence also has a second option for establishing foundation:

> The party offering the evidence must demonstrate that the record was made in the regular course of business and at or near the time of the transaction. A proponent may lay an adequate foundation through the testimony of the custodian of the records or another person familiar with the business and its mode of operation. *Land & Lakes Co. v. Indus. Comm'n*, 359 Ill. App. 3d 582, 590 (2nd Dist. 2005).

After meeting the requirements of foundation and admissibility, Section 8(a) of the Act states:

> The employer shall provide and pay the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule, subject to Section 8.2, in effect at the time the service was rendered for all the necessary first aid, medical and surgical services, and all necessary medical, surgical and hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury . . . 820 ILCS 305/8(a).

Petitioner is entitled only to such reasonable and necessary medical expenses that are causally related to the accident. "The award should only reflect those services which were determined to be required to diagnose, relieve, or cure the effects of claimant's injury." *Univ. of Ill. v. Indus. Comm'n,* 232 Ill. App. 3d 154, 163 (1st Dist. 1992). It is Petitioner's burden to prove her entitlement to an award of medical expenses. *Westin Hotel v. Indus. Comm'n*, 372 Ill. App. 3d 527, 546 (1st Dist. 2007).

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Without the medical bills being offered into evidence, there is no way to establish foundation and no way the Arbitrator can rule on admissibility. Without the medical bills being offered into evidence, there is no way to determine whether a specific charge was necessary and reasonably "required to diagnose, relieve, or cure the effects of claimant's injury." *Univ. of Ill. v. Indus. Comm'n*, 232 Ill. App. 3d 154, 163 (1st Dist. 1992). While the medical records offered into evidence by Petitioner may lend credence to the reasonableness and necessity of the treatment rendered, it is not evidence of the amount presently due and owing the provider. Furthermore, without the medical bills being offered into evidence, there is obviously no way to determine what amount the Respondent is required to pay in accordance with Section 8(a) and Section 8.2 of the Act. 820 ILCS 305/8.2.

Petitioner relies on *RG Constr. Servs. v. Ill. Workers' Comp. Comm'n*, 2014 IL App (1st) 132137WC, for the proposition that testimony only is sufficient to support an award of medical bills. The Appellate Court's opinion in *RG Constr. Servs.* pertained to the reasonableness and necessity of treatment, which was supported by the medical records. However, the specific issue on Review herein is the proper calculation of the medical bills awarded at arbitration, not the reasonableness and necessity of treatment rendered therein. Thus, *RG Constr. Servs.* is distinguishable from the present case.

Petitioner also cites *Compass Grp. v. Ill. Workers' Comp. Comm'n*, 2014 IL App (2d) 121283WC. The Respondent in *Compass Grp.* stipulated to pay specifically enumerated medical expenses in the event the matter was deemed compensable. This case is distinguishable from the present claim as no such stipulation was made by Respondent. Petitioner also states that the Appellate Court rejected the argument made by the Respondent in *Compass Grp.* as to "duplicate and unsubstantiated bills." Again, this is factually off-point as there is no "duplicate and unsubstantiated bills" to even discuss as Petitioner did not offer into evidence any medical bills whatsoever for Network Durable Equipment and North Chicago Medical.

Petitioner next argues that Illinois Rule of Evidence 1006 provides "that a summary of the charges is an appropriate admission unless the hearing officer requires the production of the actual bills." Rule 1006 really states:

> The contents of voluminous writings, recordings, or photographs which cannot conveniently be examined in court may be presented in the form of a chart, summary, or calculation. The originals, or duplicates, shall be made available for examination or copying, or both, by other parties at reasonable time and place. The court may order that they be produced in court. Ill. R. Evid. 1006.

Petitioner claims that under Rule 1006, the Arbitrator's Exhibit 1 (the Request for Hearing form) and Respondent's Exhibit 1 (an itemization of the medical bills it paid) are sufficient evidence of what is due and owing to Network Durable Equipment and North Chicago Medical. The Petitioner has made no showing that the alleged medical bills due and owing were

17IWCC0399

voluminous or could not be conveniently examined by the Arbitrator. Petitioner's attempt to hide behind Rule 1006 is not only incredible, it is plainly absurd.

Finally, Petitioner argues that Respondent "never objected to or disputed that petitioner accrued certain bills related to her treatment and identified on Arbitrator's Exhibit 1." (Petitioner's Brief, pg. 8). The Request for Hearing form clearly indicates that Respondent disputed the medical bills alleged by Petitioner. According to Section 9030.40 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, the purpose of a Request for Hearing form is to memorialize "the stipulation of the parties and a settlement of the questions in dispute in the case." It is without question that Respondent disputed the medical bills listed on the Request for Hearing form. Now that the claim is under Review before the Commission, Respondent's sole dispute is the proper calculation of the medical bills awarded.

The Commission finds Respondent is not responsible for the alleged medical charges of Network Durable Equipment and North Chicago Medical as Petitioner failed to present a copy of the medical bills allegedly due into evidence. Respondent shall pay to Petitioner reasonable and necessary medical services rendered by Center for Minimally Invasive Surgery (PX4), Dr. Gregory Primus (PX2), and Advocate South Suburban Hospital (PX3), pursuant to Section 8(a) and Section 8.2 of the Act, as the Petitioner submitted a copy of the medical bills due into evidence.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed June 8, 2016, is hereby modified as stated above, 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.

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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: JUN 27 2017

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

MJB/pm
O: 5-16-17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUCHANAN, THORLAN
Employee/Petitioner

Case# **11WC042542**

UCAN
Employer/Respondent

17IWCC0399

On 6/8/2016, 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 0.43% 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:

1377 PARENTE & NOREM PC
PARAG P BHOSALE
221 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

1604 STELLATO & SCHWARTZ
RYAN A ERIKSON
120 N LASALLE ST 34TH FL
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

THORLAN BUCHANAN
Employee/Petitioner

v.

UCAN
Employer/Respondent

Case # 11 WC 42542

Consolidated cases: _____

17IWCC0399

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **CHICAGO, IL**, on **4/21/16**. 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 **6/09/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,000.00**; the average weekly wage was **$500.00**.

On the date of accident, Petitioner was **31** 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 **$55,662.34** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$55,662.34**.

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 **$333.33/week** for **186 weeks**, commencing **11/18/11** through **11/18/15**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$55,662.34** for temporary total disability benefits that have been paid.

Respondent shall pay to Petitioner reasonable and necessary medical services of **$321,423.91**, 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 **164.75 weeks**, because the injuries sustained caused **65% loss of the leg** and **5% loss of a person as a whole**, as provided in Sections 8(e) and 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.

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FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) medical bills; 3) temporary total disability; and 4) the nature and extent of Petitioner's injury. *See,* AX1.

Petitioner's testimony

Ms. Thorlan Buchanan (the "petitioner") testified that she is a 35-year-old college graduate who is currently working towards a master's degree. She started working for UCAN (the "respondent") as a full-time juvenile care assistant in 2007. The respondent provides in-house care and treatment for troubled and 'special needs' youths, and Petitioner's job required her to supervise these individuals on a daily basis. The job required her to be on her feet at least 6 hours of her 8-hour day. It was commonplace for the juveniles to fight each other, and the petitioner's duties included intervening when altercations occurred.

On June 9, 2011, a 15-year-old and a 16-year-old began fighting. The 16-year-old weighed over 200 pounds, and when the petitioner tried to break up the fight, the 16-year-old pushed her. The petitioner twisted her right knee and then hit the same knee on the concrete floor. She had some swelling, but having been a collegiate athlete, she thought that it would eventually go away on its own. She did not seek immediate medical treatment.

Over the next ten (10) days, the petitioner noticed that the swelling and pain in her right knee became worse. She contacted her supervisor, Rhonda Simpson, and requested authorization to see a doctor. It wasn't until June 21, 2011, that Dr. Annie Callangan, at CSO Therapy, was able to see her.

Dr. Annie Callangan

On June 21, 2011, Dr. Callangan recorded 5/10 right knee pain that the petitioner described as being on the "inside." She referred her for an x-ray and put her on modified duty without any "restraining work." Dr. Callangan noted under "MEDICAL CAUSATION" that "[t]his problem is related to work activities." The x-ray was positive for "effusion." She saw the petitioner again on June 24, 2011 and recorded 8/10 pain. She continued her modified duty restriction and referred Petitioner to Dr. Gregory Primus, an orthopaedic surgeon. PX1, p.10.

Dr. Gregory Primus

The petitioner had seen Dr. Primus prior to the subject accident from June 1, 2010 to May 31, 2011 for an unrelated right shoulder injury. She next saw him on July 1, 2011 upon referral from Dr. Callangan where he recorded a June 9, 2011 incident that involved a "direct blow" after a "fall at work." He noted pain with walking, running, jumping, and direct pressure. After he found her physical examination to be consistent with a medial meniscus tear, he referred her for a right knee MRI.

He saw her on July 19, 2011 and reviewed the MRI. In that it was relatively unremarkable, he suggested that she begin a course of physical therapy and fitted her for a brace. He kept her on sedentary duty, which the respondent accommodated.

The petitioner continued with monthly office visits and physical therapy until September 16, 2011, when Dr. Primus recommended a second opinion because nothing seemed to be helping her recovery. PX2, pp.64-77, 92.

Dr. Steven Chandler

She saw Dr. Steven Chandler on July 21, 2011 for the second opinion and he administered a steroid injection. He further recommended an MRI with contrast, a diagnostic arthroscopy, and visco-supplementation injections. She returned to Dr. Primus on September 26, 2011 to proceed with the diagnostic arthroscopy that Dr. Chandler recommended. PX6, pp. 93, 730-731.

Dr. Daniel Troy, IME #1

On October 18, 2011, the petitioner saw Dr. Daniel Troy for Respondent's section 12 examination. Dr. Troy disputed that she needed surgery and thought that she could return to work in line with the results of an FCE. RX2.

On November 18, 2011, the respondent informed the petitioner that they could no longer accommodate her sedentary work restrictions. The petitioner ceased receiving a paycheck and did not receive any temporary total disability ("TTD") or maintenance.

On November 30, 2011, Dr. Primus performed a right knee arthroscopic abrasion arthroplasty with microfracture of the lateral femoral condyle and synovectomy. During the procedure, Dr. Primus noted that several fragments of cartilage needed to be debrided. PX3, p.469-470.

On December 28, 2011, the respondent terminated Petitioner's employment. From December 28, 2011 through November 18, 2015, the petitioner conducted a self-guided search for new employment. She was continuously unsuccessful because potential employers could see her on crutches or walking with her external right knee brace.

From December 9, 2011 through May 25, 2012, Dr. Primus saw her every month and continued her physical therapy during that time, but noted little to no improvement. He reduced her restrictions to medium duty, but he noted that an osteochondral lesion he found during the surgery might require a second arthroscopy. PX2.

On June 18, 2012, Dr. Primus noted that her symptoms were not improving and decided that she may be a candidate for cartilage reconstruction with a transplant. After monthly visits with Dr. Primus, continued physical therapy with no improvement, on June 12, 2013, Dr. Primus performed a right

knee arthroscopic assisted osteochondral allograft transplantation. The petitioner continued seeing Dr. Primus at least once per month, and by December 24, 2013, he noted that she was "getting very frustrated with the pain." She testified that she decided at that point to get a second opinion.

Dr. Michael Terry

On January 14, 2014, she presented to Dr. Michael Terry at Northwestern for a second opinion. He recommended a third arthroscopy "to evaluate the medial meniscus as well as evaluate the allograft and to evaluate for any possible loose bodies or fragmentation." PX8, pp. 749-750.

After another MRI on January 20, 2014, Dr. Primus recommended that they proceed with surgery to look at the graft and determine if there was any structural pathology that was causing her continued pain. This surgery was performed on April 16, 2014, with Dr. Primus completing: (1) a removal of loose bodies; (2) a takedown of chondral fix transplant on the lateral posterior femoral condyle; (3) chondroplasty of the medical femoral condyle; and (4) abrasion chondroplasty of the trochlear groove involving the superior inter-condylar notch and cartilage harvest for ACI procedure. The harvested cartilage was kept sterile for a Genzyme representative to take for workup for future re-implantation.

Dr. Troy IME, #2

On May 8, 2014, the petitioner had a second section 12 examination by Dr. Troy. This time Dr. Troy concluded that there appeared to be "causality established to the June 9, 2011 work accident with the subsequent osteochondral injury that was induced to the lateral femoral condyle." He believed that all treatment to date was acceptable and that Petitioner would need additional medical care, including "stage 2 of the Carticel reimplantation procedure in ordered (sic) to assist with reconstitution of the lateral femoral condyle." The petitioner should only work a sedentary position, which the respondent did not accommodate. RX3.

After another three (3) months of physical therapy, on July 11, 2014, Dr. Primus performed the re-implantation surgery that Dr. Troy recommended. This was the petitioner's fourth and final surgery.

She continued seeing Dr. Primus and by December 2, 2014, she was experiencing low back pain. The petitioner testified that this problem developed over time due to her constant limp, which put stress on her back. Dr. Primus referred her for an EMG study which was performed on January 7, 2015. The study revealed irritation of the right L5-S1 nerve roots. Dr. Primus wanted her to see a neurologist and pain management physician to treat this back condition. The back symptoms continued through her February 17, 2015 visit. PX12.

Dr. Kern Singh, back IME

Rather than approve the neurologist and pain management referral, the Respondent sent her once again for a section 12 examination. She saw Dr. Kern Singh, who concluded that the back condition was not related to her June 9, 2011 work accident because she did not have back symptoms

immediately after the incident. He did not provide an opinion about the back pain being secondary to her altered gait, which was induced by her right knee injury. RX5.

Dr. Troy, IME #3

The petitioner had a final section 12 exam with Dr. Troy on March 9, 2015. Dr. Troy believed at this point her right knee pain was more muscular-based and would continue to improve over time. He advised that she should continue with a home-based exercise program and could return to work. In the future she might benefit from "further intervention based on the findings of the MRI in the region of the lateral femoral condyle, but at this point in time no further intervention" was required. RX4.

On May 30, 2015, Dr. Primus noted that The petitioner's right knee injury "effected the normal biomechanics throughout her recovery process that irritated her lumbar spine and most likely lead to the irritated nerve root on the EMG." With regard to her knee, Dr. Primus wanted her to undergo a second opinion with a fellowship-trained knee surgeon for a final assessment before rendering her at maximum medical improvement. He did not anticipate that she would need any further medical care in the near future. He did not agree with Dr. Singh and Dr. Troy that she could work full duty without any restrictions.

May 21, 2013 evidence deposition of Dr. Gregory Primus

Dr. Primus is a board-certified fellowship-trained orthopaedic and sports medicine surgeon whose practice is 70% devoted to knee and shoulder injuries. He has been in private practice since 2007.

Taken prior to the petitioner's surgeries on June 12, 2013, April 16, 2014 and July 11, 2014, Dr. Primus' deposition testimony included the following opinions to a reasonable degree of medical and surgical certainty: (1) The petitioner's right knee injury was caused by her June 9, 2011 accident where she fell and had a direct blow with the ground; (2) her work restrictions were medically necessary and arose out of the same accident; (3) during the November 30, 2011 arthroscopy he identified a chondral lesion that was caused by the accident; and (4) the future cartilage transplant surgeries were all necessary as a result of the accident. PX11, pp. 5-6, 17-18, 23, & 32.

Petitioner's current condition

The petitioner testified that she still has right knee pain on a daily basis. Her pain level has improved after four knee surgeries and countless physical therapy sessions. She performs her home exercises twice a day, but still is not able to run or jump, due to fear she may re-aggravate her knee condition. She began working within her restrictions on November 18, 2015 with a new employer. She teaches special education at a charter school and is not required to spend much time on her feet. She only has to attend to one student at a time. The petitioner continues to see Dr. Primus every 6-8 weeks so that he may monitor her condition.

CONCLUSIONS OF LAW

17IWCC0399

F. Is Petitioner's current condition of ill-being causally related to the June 9, 2011 work injury?

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin v. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v. Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v. Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v. Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Arbitrator finds that the petitioner's right knee and back injuries were causally related to her June 9, 2011 work injury. Dr. Primus' records as well as his deposition testimony provide a causal connection between the accident and the right knee injury. Second, Dr. Callangan provided a causal connection in her June 21, 2011 record. Thirdly, Dr. Troy, Respondent's section 12 physician, wrote in his May 8, 2014 report that he found "causality established to the June 9, 2011" work accident. There is no medical opinion that disputes a causal connection, and absent such evidence, the Arbitrator finds and concludes that Petitioner has proven, by a preponderance of the evidence, that there is a causal relationship between her current condition of ill-being and the work-related accident.

Regarding the back injury, the Arbitrator is not persuaded by Dr. Singh's opinion that there is no causal connection simply because of the delay in documented back complaints. The Arbitrator is persuaded by a combination of the petitioner's testimony and Dr. Primus' opinion that the back injury emerged over time, as the petitioner's biomechanics were altered due to her knee injury. There was no intervening event or evidence offered of a degenerative condition. The Arbitrator finds that all symptoms do not have to appear immediately after an accident for them to be related. It would not be expected that an altered gait have an immediate impact on the petitioner's back, therefore, symptoms would not have appeared immediately after the accident.

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

As stated by Respondent's section 12 examiner Dr. Daniel Troy, all four of the petitioner's surgeries, her physical therapy, her tests, and her medications were reasonable and necessary. There is nothing in evidence noting that any of the treatment was excessive or redundant. The Arbitrator therefore finds that the Respondent shall pay to Petitioner $321,423.91 in medical bills listed on the Request for Hearing, subject to Sections 8(a) and 8.2 of the Act.

K. What temporary benefits are in dispute?

The Arbitrator finds that the Respondent removed the petitioner from working light duty on November 18, 2011, and terminated her completely on December 28, 2011. This constitutes a failure to accommodate the petitioner's restrictions as set by Dr. Primus; restrictions that Dr. Troy agreed were reasonable and necessary as a result of the June 9, 2011 work accident. In that the petitioner complied with her obligation to seek employment and mitigate her damages, the petitioner is entitled to temporary total disability ("TTD") payments until the first date of her employment with her new employer on November 18, 2015.

Although Dr. Troy believed that the petitioner could return to work without restrictions on March 9 2015, the Arbitrator finds that Dr. Primus was in a better position to determine the extent of the petitioner's physical limitations. Since Dr. Primus had not removed all restrictions through his last record, she would still be entitled to TTD until her new job began.

The Arbitrator also notes that Section 7110.10 of the Rules Governing Practice provides: "[t]he employer or his representative, in consultation with the injured employee and, if represented, with his or her representative, shall prepare a written assessment of the course of medical care, and, if appropriate, rehabilitation required to return the injured worker to employment when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of injury, or when the period of total incapacity for work exceeds 120 continuous days, whichever first occurs." Since the period of total incapacity in the subject case exceeded 120 continuous days, the respondent should have provided vocational assistance and maintenance payments.

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

The Arbitrator notes that this accident occurred prior to the September 1, 2011 amendments to the Act. The Arbitrator finds that the injuries sustained by the petitioner caused 65% loss of the right leg and 5% loss of a person as a whole, as provided in Section 8(e) of the Act. Petitioner had a confirmed medial meniscus tear, an osteochondral lesion, and underwent 4 major knee surgeries. She continues to be evaluated by her surgeon on a regular basis. She will undoubtedly be cursed with a defunct right knee for the rest of her life. With regards to her back, the petitioner has confirmed L5-S1

17IWCC0399

radiculopathy. Though the symptoms were not as severe as her knee symptoms, she will still have an altered gait, which will continue to affect her back.

17IWCC0399

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11WC42542
SIGNATURE PAGE

Signature of Arbitrator

June 8, 2016
Date of Decision

JUN 8 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

☐ 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

JOHN BOHENTIN,
Petitioner,

17IWCC0393

vs.

NO: 11 WC 45957

EUCLID BEVERAGE,
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 permanent partial disabilty, wages, and maintenance, 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 issues decided in the Decision of the Arbitrator were causal relationship between Petitioner's current condition of ill-being and his injury, temporary benefits, and the nature and extent of his injury. Petitioner's current condition of ill-being was found to be causally related to his injury and temporary total disability and maintenance benefits under Section 8(a) of the Act and a permanent partial disability benefit under Section 8(d)1 of the Act were awarded. The Commission finds it is more appropriate to award Petitioner the permanent partial disability benefit under Section 8(d)2 of the Act rather than Section 8(d)1 and modifies the Decision of the Arbitrator accordingly.

Entitlement to a wage differential award requires a claimant to prove: "(1) a partial incapacity that prevents him from pursing his usual and customary line of employment and (2) an impairment of earnings." Copperweld Tubing Products v. Illinois Workers' Compensation Commission, 402 Ill.App.3d 630, 633, 931 N.E.2d 762, 341 Ill.Dec. 865 (1st Dist. 2010).

Petitioner satisfies the first prong of Copperweld as the imposed permanent restrictions placed upon him preclude him from resuming his career as a sales supervisor in the beverage delivery industry. As a sales supervisor, he was responsible for delivering and stocking cases of beer and, when necessary, erecting displays. The imposed permanent restrictions of no lifting in

excess of ten pounds and bending and/or stooping only as tolerated would prevent Petitioner from these tasks.

Petitioner, however, failed to satisfy the second prong of Copperweld. "[S]ection 8(d)(1) of the Act instructs the Commission to look that the amount the claimant 'is earning or *is able to earn* in some suitable employment or business after the accident.'" Copperweld Tubing Products, 402 Ill.App.3d at 634. (Emphasis in the original.) He, personally, cannot demonstrate how much he is earning or could earn in some suitable employment or business because, he, per his own testimony, has not sought employment since he was released to return to work on April 24, 2012. The Arbitrator, citing Copperweld, found Petitioner's "voluntary decision to remove himself from the work force" was not an impediment to him being eligible for an award under Section 8(d)1 of the Act. The Commission finds Copperweld inapplicable to Petitioner's situation.

The claimant in Copperweld, at the time of his arbitration hearing, was not employed. Copperweld Tubing Products, 402 Ill.App.3d at 634. At the arbitration hearing, however, "the claimant testified that he conducted a self-directed job search and obtained a position within his physical capabilities, a job as a security guard at Securatex. The claimant states he was paid $8 per hour and worked forty hours each week." Copperweld Tubing Products, 402 Ill.App.3d at 634. The court noted the claimant's rate of pay fell within the range of pay the claimant's vocational rehabilitation counselor believed the claimant was capable of earning without his professional assistance and subsequently upheld the Commission's awarded benefit under Section 8(d)1 of the Act as "the Commission could reasonably rely on the claimant's job at Securatex in determining that he had proven that his earnings were impaired." Copperweld Tubing Products, 402 Ill.App.3d at 634-635. The Commission finds it is able to differentiate Copperweld from the present case.

In the present case, Petitioner abandoned the job market on April 24, 2012. As noted above, he testified that he did not look for work after that day. Petitioner also testified that he did not interview with Respondent for an internal position that was within his restrictions. The claimant in Copperweld, if he abandoned the job market, did so only after he returned to work as a security guard and only after he demonstrated what he was capable of earning. Had Petitioner obtained any employment within his restrictions and then ceased working, then his circumstances would be within the orbit of Copperweld.

The Commission notes Petitioner retained the services of Lisa Helma, a certified rehabilitation counselor with Vocamotive Vocational Rehabilitation Services, and met with Ms. Helma on June 9, 2015. This one meeting occurred more than three years after Petitioner was released to return to work and less than four months before the September 28, 2015, arbitration hearing. The Commission finds both the evaluation report and the labor market survey created by Ms. Helma on Petitioner's behalf were done so in anticipation of litigation and are given no weight. Furthermore, it appears Ms. Helma was not made aware of Petitioner's previous employment as a Delivery Manager, a position that included possible responsibilities that would have allowed Ms. Helma to broaden the scope of employment opportunities she sought for Petitioner.

Petitioner unquestionably lost the ability to work at his usual and customary line of employment as a sales supervisor not only for Respondent but also any potential employer that would require him to lift in excess of ten pounds and require him to bend and/or stoop with any

17IWCC0393

regularity. His election not to work after being medically cleared to work again prevented him from establishing what he is capable of earning. His election to rely on Ms. Helma's labor market survey to establish what he may be capable of earning resulted in unacceptable speculation, particularly given that Ms. Helma was not given a complete accounting of Petitioner's work history. For these reasons, the Commission finds it more appropriate to compensate Petitioner for the loss of his trade under Section 8(d)2 of the Act than for a presumptive diminution of earning capacity.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed with the Commission on April 6, 2016, is modified to vacate the permanent partial disability benefit awarded under Section 8(d)1 and award the permanent partial disability benefit under Section 8(d)2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $713.91 per week for a period of 22 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner maintenance benefits of $713.91 per week for a period of 162-6/7 weeks, commencing April 25, 2012, through June 8, 2015, as provided for under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $642.52 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 man 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 in the amount of $13,360.71 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: JUN 27 2017
KWL/mv
O-5/2/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0393

BOHENTIN, JOHN
Employee/Petitioner

Case# 11WC045957

EUCLID BEVERAGE
Employer/Respondent

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:

0276 BURNETT & CARON LTD
ROBERT W BURNETT
1776 LEGACY CIRCLE SUITE 116
NAPERVILLE, IL 60563

5001 GAIDO & FINTZEN
ROBERT L SMITH
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0393

John Bohentin
Employee/Petitioner

v.

Euclid Beverage
Employer/Respondent

Case # 11 WC 45957

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 **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton**, on **September 28, 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 **May 24, 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 **$55,684.72**; the average weekly wage was **$1,070.86**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled a credit of **$13,360.71** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$13,360.71**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$713.91**/week for **22** weeks, commencing **November 23, 2011** through **April 24, 2012**, pursuant to Section 8(b) of the Act.

Respondent shall be given a credit of **$13,360.71** for temporary total disability benefits that they have been paid Petitioner.

Maintenance

Respondent shall pay Petitioner maintenance benefits of **$713.91**/week for **162-6/7** weeks, commencing **April 25, 2012** through **June 8, 2015**, as provided in Section 8(a) of the Act.

Permanent Partial Disability: Wage differential

Respondent shall pay Petitioner permanent partial disability benefits, commencing on **June 9, 2015**, of **$433.91**/week and continuing for the duration of the disability, because the injuries sustained caused an impairment of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **April 25, 2012** through **September 28, 2015**, and shall pay the remainder, if any, in weekly benefits.

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

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

Brian T. Cronin

Signature of Arbitrator

April 6, 2016

Date

APR 6 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN BOHENTIN,

Petitioner

v.

EUCLID BEVERAGE

Respondent

17IWCC0393

11 WC 45957

FINDINGS OF FACT

Petitioner testified that he was injured on May 24, 2011. At that time, he was employed as a Sales Supervisor by Respondent, a beer distributor, for whom he had been employed since 1999. That position required that he call on various retailers, such as Jewel-Osco, and take orders for beer sales, fill shelves, and build displays that ranged from ten to one thousand cases of beer. He further testified that the job required repetitive lifting of up to fifty pounds and an ability to bend, twist and reach all day long.

Before Respondent hired him, they required him to pass a functional screen and demonstrate an ability to lift fifty pounds. (Px.5)

At 8:00 a.m. on the date of accident, Petitioner was working his regular-duty job and was filling a cooler at Jewel-Osco in Lombard, IL. At that time, he experienced a sharp pain in his back that radiated all the way down his right leg. Petitioner testified that such pain "knocked [him] down." Petitioner then contacted Respondent's Human Resources Director, who instructed him to go to Tyler Medical Services, which he did that same day. (Px.3) Petitioner was given light-duty restrictions, which Respondent accommodated through November 22, 2011.

Petitioner testified that prior to May 24, 2011, he never had a low back injury and never received medical care for a low back injury.

Petitioner was seen by several physicians at Tyler and continued on restrictions during that time period. (Px.3) Medications and physical therapy were provided, and ultimately an MRI of the lumbar region was carried out on June 15, 2011. The radiologist's impression of such images is, as follows:

(1) Degenerative change in the lumbar spine with disc disease at the L2-L3 to L5-S1 levels.

(2) Associated lower lumbar ligamentum flavum and facet hypertrophy further contributes to central canal and foraminal narrowing especially at the L4-L5 and L5-S1 levels as described. (Px.10)

On September 30, 2011, Christopher J. Bergin, M.D., Respondent's Section 12 examining physician, saw Petitioner. He presented treatment options to Petitioner and provided a causation opinion. Dr. Bergin also imposed activity restrictions on Petitioner at that time. Those restrictions were "no lifting greater than 10-20 pounds with limited bending and twisting." (Rx.1)

On February 6, 2012, Larry McGrail, Vice President of Operations for Respondent, authored a letter to Petitioner in which he invited Petitioner to interview for the position of Warehouse Manager that had just become available. The letter states that the position requires the Warehouse Manager to have the ability "to manage people and processes", and that the Warehouse Manager "is responsible for the staff, protecting the integrity of inventory, equipment and the facility and ensuring the trucks get loaded". (Rx.3)

Petitioner acknowledged receiving the letter from Mr. McGrail. Petitioner testified that he did not respond to the offer of an interview for the Warehouse Manager position because he did not feel he was qualified for the job.

On February 7, 2012, Dr. Bergin examined Petitioner, found him to be at maximum medical improvement and recommended that Petitioner undergo a functional capacity evaluation ("FCE"). Dr. Bergin restated his causation opinion at that time. (Rx.2)

The Tyler physicians referred Petitioner to neurosurgeon Mathew J. Ross, M.D., with whom Petitioner continued to treat. Dr. Ross first saw Petitioner on February 28, 2012. The doctor offered treatment options, which included injections and a surgical decompression. Petitioner has not undergone surgery, though it was presented as a treatment option by both Dr. Ross and Dr. Bergin if the injections did not provide lasting relief. Dr. Ross referred Petitioner to Dr. James Kelly at Du Page Pain Center for injections. (Px.2)

Petitioner underwent two injections (Px.2), which, per Petitioner's testimony, resulted in long-term pain relief for a couple of years.

On April 19, 2012, Dr. Ross saw Petitioner and recommended another injection. (Px.1) Such injection was not authorized by Respondent.

On April 24, 2012, Dr. Ross issued the following permanent work restrictions for Petitioner: "May lift up to 15 lbs. Alternate sit/stand as needed." (Px.1)

On January 10, 2014, Dr. Ross saw Petitioner and recommended another cortisone injection as well as an FCE. Such injection was not authorized by Respondent.

An FCE was never scheduled. Petitioner testified that he agreed to have the FCE, but that the insurance company would not pay for it.

Petitioner testified that following his accident, he continued to work for Respondent through November 22, 2011. On that date Respondent's Human Resources Director, Sonia Madalinski, and Respondent's President, Emmett McEnery, informed Petitioner that the light-duty restrictions would no longer be accommodated. For several weeks prior to such meeting, Petitioner assisted another driver by providing guidance and advice only; Petitioner did not perform any of the lifting activities of the job during those weeks.

Petitioner has remained off work from November 23, 2011 through September 28, 2015.

Petitioner testified that he requested vocational rehabilitation services from Respondent, but that such services were never provided.

Petitioner testified that at no point did he look for work.

Petitioner applied for, and then began receiving, social security disability benefits, retroactive to May 2012. The Social Security Decision is dated September 22, 2012. (Px.8)

Respondent terminated Petitioner's temporary total disability benefits on April 24, 2012.

Petitioner testified that the position of Warehouse Manager was never offered to him, only the offer of an interview. Respondent did not offer him any work within his restrictions of after April 24, 2012. Petitioner testified that he possessed no training, education or skills in managing a warehouse. He further testified that he had no experience or training in inventory control and management, employee scheduling, or product shipment and scheduling. He also stated that he has no experience or training in equipment and property management, or in dealing with bills of lading.

Petitioner testified as to his educational and vocational background. He has a high school diploma and one uncompleted non-credit course in finance at a community college. He testified that Respondent and prior employers did not provide Petitioner with any additional

training or education, other than the occasional one-hour sales presentation that some of Respondent's suppliers conducted. Petitioner uses a computer for email and internet searches, and describes his keyboarding skills as hunting and pecking. He has no training or education in the use of database programs or Excel spreadsheets.

Petitioner testified that Respondent provided Petitioner with a hand-held device to place orders of customers. He described the process as scrolling down to the customer name and putting in the quantity of product to be ordered. He had no other use for the device, and testified that someone else at the company had programmed the device and would take the order information from the device after he entered the quantity to be ordered.

Prior to his employment with Respondent, Petitioner worked for Courtesy Distributors. He held the position of Delivery Manager for four months, and prior to that, he held the position of Delivery Route Driver for eighteen years. During the four months he was Delivery Manager, he would check on the work of Delivery Drivers, and would make sure they were properly displaying and rotating the merchandise. He recorded this information on a form in a clipboard, and would then submit the form to his supervisor. He did not use a computer in that position and did not manage inventory or sales. He also testified that in that role, he did not hire, evaluate or terminate any employees.

At the request of Petitioner, Petitioner met with and was interviewed by a Certified Rehabilitation Counselor at Vocamotive vocational rehabilitation services on April 27, 2015. Lisa Helma, C.R.C., of Vocamotive interviewed him and authored the Initial Evaluation Report, Labor Market Survey and Rehabilitation Plan. (Px.4) Petitioner's Exhibit #4 is the only expert vocational evidence provided.

Ms. Helma stated in her Initial Evaluation Report that she had reviewed the February 6, 2012 correspondence form Respondent to Petitioner regarding the Warehouse Manager position as well as several other documents and records, including Petitioner's personnel and medical records, as well as the Dictionary of Occupational Titles ("DOT"). After interviewing Petitioner and researching these issues, she inserted in her report DOT's job description of a Distribution Warehouse Manager:

> Directs and coordinates activities of wholesaler's distribution warehouse: Reviews bills of lading for incoming merchandise and customer orders in order to plan work activities. Assigns workers to specific duties, such as verifying amounts of and storing incoming merchandise and assembling customer orders for delivery. Establishes operational procedures for verification of incoming and outgoing shipments, handling and disposition of merchandise, and keeping of warehouse inventory. Coordinates activities of distribution warehouse with activities of sales, record control, and purchasing departments to ensure availability of merchandise. Directs reclamation of damaged merchandise. (Px.4)

Ms. Helma wrote that Distribution Warehouse Manager is classified as a skilled (SVP-6) position at the Sedentary level of physical demand. Ms. Helma concluded:

"It is noted that based upon his previous reported job duties, Mr. Bohentin does not have previous experience in this capacity. Based upon the results of the Labor Market Survey, Mr. Bohentin would not be a qualified candidate for current Warehouse Manager positions at other entities." (Px.4)

The vocational expert went on to provide her opinions regarding Petitioner. "First, it is the opinion of this consultant that Mr. Bohentin has lost access to his usual and customary line of occupation of Malt Liquor Sales Representative. Second, it is the opinion of this consultant that Mr. Bohentin remains employable at this time. He should be able to locate employment in any position congruent with his previous experiences and physical capabilities. Third, and with

regard to wage earning potential, it is the opinion of this consultant that Mr. Bohentin's most probable wage earning potential at this time is between $9.00 and $12.00 hourly". (Px.4)

On cross-examination, Petitioner testified that he did not explain to Ms. Helma that he used a hand-held computer when he worked for Respondent.

Emmett McEnery, president and CEO of Euclid Beverage, testified at trial. Mr. McEnery testified with regard to Petitioner's resume', which Petitioner presented to Euclid Beverage in 1999 at the time he was hired. Mr. McEnery was part of the hiring team in 1999 and it was his recommendation that John Bohentin be hired based upon the resume'. (Px.6) Mr. McEnery went on to testify that John Bohentin had been a good employee at Euclid Beverage, and was given positive performance appraisals. John's responsibilities included increasing sales and distribution in his area. He could not sell to anyone who did not have a liquor license, and he had to apply the proper discount to each customer. Different metrics are used for customers in order to determine the proper discount. John Bohentin's pay was tied to how well he did his job. Given the highly-regulated nature of the business, Mr. McEnery testified, a thorough knowledge of on-the-job trade practices was essential.

Mr. McEnery also testified about Euclid Beverage's special software for beer distribution, which was programmed into the hand-held device that John Bohentin used. This device was used for orders, inventory management and other information. According to Mr. McEnery, Sales Supervisor such as Mr. Bohentin would use the hand-held device for many purposes, in addition to orders. This computer software system for sales was on the same platform as the warehouse inventory system, and did not require advanced training. Mr. McEnery further testified that Respondent provided training for Petitioner to become Sales Supervisor. It was important to Mr. McEnery was John Bohentin's had 30 years of experience in the alcohol sales business. It was

Mr. McEnery's testimony that John Bohentin would be a good fit for the February 2012 Warehouse Manager position. It was Mr. McEnery's recommendation, at the time, that Mr. Bohentin be considered for the job. Mr. McEnery testified that the special skill set possessed by Mr. Bohentin would suit him well for the different facets of the job.

Mr. McEnery testified that there are 150 full-time employees in the warehouse.

On cross-examination, Mr. McEnery testified that he himself was not a Certified Rehabilitation Counselor. He also testified that the position of Warehouse Manager was never offered to Petitioner, and that no offers of permanent employment within the medical restrictions were ever offered to Petitioner. He testified that he was aware that Petitioner worked for four months as Delivery Manager for Courtesy Distributors. He testified that he is aware that Respondent's Section 12 physician imposed permanent restrictions and that due to such restrictions, Petitioner has permanently lost the Sales Supervisor position.

Larry McGrail, the Vice-President of Operations for Euclid Beverage, also testified at trial. He testified that there are fifteen managers and 130 other employees at the company. Mr. McGrail had direct supervision over the Warehouse Manager position. He testified that there were three shifts. Each shift had a Warehouse Manager. The Warehouse Managers worked as a team, and under them were personnel management employees, such as in quality control. Each Warehouse Manager is like "the captain, the boss of the ship." The responsibilities of this position included being in charge of the inventory, as well as "overseeing the teams and groups and the managers, supervisors, employees that are doing these functions". Mr. McGrail testified that he himself started at the ground level, first as a Merchandiser, then as a Sales Supervisor, a Warehouse Manager, and then to the Director of Operations. He knew Petitioner well, and knew Petitioner's skill set. He felt Petitioner had a lot of things that a good candidate would have and

that he would get along with the group. Mr. McGrail was not aware, however, that Petitioner worked as Delivery Manager for Courtesy Distributors for only four months.

Mr. McGrail testified that any training Petitioner would need in the inventory software system that Warehouse Managers use would be available.

Mr. McGrail also testified to Petitioner's familiarity with the computer system, his background, and his suitability for the Warehouse Manager job. This was the basis for the February 6, 2012 letter to Mr. Bohentin in which he invited him to interview for the Warehouse Manager position.

Mr. McGrail testified that John Bohentin did not reply to the letter in which he invited him for an interview. Mr. McGrail testified that when he did not hear from John Bohentin after he sent the February 6, 2012 letter, he had his staff make efforts to reach Mr. Bohentin by phone.

Mr. McGrail then needed to move forward with the hiring process, and reviewed applications for more than 40 individuals. He eventually hired a permanent Warehouse Manager. That job paid approximately $50,000.00 at the time, but the salary ranged from the high thirties to low seventies.

Mr. McGrail testified that different Warehouse Managers brought different skill sets.

Mr. McGrail testified that the person Respondent hired for the position of Warehouse Manager he had approximately five years of experience working in the warehouse and had been working as an assistant to the Warehouse Manager. He agreed that Petitioner had never worked in that position. Yet, the new Warehouse Manager previously worked in sales for Respondent and had no experience with a computer other than his work at Euclid Beverage.

Mr. McGrail agreed that the Warehouse Manager position was an "at will" position, so that if Petitioner had been offered the position and hired, he could have been terminated at any time. Mr. McGrail also agreed that Petitioner's had permanently lost his job of route salesman due to the work restrictions imposed on him by Respondent's Section 12 examining physician, Dr. Bergin.

Mr. McGrail testified that sales employees were provided with a hand-held device with all the software already installed for them and the supervisor would instruct them how to use it. There was no classroom training for the hand-held computer.

Mr. McGrail testified that he did not offer Petitioner a permanent job within his restrictions because Petitioner did not even come in for an interview.

Mr. McGrail is not a Certified Rehabilitation Counselor or a vocational rehabilitation expert.

Both McGrail and McEnery testified that it was their strong preference to hire from within.

Mr. McEnery and Mr. McGrail testified that they were not contacted by Vocamotive about the operations at Euclid Beverage or the job requirements of the Warehouse Manager position.

CONCLUSIONS OF LAW

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

Petitioner's treating physician, Matthew J. Ross, M.D., opined that Petitioner had an L5-S1 disc herniation and foraminal stenosis. (Px.1)

Respondent's Section 12 examining physician, Christopher J. Bergin, M.D., wrote that Petitioner stated that on May 24, 2011, he injured his low back while lifting at work, and that he was asymptomatic prior to the lifting injury. Dr. Bergin opined that this lifting mechanism "is reasonable to aggravate an underlying degenerative condition, namely the synovial cyst and degenerative process at L4-5." Dr. Bergin further opined that if, indeed, John Bohentin was asymptomatic prior to this incident, then there is a causal relationship. (Rx.1)

Petitioner provided unrebutted testimony that prior to May 24, 2011, he never had a low back injury and never received medical care for a low back injury.

Therefore, the Arbitrator finds that a causal relationship exists between Petitioner's current condition of ill-being of his low back and the accidental injury of May 24, 2011.

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

Petitioner testified that he continued to work for Respondent from the date of the accident through November 22, 2011. On November 22, 2011, Petitioner attended a meeting with Emmett McEnery, Respondent's President and CEO, and Sonia Madalinski from Human Resources. At that meeting, Petitioner was told that light-duty work was no longer available. Respondent began to pay TTD benefits.

On February 6, 2012, Larry McGrail, Vice President of Operations for Respondent, authored a letter to Petitioner in which he invited Petitioner to interview for the position of Warehouse Manager that had just become available. (Rx.3)

Petitioner acknowledged receiving the letter from Mr. McGrail. Petitioner testified that he did not respond to the offer of an interview for the Warehouse Manager position because he did not feel he was qualified for the job.

On February 7, 2012, Respondent's Section 12 physician, Dr. Bergin, saw Petitioner for a follow-up evaluation. (Rx.2) After conducting a physical examination, Dr. Bergin reiterated his prior diagnosis that Petitioner had sustained an aggravation of the pre-existing degenerative conditions. Dr. Bergin presented the option of an epidural injection or a surgical procedure that would include a laminotomy and foraminotomy. The doctor noted that surgery would be "very elective." Petitioner "adamantly refused any further care." Dr. Bergin found that Petitioner "has clearly reached maximum medical improvement" and recommended a functional capacity evaluation and a return to work with those restrictions. Such restrictions would be permanent. (Rx.2)

Petitioner testified that he was willing to undergo the functional capacity evaluation, but that such test was never scheduled.

Respondent's third party administrator followed up with Petitioner's attorney with letters of March 1 and March 8, 2012. (Rx.5, Rx.6)

Petitioner returned to his treating physician, Dr. Ross, on February 28, 2012. Per Dr. Ross' report, Petitioner had not seen him since September 2011. Petitioner told Dr. Ross that his right leg symptoms had worsened. Dr. Ross prescribed a Medrol Dosepak. Petitioner agreed to

undergo a nerve block and transforaminal cortisone injection of the right L5 nerve root, and possibly the L4 nerve root. (Px.1) Dr. Ross referred him to the Du Page Pain Center. (Px.2)

Petitioner underwent two injections, which, per Petitioner's testimony, resulted in long-term pain relief for a couple of years.

Petitioner then returned to Dr. Ross on April 19, 2012. Dr. Ross recommended one more injection, but stated that if he did not experience any improvement, he recommended that Petitioner consider surgical decompression. Such injection was not authorized.

On April 24, 2012, Dr. Ross released Petitioner to return to work, effective April 25, 2012, with the following restrictions: "May lift up to 15 lbs. Alternate sit/stand as needed." (Px.1)

Accordingly, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from November 23, 2011 through April 24, 2012. Respondent is entitled to a credit in the amount of $13,360.71 for TTD benefits previously paid. (Ax.1, Section 9)

Petitioner claims that he is entitled to maintenance benefits from April 25, 2012 through June 8, 2015.

Section 8(a) of the Act, states, in pertinent part, the following:

"The employer shall also pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto. If as a result of the injury the employee is unable to be self sufficient the employer shall further pay for such maintenance or institutional care as shall be required *** The maintenance benefit shall not be less than the temporary total disability rate determined for the employee."

The Arbitrator notes that Section 8(a) requires the employer to pay only those maintenance costs and expenses that are incidental to rehabilitation. That means that an employer is obligated to pay maintenance benefits only "while a claimant is engaged in a prescribed vocational rehabilitation program." W.B. Olson, Inc. v. Illinois Workers' Compensation Commission, 981 N.E.2d 25, 366 Ill. Dec. 960 (1st Dist. 2012)

The Arbitrator notes that the Appellate Court has construed the statutory term "rehabilitation" broadly to include an injured employee's self-initiated and self-directed job search. Please see Roper Contracting v. Indus. Comm'n, 812 N.E.2d 65, 285 Ill. Dec. 476 (5th Dist. 2004) If a claimant is not engaged in some type of "rehabilitation" (i.e., physical rehabilitation, formal job training, or self-directed job search), the employer's obligation to provide maintenance is not triggered.

In the case at bar, Petitioner provided unrebutted testimony that he requested that Respondent provide vocational rehabilitation. Respondent did not provide vocational rehabilitation and did not draw up a vocational rehabilitation assessment or plan, pursuant to Section 7110.10 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

Respondent did invite Petitioner to interview for the position of Warehouse Manager that had just become available. The physical requirements of the Warehouse Manager position were within Petitioner's work restrictions.

Petitioner testified that he declined to respond to Euclid Beverage and the opportunity to interview for the Warehouse Manager position.

Petitioner testified that at no point did he look for work.

Petitioner applied for, and then began receiving, social security disability benefits, retroactive to May 2012. The Social Security Decision is dated September 22, 2012. (Px.8)

A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in earning power and there is evidence rehabilitation will increase his earning capacity. National Tea Co. v. Indus. Comm'n, 454 N.E.2d 672, 73 Ill. Dec. 575 (1983). If an injured employee has sufficient skills to obtain employment without further training or education, that is a factor that weighs against an award of vocational rehabilitation. (Ibid.) Another factor to consider is the "trainability" of an injured employee, given his age, education, prior training and occupation. (Ibid.)

In Schoon v. Indus. Comm'n, 630 N.E.2d 1341, 197 Ill. Dec. 217 (3d Dist. 1994), the Appellate Court held that as the claimant did not want to return to work, an effort to rehabilitate him was not logical and therefore, rehabilitation is neither mandatory nor appropriate if an injured worker shows no intention of returning to work. However, Schoon is distinguishable from the case at bar in that the respondent there had initiated a vocational rehabilitation program and claimant chose not to participate in such program.

In the case at bar, Lisa Helma, C.R.C., opined that Petitioner did not have previous experience in the capacity of warehouse management, and, based upon the results of the Labor Market Survey, would not be a qualified candidate for current Warehouse Manager positions at other entities. The qualifications listed for Warehouse Manager or Warehouse Supervisor at NFI Industries, Sterling Engineering, and SD Wheels exceed John Bohentin's qualifications. Moreover, the fact that from the pool of 40 candidates considered for the Warehouse Manager position Respondent ultimately hired a man with five years of experience as an assistant

warehouse manager demonstrates that Respondent would, in all likelihood, not have offered the position to Petitioner if he had interviewed for it.

Ms. Helma opined that following the accidental injury, Petitioner was unable to return to his job of Sales Supervisor for Respondent due to his work restrictions and that he experienced a reduction in his earning power.

The Arbitrator finds the opinions of Ms. Helma to be more persuasive than the opinions of Messrs. McEnery and McGrail. Respondent did not offer the opinions of a vocational rehabilitation expert.

The Arbitrator likens Respondent's invitation to interview for the Warehouse Manager position to an invitation to interview for a position in which the physical requirements exceed Petitioner's work restrictions.

The Arbitrator concludes that as Petitioner was not qualified for the position of Warehouse Manager at Respondent, and as he was unable to return to his old job for Respondent and thus experienced a reduction in his earning power, he was entitled to receive vocational rehabilitation services and, consequently, maintenance benefits after he reached maximum medical improvement.

Petitioner has a high school education and, other than an incomplete class at a community college, denied any advanced education, trade or vocational school, military service or union apprenticeship. He denied having any mechanical, carpentry, electrical or plumbing skills. Petitioner completed formal, on-the-job training in sales. He has worked as a Delivery Driver and Sales Supervisor for 30 years. Such positions required him to lift up to 50 pounds and to bend, stoop and reach all day long. He worked four months as a Delivery Manager. He

previously had a CDL A driver's license, but as of April 27, 2015, had only a standard Illinois driver's license. He denied having any other licenses, certifications or skills of any kind.

Based on the facts and the law, the Arbitrator finds that Petitioner is entitled to maintenance benefits from April 24, 2012 through June 8, 2015.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator concludes as follows:

Petitioner's resume' indicates that from "1999-July", Petitioner worked as a Delivery Manager for Courtesy Distributors. (Px.6) He wrote in such resume' that he has hands-on experience in the wholesale to retail delivery of merchandise and on-the-spot problem solving for both on and off premises accounts. He further wrote that he is an enthusiastic team player and manager of delivery staff of 40 with a proven track record of maintaining superb customer satisfaction. Petitioner then identified his key areas of strength:

- Ability to manage all aspects of union delivery staff derived from 18 years experience in industry
- Employee scheduling, training, supervision and evaluation
- Managed customer complaint resolution and mechanisms for long (sic) solution implementation
- Developed programs and processes to monitor and control inventory shrinkage
- Consult daily with Director of Operations (Px.6)

Petitioner's position of Delivery Manager for Courtesy Distributors, which he held for four months, ended when Courtesy Distributors was purchased by another entity.

Petitioner began working for Respondent on December 6, 1999. He was hired as a Merchandiser.

Within the subpoenaed personnel file is the following February 22, 2007 entry that addresses Petitioner's abilities:

"John, if desired, has the ability to move up to management. John does a great job and is very organized. He is looked up to in the group." (Px.6)

On May 24, 2011, Petitioner held the position of Sales Supervisor for Respondent.

The Arbitrator notes that Petitioner used Respondent's hand-held computer when he worked as Sales Supervisor. Mr. McGrail testified that any training Petitioner would need in the inventory software system that Warehouse Managers use would be available. The Arbitrator further notes that Petitioner had a great deal of experience in sales and merchandising.

Notwithstanding, the Arbitrator has found the opinions of Lisa Helma, C.R.C., to be more persuasive than the opinions of Messrs. McEnery and McGrail.

Respondent argues that even though Petitioner was able to work, he voluntarily took himself out of the work force by declining the offer of an interview for Respondent's Warehouse Manager position, by not looking for a single job in over three years, and by applying for and receiving SSDI benefits, effective May 1, 2012.

A claimant's voluntary decision to remove himself from the work force does not preclude a wage differential award. Copperweld Tubing Products Co. v. Illinois Workers' Compensation Commission, 402 Ill. App. 3d 630, 634, 931 N.E.2d 762, 341 Ill. Dec. 865 (1st Dist. 2010) Instead, a wage differential award is determined by comparing the claimant's prior earning capacity to the amount he "is earning or is able to earn in some suitable employment or business after the accident." 820 ILCS 305/8(d)(1) (West 2008); see Copperweld Tubing Products, 402

Ill. App. 3d at 634. Wood Dale Electric v. Illinois Workers' Compensation Commission, 986 N.E.2d 107, 369 Ill. Dec. 158 (1st Dist. 2013)

To receive a section 8 (d) (1) wage differential award, "an injured worker must prove (1) that he or she is partially incapacitated from pursuing his or her usual and customary line of employment and (2) that he or she has suffered an impairment in the wages he or she is able to earn". Cassens Transport Co. v. Indus. Comm'n, 218 Ill. 2d 530 (2006)

In regard to the differential rate per week, Respondent presented no vocational rehabilitation opinions or evidence. Petitioner had been compensated at the rate of $1,070.86 per week. (Ax.1) Petitioner retained a vocational rehabilitation expert, Lisa Helma, C.R.C., of Vocamotive. She submitted her opinions in the Initial Evaluation Report, the Labor Market Survey, and the Rehabilitation Plan. (Px.4) She opined that Petitioner would be expected to earn in a range of $9.00 to $12.00 per hour. Respondent presented no vocational rehabilitation evidence in opposition to the findings of Vocamotive as to the expected wage differential.

The Arbitrator selects the mid-point of this range, or $10.50 per hour, which equates to $420.00 for a 40-hour week. Thus, pursuant to Section 8(d)1 of the Act, the wage differential per week is ($1,070.86 – $420.00) x 2/3 = $433.91.

The Arbitrator finds that Petitioner is entitled to permanent partial disability benefits of $433.91/week, commencing on June 9, 2015 and continuing for the duration of the disability, because the injuries sustained caused an impairment of earnings, as provided in Section 8(d)1 of the Act.

Brian T. Cronin
Arbitrator

April 6, 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 Employer-employee relationship, Accident/causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kasim Topic,

Petitioner,

vs. NO: 12 WC 10235

KS Trucking and the Illinois Treasurer
as Ex officio Custodian of the
Injured Workers' Benefit Fund-(IWBF),

Respondent.

17IWCC0361

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employer-employee relationship, accident, causal connection, temporary total disability (TTD), medical expenses, and permanent partial disability (PPD), and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner was a 47 year old employee of Respondent, who described his job as a semi-truck driver. He has two adult children. Petitioner testified that he had worked for Respondent KS Trucking; he was first hired in 2005. He believed when he was working for Respondent they were located on Loomis and Pershing in Chicago, he had heard from other drivers that they are now located in Joliet. Petitioner testified that KS Trucking is owned by Kemal Hodjic. On the date of accident, January 11, 2012, Petitioner testified that he was working for Respondent as a driver. Petitioner stated that his job was to pick

up the paper assignment from Mr. Hodjic, turn on the truck in the morning, pick up his load and deliver it and then return back. Petitioner testified that every night he would get his paper assignment with the container number, ID, where the load was and where to drive it to. The assignment was in an envelope with the driver's name on it if Mr. Hodjic was not in the office when Petitioner came back from the prior assignment. The assignment was for the next day and there was a box in the front office where the envelope would be dropped for the next day assignments. Petitioner testified that the freight he hauled was behind sealed doors and there were no questions of what he was hauling. He testified that he made $40,000 to $45,000. When they were leaving the Respondent's yard they were given a paper with a rough description of the load, but he never really knew for sure what they were driving; there were no questions. Petitioner testified he was to pick up the load from the yard and drive it to different locations. Petitioner testified it happened many times that they would drive to the destination and open the doors and remove the seals and that would be the first time they actually knew what they were hauling; the containers were sealed. Petitioner again noted he would receive the assignments from Mr. Hodjic or from a box if Mr. Hodjic was not there. Petitioner testified that he could not choose between the assignments. He never tried to change assignments. Petitioner testified that Respondent supplied him with the truck, a jacket and T-shirt type uniform, a gas card and what he needed to spend on the road; all the materials he needed. Petitioner only drove for Respondent; no other tasks. Petitioner did file taxes for his earnings at Respondent. On the date of accident, January 11, 2012, Petitioner testified he picked up the container and drove to the destination he was required to go to. Petitioner testified that at the destination (American Tire, Mt. Vernon) there were small instructions regarding where to unload. Petitioner had called in and was given instructions of what to do next as he did not know what to do with the load or where to park it. Petitioner stated he was told to wait patiently, that a man would come and tell him exactly where to drive and where to park. Petitioner stated that people arrived and told him the exact place to park and Petitioner followed them. Petitioner testified that when he parked he realized that the parking dock was not even. Once he was parked he was given tools to cut off the seal. Petitioner stated that he cut off one seal and opened one door and there was pressure when he was opening the 2nd door. Petitioner stated that when he opened it the entire load slid onto him. He indicated once he came to he was on a fabric/manufacturing room, he did not know anything else. (NOTE--Venue had been changed from Mt. Vernon to Chicago due to need for a Bosnian interpreter). Petitioner testified that he recalled opening the doors and recalled blacking out. Petitioner testified that when he came to the first thing he saw was blood all over his body and his legs and arms were numb. Petitioner stated he woke in a room similar to an ambulance room in his country and there was a doctor that was probably working for a factory. Petitioner recalled seeing two other men when he came to and they tried to ask him if they could bring him someplace. Petitioner noted that he was far from home and that he was injured and had no one that spoke his language or anyone he knew. Petitioner testified the first thing he did when he came to was to call his boss and tell him he was injured and that he could not bring the truck back home. Petitioner stated that Mr. Hodjic said to be patient and wait and then try to drive; Petitioner stated he told him he would do his best to at least move the truck to the side.

- Petitioner first sought treatment at Concentra January 12, 2012. Respondent sent him there to get checked out and stated that Respondent would pay for everything. Petitioner indicated that he was told to go to the downtown Chicago Concentra; Petitioner had 2 follow ups at Concentra. Petitioner had been diagnosed with a nasal fracture, bilateral wrist contusions, facial contusions and a cervical strain. An EMG/NCV and a referral to a neurosurgeon were ultimately recommended as they did not know what was wrong. Petitioner then was first seen at Hinsdale Orthopedics on January 19, 2012 where cervical and lumbar MRI's were recommended. Petitioner underwent the lumbar MRI on February 2, 2012 and the cervical MRI on February 9, 2012 at Hinsdale Orthopedics. Petitioner followed up at Hinsdale Orthopedics on February 25, 2012 where the MRI results were discussed (Lumbar MRI showed protrusions at L5-S2 and L3-4 as well as a L4-5 disc bulge) and he was referred to a neurosurgeon. Petitioner was seen at West Suburban Neurological Associates on March 1, 2012 and a brain MRI was recommended and performed there as well as a surgical consult. Petitioner then saw Dr. Mardjetko at Illinois Bone & Joint. Petitioner was seen at Center for Brain & Spine Surgery by Dr. Bauer on April 26, 2012 who recommended another MRI and CT of the cervical spine. Petitioner had the MRI and CT July 10, 2012 at MRI Lincoln Imaging Center and then had follow up with Dr. Bauer July 11, 2012. Dr. Bauer recommended a discectomy fusion and corpectomy. Petitioner ultimately had the surgery on February 21, 2013. Prior to that surgery he had seen Dr. Mardjetko on February 13, 2013 at Illinois Bone & Joint. Drs. Bauer and Mardjetko performed surgery on Petitioner at Lutheran General Hospital. Petitioner had follow ups with the doctors. On July 1, 2013 Dr. Bauer recommended another cervical CT which was done at Lutheran General. The doctors ultimately recommended therapy which Petitioner underwent at ATI October 15, 2013 through November 8, 2013 (initial visit and then 12 sessions). Petitioner continued follow ups with the doctors and on February 25, 2014, Petitioner had another MRI at MRI Lincoln Imaging Center. Petitioner agreed August 12, 2014, he had another spine CT at Swedish Covenant. Dr. Bauer found his condition was stable September 3, 2014.

- Petitioner indicated at hearing he was uncomfortable and could not find a comfortable position. He noted from his knees down his legs were cold and his arms were numb. Petitioner stated he currently does have pain in his legs and shoulders and when he sits he feels stiff and has back pain; he takes pain medication every 4 hours. He stated his arms were numb and he could not feel his hands (arms, elbows down). Petitioner indicated he shakes his hands like he forgets they are his. He indicated if he does work with his hands for a long time they get numb and he feels nothing. Petitioner stated that he cannot do what he did before; he stated he was a ruined man. He has not run in 4 years. He stated he used to play soccer and sports, but no more, he cannot go to the park with his grandchildren. Petitioner does chores but he cannot work or do anything now. Petitioner stated that he lost his CDL. He stated he can no longer paint or bend or lift; he does not know what he can do anymore. He could not pass the medical exam for his CDL. He has difficulty holding urine; when driving he can get wet in seconds. He had difficulty being intimate with his wife. Petitioner testified that prior to January 11, 2012 he had never injured his cervical spine or lumbar spine or his face; he had no re-injuries since then.

The Commission notes that no one was present for Respondent, KS Trucking.

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The Commission further notes, that Respondent, IWBF, presented no testimony or exhibits into evidence to rebut Petitioner's testimony and evidence. Testimony of Petitioner was obtained via interpreter (Bosnian).

The Commission finds that Petitioner testified (unrebutted) of the relationship between Respondent and himself. Petitioner testified of Respondent supplying the truck, gas card, uniforms, and also testified of Respondent directing Petitioner's day to day deliveries. Respondent presented no evidence or testimony to the contrary. Petitioner's tax return did include indication of 'self-employment' with his earnings from Respondent, but clearly Respondent exerted the control and supplied everything including the truck, uniforms, gas card, etc., to evidence an employment relationship. The unrebutted evidence and unrebutted testimony finds that Petitioner met the burden of proving an employer-employee relationship. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, reverses the Arbitrator's decision to find and employer-employee relationship.

The Commission finds that Petitioner testified (unrebutted) of an accident opening the truck doors and the load falling onto him. There are some slight discrepancies as to exactly what fell onto Petitioner but the histories are generally consistent of that occurring and Petitioner being knocked to the ground and losing consciousness as he was struck in the face and sustained a fractured nose as well as multiple lacerations and bruises. Petitioner speaks Bosnian so the differences may be attributed to some errors in interpretation. Contrary to the Arbitrator's interpretation, Petitioner does describe a single traumatic event of the load falling onto him as he opened the trailer doors; that is not speculation. The exact contents and how it had been loaded and supported for transport to what fell on him is somewhat in question, but again a single traumatic event was described in testimony and similar histories found in the various records. Again, Petitioner was struck in the head and lost consciousness so it would be expected that some details might not be perfectly clear, and again there is the language barrier to add to the confusion and potential differences in interpretation. Petitioner's testimony is generally supported in the evidence even with the slightly different histories but still details Petitioner's testimony of a single traumatic event of the load falling onto him when he opened the doors. Respondent presented no rebuttal testimony and no exhibits contrary to Petitioner's testimony and evidence. The evidence and Petitioner's unrebutted testimony finds Petitioner met the burden of proving accident that arose out of and in the course of employment and further to find a causal relationship between Petitioner's accident/injuries and his current condition of ill-being. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, reverses the Arbitrator's decision to find accident that arose out of and in the course of employment, and further, herein, reverses the Arbitrator's decision to find a causal connection.

The Commission, with above findings of employer-employee relationship, accident, and causal connection finds evidence of authorization to be off work and Petitioner's testimony to support TTD benefits. Petitioner met the burden of proving entitlement to TTD benefits with the above findings. The Commission finds the decision of the Arbitrator as contrary to the weight of the

evidence, and, herein, reverses the Arbitrator's findings as noted above, and awards total temporary disability benefits for the period of January 12, 2012 through September 3, 2014 ((138 weeks at $156.00-(min. rate)-($21,528.00 total TTD)).

The Commission, with above findings of employer-employee relationship, accident, and causal connection finds evidence of Petitioner's injuries and resulting reasonable and necessary treatment and records and medical bills to support a medical expense award of $244,144.91. Petitioner met the burden of proving entitlement to the medical expense benefits with the above findings. The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, reverses the Arbitrator's decision as noted above, and awards $244,144.91 total medical expenses, subject to the medical fee schedule.

The Commission, with above findings of employer-employee relationship, accident, and causal connection finds evidence of Petitioner's injuries and resulting treatment and records indicating his significant condition of ill-being as a result of the injury to support a permanent partial disability award. There was no impairment rating presented. Petitioner was a 47 year old truck driver. Petitioner indicated an average weekly wage of $156.00. Petitioner has not worked since the accident, but there is no evidence to suggest permanent total disability even with his significant condition of ill-being. The medical records do, however, evidence Petitioner's ongoing significant condition of ill-being. The Commission finds that a 55% loss person as a whole as being well supported with the unrebutted testimony and evidence presented here, and considering the factors set out under §8.1b of the Act. Petitioner met the burden of proving entitlement to such a PPD award with the above findings. (275 weeks at $156.00 per week equals total PPD of $42,900.00). The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and herein, reverses the Arbitrator's decision as noted above, and awards the stated Permanent partial disability award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $156.00 per week for a period of 138 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $156.00 per week for a period of 275 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 55% loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $244,144.91 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.

17IWCC0361

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

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer 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.

The party commencing 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: JUN 15 2017
d-4/27/17
DLG/jsf
045

David S. Gore
David Gore

Stephen J. Mathis
Stephen Mathis

DISSENT

I respectfully dissent from the majority's decision. The Commission reversed the Decision of the Arbitrator and awarded compensation. The Arbitrator had denied compensation finding Petitioner did not prove accident citing inconsistencies in his histories of accident. The Arbitrator found all other issues moot, including employer-employee relationship. In my opinion, Petitioner's testimony and evidence with respect to the employer-employee relationship was insufficient to prove by a preponderance of the evidence that an employee-employer relationship existed.

Petitioner's testimony was vague and unconvincing. He testified that he believed that he had worked for the Respondent KS Trucking beginning in 2005. He thinks that when he worked for them, they were located on Loomis Street and Pershing. He testified that he "worked for him before, then I stopped working for him, switched, went to work for somebody else, returned back to work for him again, then stopped working altogether when I got injured." When the Petitioner was asked if he could provide the dates that he took his breaks from KS Trucking he responded that "I couldn't. I know I worked for him maybe a year, year-and-a-half, maybe two years, then I switched to a different company, then returned back to him, but he needs to have the records.

He needs to know it." Petitioner was not sure when he started working for KS before the January 12, 2012 accident, but testified that he worked for KS Trucking in 2011.

According to the Petitioner, he was a driver, and as a driver his duties included picking up a paper, an assignment with the container number, container ID, where the load was and where to drive it. The containers were sealed. According to the Petitioner the loads were behind "strongly sealed doors," they would be given a paper that "roughly describes the load, but we were never really sure what we were driving." When he drove the load to the destination he "would open the door, remove the seals and then for the first time see what we were actually driving." If he turned a load down he believed he would be without a job that day, although he never tried to turn a job down. The Petitioner testified that KS Trucking supplied the truck he was driving, "a gas card, all he needed to spend on the road, the jacket and T-shirt kind of uniform." There was no testimony regarding whether this was a corporate charge card for gas, or a prepaid gas card, and no indication what, if anything, was on the jacket and T-shirt in the way of a company name or logo, or even the Petitioner's name. Petitioner testified that he lived in Illinois, but admitted that he was not licensed to drive by the State of Illinois; he claimed his CDL was from the State of Michigan.

The Petitioner offered and the Arbitrator admitted Petitioner's Exhibit number 14, a copy of the 2011 Tax Returns of Petitioner Kasim Topic. Petitioner identified exhibit 14 as his tax returns for 2011. The tax returns do not have a copy of a W-2 form attached. On Form 1040, Petitioner lists his wages tips and salary for the year as $5,995.00 (line 7) and his Business Income (line 12) as $8,154.00. He lists the deductible part of the self-employment tax (line 28) as $576.00. The tax forms indicate that in 2011 the Petitioner was self-employed and that the business was called General Freight Truc [sic]. He listed as expenses: $7,607.00 for repairs and maintenance; $2,411.00 for supplies; cell phone $1,084.00; per diem $11,284.00; tolls $1,845.00; and $348.00 for working gear. On cross examination the Petitioner testified that at some point the Respondent KS Trucking withheld taxes from his checks and at another point they did not. Petitioner did not know when the time period or periods were that taxes were withheld or when they were not withheld. He testified that Respondent KS Trucking told him "it was too much complications and he just stopped." Petitioner did not know if he received any W2 forms from Respondent KS Trucking.

Petitioner testified that they did not have set weekly hours at KS Trucking, "working hours was always strongly dependent on the locations that we were supposed to drive the truck to." Petitioner testified that he was paid "according to the tour for the load, with Detroit, I received $300 for example. The amount of payment for the deliveries was determined by Kemal." (KS Trucking)

The Petitioner's testimony, together with evidence regarding his employment including the income taxes he filed in 2011 indicating that he was self-employed are not sufficient to establish an employee-employer relationship under the Act. The Petitioner's testimony was not credible. The testimony that he did not have paperwork clearly identifying what the loads he was transporting consisted of is not credible. He would have to be carrying manifests of some type describing what he was hauling and what he was delivering to establish that he brought the right products to the correct purchaser. He would be required to show that paperwork at scales along

describing what he was hauling and what he was delivering to establish that he brought the right products to the correct purchaser. He would be required to show that paperwork at scales along the way in the various cities and states that he was transporting the loads through, he would need to know what placards if any needed to be displayed on the truck and trailer in order to transport the materials. He would also need to document his delivery for purposes of payment for the materials that were shipped as well as for his own payment. Driving from state to state or even within the state outside of a fifty mile radius Petitioner is required to keep a log book, so he should have had control of the information as to when he worked for the Respondent KS Trucking in his control the number of hours, or the number of days he worked per week should be in those books.

Petitioner identified himself on his taxes as self-employed. He availed himself of deductions for "repairs and maintenance," "supplies," "other expenses," which included: "per diem," "tolls," and "working gear." On the Illinois Workers' Compensation Commission Request for Hearing the Petitioner claimed that in the year preceding the accident he earned $8,154.00 which is what he claimed on his income taxes from being self-employed in 2011. The Petitioner did not attach a copy of his W-2 form to the exhibit. Additionally, there was no evidence provided with respect to what he earned in the 10 days of 2012, before he was injured. We have only the Petitioner's testimony that he was working for KS Trucking the day he was injured.

In addition to my conclusion that Petitioner did not prove an employer-employee relationship, I agree with the Arbitrator's assessment that Petitioner's testimony was neither credible nor consistent and that he did not sustain his burden of proving accident. He testified at the hearing, under oath that when he opened door number 2 **the entire load slid onto him and when he came to he was in a room, "manufacture or fabric" (sic) and he did not know anything else.** A short time later, during the same hearing he testified that he opened the door and all he remembered was blacking out. When he came too, he saw blood all over his body, was in a room similar to an ambulance room in his country and there was a doctor that was probably working for a factory. However, two days after the injury, when Petitioner sought medical treatment at Occupational Health Centers of Illinois, (Petitioner's exhibit number 1) the Petitioner told the medical personnel that " I opened the door of the truck when boxes fell on me injuring my face, I fell back, and hit the back of my head, back , neck and both shoulders and arms." He also reported that two days ago, while he opened a truck door, boxes fell onto his face, and injured both of his hands in the process. He also noted moderate pain in the neck. Petitioner **denied loss of consciousness**, dizziness, headache, nausea, vomiting, paresthesia, bleeding **and has full recollection of the event**. The Petitioner gave varying descriptions of what fell on him, boxes to some doctors, the lid of a box to another doctor and pieces of wood to yet another, the differences between what fell and hit him are not that important, it could be a matter of communication. What does cause concern however are the differences from two days after it happened to the time of the hearing, either he did lose consciousness or he did not, either he was covered in blood or he didn't bleed, and either he has full recollection of the event or he does not, he cannot have it both ways.

The conclusion that the Petitioner failed to prove that an employee-employer relationship existed between the Petitioner and the Respondent KS Trucking is supported by the record and

17IWCC0361

accident and denied compensation

Based upon the above, I respectfully dissent from the decision of the majority.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TOPIC, KASIM
Employee/Petitioner

Case# **12WC010235**

KS TRUCKING AND IWBF
Employer/Respondent

17IWCC0361

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:

4128 RUBENS AND KRESS
ROBERT B PAWLOWSKI
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

0000 KS TRUCKING
3910 S LOOMIS
CHICAGO, IL 60609

5462 ASSISTANT ATTORNEY GENERAL
MAGGIE TIMLIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kasim Topic
Employee/Petitioner

v.

KS Trucking and IWBF
Employer/Respondent

Case # 12 WC 10235

Consolidated cases: _____

17IWCC0361

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gary Gale**, Arbitrator of the Commission, in the city of **Chicago**, on **7/8/16**. 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 1/11/12, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *unknown* 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, as he was seen at Concentra the day after the claimed accident.

Petitioner's current condition of ill-being ***is not*** causally related to the accident as there was no accident proven.

In the year preceding the injury, Petitioner earned $8,154; the average weekly wage was $156.81.

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

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

Respondent **moot** 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

ACCIDENT

The Arbitrator does not find that the Petitioner proved by a preponderance of the evidence that sustained an accident arising out of and in the course of his employment; **as he failed it occurred in a particular manner.**

The Petitioner testified at Arbitration that he opened the back door of the truck he was driving, that he was struck in his face and that he didn't remember anything until he woke up receiving medical attention.

However, **he also gave 5 varying histories in his medical records.** His initial history at Concentra on 1/12/12, the day after his claimed accident was that boxes fell on his face. His history to Dr. Lorenz on 1/19/12, a week later, was that plywood fell on top of him. On 3/1/12 he told Dr. Fronczak that the truck's load fell through the doors and onto his head, face, and shoulders. On April 26, 2012 he told Dr. Bauer that 6 large pieces of wood hit him and that he was struck in the face by a large piece of wood. The history at Lutheran General Hospital on February 21, 2013 the report of operation states that he was injured when he fell off a truck.

In Workers Compensation law where there is a single traumatic injury there is a requirement that the Petitioner prove that the accident happened at a particular time, at a particular place, and in a particular manner by a preponderance of the evidence. Petitioner failed to meet that burden. It is not sufficient that he relate an unending saga of incidents that could have been a work related injury.

A Workers Compensation accident cannot be a smorgasbord of choices with the Arbitrator speculating as to which one he should choose. Arbitration and Commission decisions by case law cannot be based on speculation.

In light of the finding that the Petitioner failed to prove accident, compensation is denied an 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

7/15/16
Date

JUL 18 2016

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

EMILY DILLON,

Petitioner,

vs.

NO: 12 WC 13100

COUNTY OF LAKE SHERIFF'S DEPT.,

Respondent.

17IWCC0395

DECISION AND OPINION ON REVIEW

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

The Arbitrator awarded Petitioner 13.75% loss of use of the man as a whole under Section 8(d)2 of the Act. The Commission hereby modifies the Arbitrator's Decision to find the Petitioner to be permanently partially disabled to the extent of 17.5% loss of use of the man as a whole.

In his Decision, the Arbitrator noted Petitioner was 28 years old on January 21, 2011, the accident date; Petitioner worked a sedentary position as a Sheriff's Department 911 dispatcher; and, her duties included occasional light duty lifting and filing. (T.13-14; T.16). A 2001 job description indicated that physical demands for the job involved sitting for long periods of time at a workstation and reaching with hands and arms. (PX6). At arbitration, Petitioner testified that she had returned to her same duties as a 911 dispatcher with Respondent, and she was working full-time. (T.27).

17IWCC0395

The Arbitrator further noted that evidence of disability was corroborated by the treating medical records. Petitioner was right-hand dominant, and she sustained a right shoulder injury that required injections and two arthroscopic surgeries. Specifically, Petitioner underwent a right shoulder arthroscopy, superior labrum anterior and posterior reconstruction, and pancapsular plication; Petitioner then had a second right shoulder arthroscopy with capsular resection, debridement of bursal scar, and manipulation under anesthesia. Petitioner's post-operative diagnosis was right shoulder arthrofibrosis, adhesive capsulitis, and status post labral repair. (PX5).

While the Arbitrator noted that Petitioner also underwent conservative treatment for sprains to her right wrist and elbow, the record only mentions that Petitioner may have suffered a right wrist strain for which she received minimal physical therapy at Accelerated Rehab. (PX2; PX3). There was no evidence of any diagnosis or treatment for Petitioner's alleged right elbow condition. Petitioner testified at arbitration that she had no pain in her right wrist or elbow. (T.27).

The last medical record in evidence was Petitioner's final physical therapy visit on November 2, 2015. On this date, Petitioner still complained of shoulder pain; the pain was at a one out of 10 level. Petitioner had continued weakness throughout her right shoulder and upper extremity; low activity endurance and decreased strength when performing resisted activities over five pounds was also noted. The therapist further found instability with clunking over right shoulder with any active elevation above shoulder level. (PX6).

As of November 9, 2015, Petitioner was at maximum medical improvement for her right shoulder condition and Dr. Chams released Petitioner with no restrictions. (PX5). The Arbitrator noted that Dr. Chams' examination revealed diffuse residual weakness, normal range of motion tests except for 80 degrees on the right internal rotation, and motor findings were minimally decreased on the right.

At arbitration, Petitioner testified that her shoulder was swollen and achy. Petitioner experienced the achiness "usually 80 percent of the day." (T.28). She said that rain and cold weather worsened her symptoms. (T.29). Petitioner also played softball once or twice a month prior to her injury. She no longer engaged in the sport after the accident. (T.29). Present physical difficulties included reaching in the back seat of her car to give her young daughter something, performing daily chores such as sweeping, doing her hair, doing her makeup, putting on her bra, and cooking; she also used sign language to communicate with her daughter who is deaf. Certain signs were difficult to complete. (T.10-11; T.30).

Based on the totality of the evidence, the Commission modifies the Arbitrator's Decision to find the Petitioner to be permanently partially disabled to the extent of 17.5% loss of use of the man as a whole.

17IWCC0395

The Commission further finds that Petitioner is not entitled to any additional award for the right wrist and elbow. The Commission finds Petitioner received minimal conservative treatment to her right wrist; there was no evidence of treatment to the right elbow; and, Petitioner testified to complete resolution of complaints to the right wrist and elbow at arbitration.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed November 29, 2016, is hereby modified as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $669.64 per week for a period of 87.5 weeks, as provided in Section 8(d)(2) of the Act, for the reason that the injuries sustained caused 17.5% loss of use of the man 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.

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: JUN 27 2017

MJB/pm
D: 5-22-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DILLON, EMILY
Employee/Petitioner

Case# **12WC013100**

COUNTY OF LAKE SHERIFF'S DEPT
Employer/Respondent

17IWCC0395

On 11/29/2016, 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 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4835 MARK M JEEP & ASSOC PC
GRAHAM J JEEP
200 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

0286 SMITH AMUNDSEN LLC
LESLIE T JOHNSON
150 N MICHIGAN AVE SUITE 3300
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

EMILY DILLON
Employee/Petitioner

v.

COUNTY OF LAKE, SHERIFF'S DEPT.
Employer/Respondent

Case # **12** WC **13100**

Consolidated cases: _____

17IWCC0395

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **10/27/2016**. By stipulation, the parties agree:

On the date of accident, **01/21/2011**, 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 **$62,722.40**, and the average weekly wage was **$1,206.20**.

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

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

Respondent shall be given a credit of **$23,446.30** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$23,446.30**. The parties stipulated at trial that all medical services and TTD benefits had been 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.

17IWCC0395

ORDER

Respondent shall pay Petitioner the sum of **$669.64**/week for a further period of **68.75** weeks, as provided in Sections 8(d)2, because the injuries sustained caused **13.75% loss of use of the body as a whole**.

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

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

Signature of Arbitrator

11/25/16
Date

ICArbDecN&E p.2

NOV 29 2016

Petitioner testified that on January 21, 2011, she was working for Respondent as a 911 dispatcher. At approximately 2:30 a.m., she was working in a standing position at her work station when her raised keyboard tray collapsed, dropped to about her waist level, and then locked into place. Petitioner stated she immediately experienced pain in her right shoulder, wrist, and elbow.

Petitioner testified she continued to work and after approximately two hours, she felt sharp shooting pain from her right shoulder through her right hand as she was filing paper overhead. She reported her pain to her supervisor and was told to go to the nearest hospital.

Records submitted show Petitioner was seen at Advocate Condell Medical Center Emergency Department on January 21, 2011 with complaints of moderate right shoulder pain. After an examination, Petitioner was diagnosed with right shoulder sprain. She was prescribed diazepam (Valium) and ibuprofen (Motrin) and instructed to follow up with her primary care physician, Nicholas Nikitas, MD, within three to five days. (PX 1)

On January 24, 2011, Petitioner followed up with Dr. Nikitas with right-sided neck pain and worsening right shoulder and wrist pain. Dr. Nikitas diagnosed strain to the right shoulder, wrist. Also diagnosed was acromioclavicular sprain/strain. The doctor ordered physical therapy and one week off work. (PX 2)

Petitioner commenced physical therapy at Accelerated Rehabilitation Centers on January 27, 2011. (PX 3)

Petitioner continued to follow up with Dr. Nikitas. On February 1, 2011, she reported persistent right shoulder and wrist pain. Her right elbow pain had improved. She was instructed to continue physical therapy and remain off work. By February 25, 2011, Dr. Nikitas noted that her symptoms and range of motion had not improved. Dr. Nikitas referred her to an orthopedic surgeon. (PX 2)

Petitioner initially saw Dr. Bradley Dunlap, an orthopedic surgeon, on March 7, 2011. He noted that Petitioner presented with persistent pain at her AC joint and worsening range of motion despite conservative treatment. X-rays were taken showing no significant degenerative changes, fractures, or dislocations. There was a type 1.5 acromion noted. After an examination, Dr. Dunlap's impression was persistent right shoulder pain despite conservative management. The doctor ordered an MRI of the right shoulder. (PX 4)

Petitioner underwent the prescribed MRI on Mach 16, 2011. The finding showed a type 2 acromion but was otherwise normal. On April 27, 2011, Dr. Dunlap recorded that Petitioner reported increased and consistent pain. Dr. Dunlap noted that she had plateaued with physical therapy and that from a "structural standpoint there was not much to do given her normal MRI findings." Dr. Dunlap recommended and administered a cortisone injection. He also recommended she complete physical therapy. (PX 4)

On June 8, 2011, Petitioner followed up with Dr. Dunlap. She reported occasional "clicking" and constant pain in her right shoulder, which was made worse with certain rotation type maneuvers. Dr. Dunlap ordered a MR arthrogram of the right shoulder. (PX 4)

Petitioner testified the MR arthrogram was delayed due to her daughter's worsening health conditions involving hearing loss. Petitioner provided that when she was finally able to resume treatment in the Spring of 2012, the MR arthrogram was initially denied by Respondent. Ultimately, Respondent approved further treatment.

On February 5, 2013, Petitioner saw Dr. Roger Chams, an orthopedic surgeon. Petitioner reported a consistent description of accident noting that she experienced right shoulder and wrist pain after a keyboard jam. Petitioner also reported that initially she had some radiculopathy which had alleviated with physical therapy. After an initial physical examination and evaluation, Dr. Chams' impression was right shoulder multidirectional

instability, rule out labral tear. The doctor recommended a right shoulder MR arthrogram and physical therapy. (PX 5)

The right shoulder MR arthrogram was completed on August 14, 2013. At her next visit with Dr. Chams, on August 26, 2013, the doctor noted the MR study demonstrated a labral tear. Dr. Chams injected the shoulder and recommended physical therapy. The doctor noted that if her symptoms did not improve with conservative care, surgical intervention would be appropriate. (PX 5)

Petitioner returned to Dr. Chams on October 8, 2013. Petitioner reported persistent right shoulder pain despite continued home exercises. Dr. Chams recommended surgical intervention which was carried out on February 10, 2014. Dr. Chams performed right shoulder surgery, consisting of an exam under anesthesia, right shoulder arthroscopy, SLAP reconstruction, and pancapsular plication. (PX 5)

Post-operatively, Petitioner continued with Dr. Chams. She underwent physical therapy at Athletico Physical Therapy commencing February 24, 2014. On June 24, 2014, Petitioner reported tightness and soreness in the right shoulder. Petitioner also conveyed frustration as she had not seen any improvement with her range of motion. Dr. Chams noted that because of tightness in the shoulder, the possibility of an arthroscopic procedure to clean up the scar tissue and do manipulation under anesthesia was appropriate. Physical therapy was continued. (PX 5)

On July 8, 2014, Dr. Chams noted Petitioner reported that although she had improvement, she still experienced tightness on her range of motion. Dr. Chams recommended a second right shoulder procedure which was completed on August 27, 2014. Dr. Chams performed right shoulder surgery, consisting of an exam under anesthesia, right shoulder arthroscopy with capsular resection, debridement of bursal scar, and manipulation under anesthesia. (PX 5)

Following surgery, Petitioner continued with physical therapy. In a progress note from Althletico, dated October 13, 2014, it was noted that Petitioner had increased range of motion in all planes of the right shoulder. She had decreased capsular tightness throughout the shoulder joint. She also had increased manual strength throughout the right rotator cuff. The therapist noted that although the range of motion and strength measurements had improved, both continued to be significantly limited in comparison to the left side. It was felt that occupational and physical therapy continued to be medically necessary. (PX 5)

Records submitted show Petitioner was diagnosed with leukemia in October 2014. Petitioner was therefore forced to suspend further treatment of her right shoulder, including physical therapy. On September 28, 2015, after months of chemotherapy, Petitioner returned to Dr. Chams to resume treatment of her right shoulder. Dr. Chams noted Petitioner had been treating herself conservatively. At that time, Petitioner reported some pain above the head and out to the side when she reached away from her body. Dr. Chams administered a cortisone injection and recommended she resume physical therapy. (PX 5)

Petitioner attended physical therapy at Athletico Physical Therapy from September 30, 2015 through November 2, 2015. (PX 6)

Petitioner's last visit with Dr. Chams occurred on November 9, 2015. At that time Petitioner reported improvement overall. She had some diffused residual weakness, which may have been related to ongoing chemotherapy treatment. An examination revealed negative findings for adduction, impingement I and II, O'Brien's, Dawbarn's, Apprehension/relocation, load/shift, Sulcus sign, belly press. Motor findings were minimally decreased on the right. Range of motion tests were normal but for 80 degrees on the right on internal rotation. Tests for tenderness to palpation were all negative. Dr. Chams cleared her for full duty work, recommended home exercise and released Petitioner at maximum medical improvement. (PX 5)

Petitioner testified that her Leukemia was currently in remission. She is working full duty in her same position. Petitioner testified that she has no pain or difficulty with her right wrist or elbow. However she experiences pain in her right shoulder every day, especially in cold and wet weather. She describes her pain as achy, sore and tight. This is made worse by daily activities like dressing and personal hygiene. Petitioner provided that she has difficulty when attempting to reach behind her body, such as the motion required to reach behind the front-passenger seat from the driver's seat in a car. She indicated the injuries have also interfered with her social life and hobbies i.e., before the accident, she would play outdoor volleyball recreationally 1-2 times a month when the weather allowed, but now she no longer plays at all. Lastly, Petitioner stated she primarily communicates with her deaf 9-year-old daughter through sign language. She indicated that certain sign maneuvers are now difficult and painful.

CONCLUSIONS OF LAW

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. 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 in a sedentary job as a Sheriff's Department 911 dispatcher with occasional light duty lifting and filing. She has returned to her pre-accident job position and is currently working full time. The Arbitrator gives this factor a moderate amount of weight.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 28 years old at the time of the accident. Because Petitioner is a young individual and her permanent partial disability will last considerably longer than an older individual, the Arbitrator gives additional weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no impairment to future earnings. The Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained injury to her right (dominant) shoulder that required 2 arthroscopic surgeries. Petitioner sustained right elbow and wrist sprains that were treated conservatively and ultimately resolved. Petitioner last saw her treating physician on November 9, 2015. Petitioner reported improvement overall. She had some diffused residual weakness. Range of motion tests were normal but for 80 degrees on the right on internal rotation. Motor findings were minimally decreased on the right. The remainder of the examination was normal. Petitioner testified that she has no pain or difficulty with her right wrist or elbow. She experiences pain in her right shoulder daily which she describes as achy, sore and tight. This is made worse by daily activities like dressing and personal hygiene. Petitioner provided that she has difficulty when attempting to reach behind her body, such as the motion required to reach behind the front-passenger seat from the driver's seat in a car. She indicated the injuries have also interfered with her social life and hobbies i.e., she no longer plays volleyballl. Lastly, Petitioner stated she primarily communicates with her deaf 9-year-old daughter through

sign language. She indicated that certain signs are now difficult and painful. The Arbitrator gives this factor greater weight.

Based on the above, the Arbitrator finds that Petitioner is permanently disabled to the extent 13.75% under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON A. BOER,

Petitioner,

17IWCC0416

vs.

NO: 12 WC 15067

CROSS COUNTRY CONSTRUCTION,

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, penalties and fees, the propriety of an *ex parte* hearing on February 3, 2016, and medical expenses both current and prospective, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The 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 Arbitrator found that Petitioner proved causal connection, that the *ex parte* hearing on February 3, 2016 was proper, and awarded medical expenses both current and prospective. The Commission has no issue with these aspects of the Decision of the Arbitrator and affirms and adopts those findings. The Arbitrator also assessed penalties against Respondent under both Section 19(k) and Section 19(l) as well as attorney fees under Section 16 of the Act. The Arbitrator did not specify the amount of penalties or fees in the award section of the decision. However, in the body of the decision, the Arbitrator specified 19(k) penalties of $25,08.46 (*sic*) (which apparently should be $25,008.46 based on the amount of outstanding medical bills the

17IWCC0416

Arbitrator awarded), 19(l) penalties of $8,970.00, and Section 16 attorney fees of "20% of all amounts awarded herein."

The Commission believes that the actions of Respondent warranted the imposition of penalties under Sections 19(l) and 19(k), as well as attorney fees under Section 16. The record indicates that at the time of arbitration there was an outstanding balance of over $50,000.00 in prescription medicine bills, and Respondent had lengthily delayed authorization of the implantation of the spinal cord stimulator. The stimulator was originally recommended by Petitioner's treating doctor as early as May 24, 2013, and Respondent's Section 12 examining doctor, Dr. Ghanayem, concurred with the recommendation on April 3, 2015. Nevertheless, Respondent did not approve the stimulator until more than a year after Dr. Ghanayem's report.

Nevertheless, the Commission has exception with the manner in which the Arbitrator assessed Section 16 attorney fees. As noted above, the Arbitrator's award section imposes unspecified penalties under Sections 19(k) and 19(l) and does not specify the amount of attorney fees under Section 16. However, in the body of the decision, the Arbitrator awarded Section 16 attorney fees of "20% of all amounts awarded herein." The Commission finds that calculation incorrect. The Commission finds that the imposition of attorney fees is only applicable to the penalties imposed under Section 19(k) and not penalties imposed under Section 19(l). In addition, because of the vague nature of the Arbitrator's language assessing Section 16 attorney fees, it could be interpreted to include the amount of the medical award as well as even the expenses associated with the prospective medical treatment the Arbitrator ordered. Therefore, the Commission modifies the award of the Arbitrator to award Section 16 attorney fees at 20% of the Section 19(k) penalties imposed for a total of $5,001.69.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay all outstanding pharmaceutical bills submitted by Petitioner and reimburse Petitioner for any out-of-pocket payments he made.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective treatment including implantation of a spinal cord stimulator recommended by Dr. Buck, treatment prior to such implantation as recommended by Dr. Sather, and all reasonable and necessary medical expenses otherwise associated with such prospective treatment.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $25,008.46 as penalties pursuant to §19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner $8,790.00 in penalties pursuant to §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $5,001.62 in attorney fees pursuant to §16 of the Act.

17IWCC0416

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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 $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: JUN 28 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-6/8/17
46

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

17IWCC0416

BOER, JASON A
Employee/Petitioner

Case# **12WC015067**

CROSS COUNTY CONSTRUCTION
Employer/Respondent

On 6/14/2016, 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 0.40% 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:

0333 SHAY & ASSOC LAW FIRM LLC
SARAH R NOLL
260 E WOOD ST
DECATUR, IL 62523

4866 KNELL & O'CONNOR
THOMAS BOYD
901 W JACKSON BLVD SUITE 301
CHICAGO, IL 60607

17IWCC0416

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)

Jason A. Boer
Employee/Petitioner

v.

Cross Country Construction
Employer/Respondent

Case # **12** WC **15067**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Quincy, IL**, on **February 3, 2016 and in Springfield, IL on March 30, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **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 as it relates to Petitioner's lumbar spine is causally related to the accident.

In the 52 weeks preceding the injury, Petitioner earned **$67,600.00.** The average weekly wage was **$1,300.00.**

On the date of accident, Petitioner was **35** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit for pharmacy payments made pursuant to Petitioner's Exhibit 29.

ORDER

The Petitioner is hereby awarded penalties and pursuant to Sections 19(k), and 19(l) of the Act. Petitioner is also awarded attorneys fees pursuant to Section 16 of the Act.

The Petitioner is entitled to prospective medical care, including: (1) Coverage of pre-surgical medical appointments, scheduled for purposes of obtaining medical clearance of placement of the spinal cord stimulator, including all appointments with Dr. Troy Buck, and to Dr. Buck's associated referrals; (2) Placement of the spinal cord stimulator after proper pre-surgical clearance; and, (3) Coverage of aquatic therapy as referred by Dr. Sather. Petitioner is entitled to coverage of his antidepressant medication and pain management medication as prescribed by Dr. Carl Sather, until such time that Petitioner receives the spinal cord stimulator. The Arbitrator reserves further ruling on the necessity of Petitioner's pain management and anti-depressant medications, after placement of the spinal cord stimulator occurs.

The Respondent is ordered to pay Petitioner's pharmacy bills contained within Petitioner's Exhibit 29, at the usual and customary rate of reimbursement. The Respondent is hereby given credit for payments previously made pursuant to Petitioner's Exhibit 29.

The Arbitrator finds that notice of Arbitration was proper.

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

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

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.

Edward Lee
Signature of Arbitrator

6/4/16
Date

ICArbDec19(b)

JUN 14 2016

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JASON BOER,)
Petitioner,)
)
-vs-) Case No.: 12-WC-15067
)
)
CROSS COUNTRY CONSTRUCTION,)
Respondent.)

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

I. Introduction.

On February 3, 2016, and March 30, 2016, bifurcated arbitration proceedings were held on the above-captioned cause of action in the cities of Quincy, and Springfield, respectively. Arbitration was held pursuant to Sections 16 and 19 of the Workers Compensation Act.

Petitioner, JASON BOER, seeks the following remedies: (1) An Order directing coverage of referred medical treatment, including aquatic therapy and placement of a spinal cord stimulator; and, (2) An Order directing payment of his outstanding medical bills, with particular emphasis placed upon the pharmacy bills as issued by the Injured Workers Pharmacy ("IWP").

II. Pre-Arbitration Findings of Fact.

A Petition for an Immediate Hearing and Notice of Motion and Order were mailed to counsel for the Respondent on December 23, 2015, providing notice that Petitioner was seeking a hearing under Sections 16 and 19 of the Illinois Workers Compensation Act. (Px. 31). The executed return receipt indicates that the pleadings were delivered on December 28, 2016. (Px. 31).

The motions were set for hearing on January 26, 2016. (Px. 31). On January 26, 2016, counsel for the Respondent, Thomas Boyd, failed to appear. Counsel for the Petitioner, Sarah Noll, telephoned Boyd. A telephonic conference ensued between Boyd, Noll, and the Honorable Arbitrator Edward Lee.

During the telephone conference. Noll made an oral motion that arbitration proceed. Noll advised that IWP had refused to provide Petitioner's prescription medication, because the Respondent had not paid for it. Further, that abrupt cessation of the prescription medication was dangerous. (Px. 31). Noll also stated that Petitioner was in need of a spinal cord stimulator.

Arbitrator Lee signed an Order setting the matter for arbitration on February 3, 2016. Arbitrator Lee informed Boyd of his ruling, and ordered that Boyd or another attorney from his firm to appear on February 3, 2016, at 11:00 am. (Px. 31).

The Parties agreed that if the Respondent filled the Petitioner, JASON BOER's, prescriptions, for one month's time, prior to arbitration, the matter would be continued until April of 2016. Arbitrator Lee also agreed. (Px. 31).

Later that day, attorney Boyd requested a copy of Arbitrator Lee's written Order, obliging him to appear for hearing on February 3, 2016. (Px. 31). Noll complied, and on January 29, 2016, e-mailed Boyd a copy of the signed Notice of Motion and Order. (Px. 31). A copy of the correspondence was provided at arbitration. (Px. 31).

III. February 3, 2016, and March 30, 2016 Arbitration Findings of Fact.

1. Appearance of the Parties.

On February 3, 2016, counsel for the Respondent failed to appear. Noll moved to proceed with arbitration, on the grounds that the Petitioner, JASON BOER's, prescriptions had not been filled. (Tr. vol. 1, pp. 5-11). Arbitrator Lee ordered that arbitration proceed, but stated that proceedings could be re-opened on the Respondent's motion. (Tr. vol. 1, p. 12.). Noll agreed. (Tr. vol. 1, p. 12).

On March 30, 2016, arbitration was re-opened at the motion of the Respondent, CROSS COUNTRY CONSTRUCTION. ("CROSS COUNTRY") Counsel for the Respondent, Thomas Boyd, filed a Motion to Strike Proceedings, arguing that a motion to proceed ex parte should have been filed prior to arbitration, and notice provided, pursuant to Rule 7030.20(c). (Tr., vol. 2, p. 8). Counsel for the Petitioner, Sarah Noll, filed a Petitioner's Response to the Motion to Strike Proceedings, attaching a copy of the notice of hearing provided to attorney Boyd, with an attorney's affidavit. (Tr. vol. 2, pp. 9-10; Px. 30).

Arbitrator Lee took the matter under advisement.

2. Testimony of Petitioner's Witnesses.

(1) Jason Boer, Petitioner.

At arbitration on February 3, 2016, Petitioner, JASON BOER, testified that he began working for the Respondent, CROSS COUNTRY, during March of 2011. On January 30, 2012, Petitioner was working on behalf of the Respondent when he sustained a spinal injury while using a sledgehammer to place poles in a center tower. (Tr., vol. 1, pp. 18-19).

As as a result of the work injury. Petitioner underwent extensive conservative treatment, including physical therapy, chiropractic care, and steroid injections. (Tr. vol. 1, pp. 18-23). The conservative therapy was unsuccessful, and as a result, on March 29, 2013. Petitioner underwent a laminotomy at the L5-S1 level, bilaterally, accompanied by a foraminotomy and a diskectomy. (Tr. vol. 1, p. 26).

Petitioner testified that the surgical intervention was unsuccessful, and that he had developed scar tissue that prevented him from undergoing additional surgery. (Tr. vol. 1, p. 26). As a result, Petitioner underwent an independent medical examination on February 27, 2014, and was evaluated by Dr. Alexander Ghanayem. (Tr. vol. 1, p. 27). Dr. Ghanayem dictated a report indicating that Petitioner may be a candidate for a spinal cord stimulator. (Tr. vol. 1, p. 27). Dr. Ghanayem eventually referred Petitioner to Dr. Troy Buck for placement of the stimulator. (Tr. vol. 1, p. 27).

Petitioner testified that his primary care physician. Dr. Carl Sather, also recommended the placement of a spinal cord stimulator. (Tr. vol. 1, p. 28).

Petitioner testified that it took over one year to receive approval of the placement of the stimulator. (Tr. vol. 1, p. 28). Further, that he had only attended four doctor's appointments with Dr. Buck for purposes of actually placing the spinal cord stimulator because the Respondent's doctors did not approve coverage of his additional appointments. (Tr. vol. 1, p. 29).

Petitioner continued to request placement of the spinal cord stimulator. (Tr. vol. 1, p. 29). Petitioner also requested approval of aquatic / water therapy. (Tr. vol. 1, 0. 37).

Petitioner testified that he had been obtaining his prescription medication through the IWP Illinois licensed pharmacy. Petitioner stated that that on November 24, 2015, he received a letter advising that IWP would no longer supply medications to Petitioner, because the Respondent was not paying for them. (Tr. vol. 1, p. 35) Petitioner explained that his original prescriptions had been provided by the workers compensation insurance provider, on behalf of the Respondent, but that the Respondent would not approve coverage of his antidepressant medication. (Tr.. vol. 1, p. 30). Therefore, Petitioner began obtaining his prescription medication from IWP. However, the Respondent had eventually stopped payment for all of his prescription medications. (Tr., vol. 1, p. 30).

Petitioner testified that he did not suffer from psychiatric injury, including depression, prior to his work injury. (Tr. vol. 1, p. 31). He explained that daily activities such as taking a shower, playing with his daughter, and walking were difficult, and that he had become very "pushed away from everybody" as a result of his inability to provide for his family. (Tr. vol. 1, p. 31).

Petitioner testified that he was paid $924.50 in temporary total disability benefits, per week. (Tr.. vol. 1, p. 35). Further, that the income did not cover his medical costs. (Tr. vol. 1, p. 35). Petitioner testified that he was currently paying for his prescription medications out of

pocket, for fear of becoming ill from withdrawal. (Tr. vol. 1. p. 34). He had begun to sell personal possessions in order to obtain his medication. (Tr. vol. 1. p. 34).

Petitioner testified that he had most recently attempted to fill his prescriptions on the morning of arbitration. February 3, 2016. but that the pharmacies had not received a prescription for him to fill. (Tr., vol. 1. pp. 37-40).

On March 30. 2016, Petitioner was re-called to the stand. Petitioner testified that he was able to obtain his prescription medications at approximately 6:00 p.m. on the night of February 3, 2016. (Tr. vol. 2, p. 16). Petitioner testified that when he attempted to refill his prescriptions the following month. in March of 2016. the Respondent, again, would not pay for the medication. Petitioner personally purchased the medication out-of-pocket. (Tr. vol. 2, p20).

Petitioner again testified that he had previously obtained the prescriptions from IWP:

Q. That's a licensed pharmacy. correct?

A. Yes.

(Tr., vol. 2, p. 22).

Petitioner explained that IWP would mail his prescriptions. so that he could avoid travelling several hundred miles to the Respondent's preferred pharmacy, CVS. (Tr. vol. 2, pp. 22-24).

On cross-examination. attorney Boyd questioned whether filling the prescription was just a matter of logistics. (Tr. vol. 2. p. 27). Petitioner replied that the prescriptions didn't help. because the Respondent didn't pay for the medication:

Q. So, if we can get a pain management doctor in Steger or close by your residence it would be a lot easier, right? You could get the prescriptions from your doctor 5 minutes away and go to a CVS, hypothetically?

A. Hypothetically, yeah, but we still would be where – even if I go they are not being paid for.

(Tr., vol. 2, p. 28)

A trial spinal cord stimulator had been surgically placed and removed on February 25, 2016. Petitioner testified that the trial stimulator temporarily had provided significant relief. (Tr. vol. 2, p. 16). Petitioner continued to request placement of the permanent spinal cord stimulator. (Tr. vol. 2, p. 17). He could not state whether the permanent stimulator installation had been approved. (Tr. vol. 2. p. 37).

(2) Dr. Carl Sather, MD

Dr. Carl Sather's evidence deposition was submitted by the Petitioner as an expert treating internist and primary care physician of the Petitioner. (x. 23). Dr. Sather testified that Petitioner's conservative medical treatment. to date. had been reasonable and necessary. (Px. 23. p. 13) Dr. Sather testified that he had reviewed the initial MRI films and radiological report taken on April 4. 2012, and that it revealed severe foraminal narrowing in the lumbar fifth vertebrae. (Px. 23, p. 15)

As a result of the MRI. Dr. Sather referred Petitioner to the Carle Spine Center for further evaluation and resultant spinal steroid injections. (Px. 23, pp. 17-19). Dr. Sather's prescribed Benadryl as a sleep medication. explaining that when a person sleeps. the body relaxes. thereby worsening pain associated with lumbar complaints such as what Petitioner had experienced. (Px. 23, p. 22). Dr. Sather also initially prescribed Relafen as an anti-inflammatory. and Hydrocodone and Diazepam. (Px. 23. p. 20)

Dr. Sather testified that Petitioner's initial spinal steroid injections only provided a few weeks' relief. (Px. 23. p. 24). During August of 2012, Petitioner continued to use Hydrocodone. Relafen, and Diazepam, together with the dietary supplement Glucosamine. (Px. 23. p. 25) Petitioner was not making improvement in his pain. and Dr. Sather substituted Norflex for Diazepam, as it was a longer-acting muscle relaxant. (Px. 23, p. 26).

Dr. Sather testified that Petitioner had undergone extensive medication adjustments over time, noting that some medicines will lose their effect over time. (Px. 23. p. 25). Specifically, muscle relaxants and opioids clinically will lose their effect over time, leaving people many times to have to escalate their dosage. (Px. 23, p. 26). Dr. Sather explained that the Hydrocodone originally prescribed to Petitioner was beginning to lose its effect. and therefore Morphine was prescribed to act as a long-acting agent. (Px. 23. p. 26). The Relafin was stopped during August of 2012. in order to determine whether the medication was assisting with Petitioner's symptoms. (Px. 23. p. 27).

Dr. Sather testified that after injections were unsuccessful in alleviating Petitioner's symptoms. Dr. James Harms. spinal surgeon, recommended surgical intervention during September of 2012. (Px. 23, p. 28).

Dr. Sather testified that Petitioner presented for examination during October of 2012. he already demonstrated adjustment disorder, if not actual depression and anxiety, as a result of the ongoing chronic pain, the loss of his job. and difficulty with his abilities to assist with finances and his family. (Px. 23. pp. 28-29).

Dr. Sather testified that Petitioner's injury had cost him a loss of function that directly contributed to a difficult transition of dealing with his chronic illness, and had resulted in depression and anxiety. (Px. 23, p. 30). The physician explained that depression and anxiety are extremely common for people in situations of chronic pain and uncertain illness. (Px. 23, p. 30).

Therefore, Dr. Sather began prescribing Celexa to act as an antidepressant and anti-anxiety medication. (Px. 23, p. 30). He explained that the medication has been clinically found to assist persons dealing with chronic illness by treatment of the mental illness associated with it. (Px. 23, p. 30). Dr. Sather also prescribed Serotonin and Trazadone to assist Petitioner with sleeping. (Px. 23, p. 31).

Dr. Sather personally wrote a letter to the insurance provider, Applied Underwriters, on October 29, 2012, advising that Petitioner was suffering from clinical anxiety and depression related to his chronic state of pain. (Px. 23, p. 34).

(3) Lynn Peters, Pharmacist.

During arbitration on February 3, 2016, pharmacist Lynn Peters, a certified pharmacy technician at CVS Pharmacy, spoke to Attorney Noll and to Honorable Arbitrator Lee. (Tr. vol. 1, p. 42). Peters advised that she did not have a copy of Petitioner's prescriptions, and the medication was not ready for Petitioner to pick up. (Tr. vol. 1, p. 4-45) Peters stated that the prescriptions were located at Dr. Sather's office specifically at the Carle Clinic in Mahomet. (Tr. vol. 1, p. 44).

(4) Testimony of Respondent's Witnesses.

The Respondent did not call any witnesses to testify.

3. Medical Evidence Submitted.

Petitioner initially sought conservative chiropractic treatment. (Tr. vol. 1, p. 20). Continued at Mahomet Chiropractic until April 20, 2012. (Id; Px. 5). However, the pain continued.

On March 30, 2012, Petitioner sought additional medical advice from his primary care physician, Dr. Carl Sather, MD, at the the Carle Clinic in Mahomet, Illinois. (Tr., vol. 1, pp. 22; Px. 23). Dr. Sather performed a physical evaluation, and noted severe electrical pain down Petitioner's left leg to ankle. Dr. Sather referred Petitioner for an MRI, and physical therapy. (Px. 8) Petitioner was also prescribed Salsalte, Norco, and Diazepam for symptom management. (Px. 8).

On April 4, 2012, an MRI was taken of Petitioner's lumbar spine. (Px. 7). It revealed that Petitioner suffered from a congenitally small spinal canal, with severe foraminal narrowing on the left at the L5-S1, and moderate foraminal narrowing on the right at the L5-S1 level. (Px. 7).

As a result of the radiological findings, Dr. Sather referred Petitioner to the Carle Spine Institute for further evaluation. (Px. 8). An initial examination was conducted on April 16, 2012, by Nurse Practitioner Glennett Barrett. (Px. 8). Barrett reviewed the MRI and also noted spinal stenosis and a lateral disc bulge at the L5-S1 level. Barrett recommended continued pain

medication, potential physical therapy, and an L5 nerve root block on the left lumbar side. (Px. 8).

On April 26, 2012, Petitioner returned to Dr. Sather, who discontinued the use of Salsalte, and prescribed Relafen in its place. Dr. Sather continued to prescribe Norco and Diazepam for symptom relief. (Px. 8).

On June 29, 2016, Petitioner returned to the Spine Institute, and was evaluated by Dr. James Harms, neurosurgeon. (Px. 8). Dr. Harms reviewed the MRI and diagnosed a herniated disc into the foramen at the L5-S1 level, consistent with the patient's symptoms. The neurosurgeon recommended epidural steroid injections as both a diagnostic and therapeutic measure, stating that if the injection helped dramatically for over four weeks, it would "mean that surgery would have a high probability of helping out." Alternatively, the Petitioner's "next best" option was physical therapy, or nerve conduction studies. (Px. 8).

On July 17, 2012, Dr. Ahmad Zeeshan, MD, performed a left L5 transforaminal selective nerve injection, administering a mixture of Triamcinolone and Marcaine. (Px. 10).

On August 2, 2012, Petitioner advised Dr. Sather's office that the initial injections were helpful for three weeks' time. (Px. 8). On August 08, 2012, Petitioner returned to the Spine Clinic, and advised that he was a "lot better," after the injection, but that the pain was slowly returning. (Px. 8). Dr. Harms recommended physical therapy.

Petitioner attended physical therapy at Carle Physical Therapy Services until September of 2012, at which time he was referred back for further physician evaluation. (Px. 9). The back pain continued. During the interim, and on August 16, 2012, Dr. Sather substituted Norflex for Diazepam, and prescribed long acting Morphine for pain control. Petitioner was advised that he could utilize Norco for breakthrough pain. (Px. 8).

On August 10, 2012, an Independent Medical Examination was conducted by Dr. Mark T. Nolden, MD, at Northshore Orthopaedics. (Px. 11) Dr. Nolden opined that the steroid injections were reasonably necessary, and that surgical intervention would be a possibility if Mr. Boer experienced radiculopathic pain. (Px. 11).

On September 5, 2012, Petitioner returned to the Spine Institute. (Px. 8). The epidural's effects had decreased. Dr. Harms again reviewed the MRI, and again assessed foraminal stenosis from disc bulging and spurring, noting that Petitioner had a smaller spinal canal than average to start with. (Px. 8). Dr. Harms stated that "surgery is a reasonable option," and that another steroid injection could be administered as well. (Px. 8).

The back pain continued. On October 17, 2012, Petitioner returned to Dr. Sather, who assessed "depression and anxiety after prolonged adjustment disorder with mixed response from chronic pain." (Px. 8). Dr. Sather prescribed Celexa to treat Petitioner's depression and anxiety, and Trazodone to aid in sleep. (Px. 8).

The anti-depressant medication was not approved, and on October 29, 2012, Dr. Sather wrote a letter to the Respondent's insurance provider, Applied Underwriters, stating:

> It has come to my attention that the request for treatment of insomnia and disordered mood (clinical anxiety and depression) is being questioned as it relates to the patient's pain and current state of disability relative to the past accident at work. I have noted a clinical change in the patient over the last 6 months since the initial visit I had with him. He has been attempting to cope with the poor sleep from back pain but after no success for months now, he has requested a non-addicting sleep aid that is a standard treatment. We have already been escalating his pain medication to treat what the injections have not been able to accomplish. His abilities to perform work (i.e. physical function) have been severely limited both at work and at home. He has met clinical criteria for depression and anxiety after having had adjustment disorder with mixed features that was prolonged after the accident. The standard treatment for this is an SSRI agent. The issues did not exist prior to the injury. He would not have these symptoms if he was able and busy working and he would not need these medicines if he was able and busy performing his skilled labor. These are not unreasonable requests and I ask that you please reconsider the causal relationship and coverage of these medications as part of his treatment.... (Px. 8).

On October 18, 2012, Dr. Zeeshan administered an additional left L5-S1 transforaminal epidural injection. (Px. 12).

On November 19, 2012, Petitioner returned to Dr. Sather. His depression medications had not been covered by the Respondent. (Px. 8). Dr. Sather assessed back pain with radiculopathy that extended into the right leg, and stated that he would work with Petitioner's lawyer in an attempt to obtain medicine coverage. (Px. 8).

Also on November 19, 2012, Petitioner returned for follow-up examination with Dr. Harms. He had suffered multiple falls, and his legs were beginning to "give out." (Px. 8). Dr. Harms opined that the foraminal stenosis was causing the problems, and possibly impingement of the spinal cord. Dr. Harms again stated that surgery was reasonable, and recommended that Petitioner meet with occupational therapy in order to address the problems with his employer. (Px. 8).

On January 4, 2013, Petitioner returned to Dr. Sather. The surgery was not yet approved, and his pain continued to increase. (Px. 8). The antidepressants had assisted Petitioner's depressive symptoms, and he reported feeling more stable. (Px. 8). Dr. Sather assessed that Petitioner's sensitivity to opioids was decreasing, and prescribed Prednisone and increased Morphine. Dr. Sather also requested an additional MRI, to rule out significant change. (Px. 8).

On January 10, 2013, an additional MRI was taken of Petitioner's lumbar spine. (Px. 13). The MRI continued to reveal a left foraminal L5-S1 herniation, accompanied by arthropathy, which impinged upon the left L5 ganglion. (Px. 13).

On January 25, 2013, Petitioner returned to the Spine Clinic, and Glennett Barrett, NP, opined that the results of the January 10, 2013, MRI were very similar to those of the April 4, 2012 MRI. (Px. 8). Surgery was again stated as the reasonable treatment option "at any time," that "work comp will approve that." (Px. 8).

On March 29, 2013, Petitioner underwent a laminotomy at the L5-S1 level, bilaterally, accompanied by foraminotomies and diskectomies. (Px. 15).

Unfortunately, the post-surgical result was not optimal. (Px. 8). Petitioner continued to suffer from extreme pain. On April 10, 2013, Dr. Harms stated that Petitioner's symptoms were indicative of sensitive nerves, and advised that symptom management may be a "lifelong" issue. (Px. 8). Dr. Harms requested that Dr. Sather take over management of all pain management, stating that "the prognosis for improvement with surgery is not that good." (Px. 8).

By April 22, 2013, Petitioner began complaining of bilateral leg numbness, and increased pain, to Dr. Harms. (Px. 8). Dr. Harms ordered an additional MRI.

On May 20, 2013, an MRI was taken of Petitioner's lumbar spine. (Px. 16). It revealed postsurgical changes from the bilateral laminotomy, with moderate epidural fibrosis surrounding the left S1 nerve root. (Px. 16).

On May 20, 2013, Dr. Harms reviewed the MRI and opined that additional surgery was not a suitable treatment, stating that nerve medication and exercise may assist with Petitioner's symptoms. (Px. 8). Dr. Sather increased Petitioner's Celexa and Ativan, noting that Petitioner was "tearful and angry significantly with loss of ability to contribute to family needs, income, relationships, childcare." (Px. 8).

Dr. Sather referred Petitioner to Dr. Hyuncul Jung, MD, an anesthesiologist specializing in pain management. (Px. 3). On May 24, 2013, Petitioner presented to the Department of Interventional Pain Center for examination. Dr. Jung performed a physical examination and reviewed Petitioner's MRI. The anesthesiologist assessed post-surgical findings at the L5-S1 level, accompanied by epidural fibrosis around the S1 nerve root. Dr. Jung stated that Petitioner's pain was caused by the epidural fibrosis around the left side of his S1 nerve root, and recommended caudal epidural steroid injections, followed by a spinal cord stimulator. (Px. 3).

On June 17, 2013, Petitioner returned to Dr. Sather, who increased Petitioner's Celexa. Petitioner was prescribed Calcium/Vitamin D, Celexa, Gabapentin, Hydrocodone, Lorazepam, Morphine, and Trazadone. Petitioner's Robaxin and Norflex were discontinued, and Baclofen, a muscle relaxant, was prescribed. (Px. 8).

On July 09, 2013, Dr. Jung administered an additional caudal epidural steroid injection, in an attempt to alleviate the symptoms associated with Petitioner's epidural fibrosis. (Px. 8).

On September 11, 2013, Petitioner returned to Dr. Sather. The steroid injection on July 20, 2013, had not alleviated Petitioner's symptoms. (Px. 8). The second injection had been refused by workers compensation. (Px. 8). Petitioner had begun spilling urine overnight, as he slept, and his entire left leg was numb. (Px. 8). He had fallen on numerous occasions. (Px. 8). Petitioner requested a referral for a second opinion on ways to help with the progressive neurologic issues. (Px. 8).

On February 27, 2014, Dr. Alexander Ghanayem, MD, performed an independent medical examination, conducting a physical examination and review of Petitioner's radiological records. (Px. 1). The surgeon opined that Petitioner, "Has not had a good functional outcome from surgical intervention," and diagnosed a "failed back" type of syndrome, due to significant post-operative scarring at the L5-S1 level of Petitioner's spine. (Px. 1).

On February 27, 2014, Dr. Ghanayem wrote a letter to counsel for the Respondent, stating that Petitioner was currently disabled, and may be an appropriate candidate for the placement of a dorsal column stimulator. (Px. 1). Further, that placement of the spinal stimulator would allow the Petitioner the opportunity to wean off of his current prescription pain medications. (Px. 1).

The spinal cord stimulator was not approved. On April 14, 2014, Dr. Carl Sather, recommended water therapy, placement of a spinal cord stimulator, and continued use of prescription medication. (Px. 4; Px. 8).

On June 5, 2014, Dr. Carl Sather, MD, also wrote a letter to counsel for the Petitioner, and the Respondent, recommending the placement of the spinal cord stimulator. (Px. 2). Dr. Sather continued to recommend aquatic therapy, the use of prescription medications, and placement of the spinal cord stimulator over the following months. (Px. 8).

On November 14, 2014, Petitioner returned to Dr. Sather. The spinal cord had not been implanted, and aquatic therapy had been rejected as "not medically oriented." (Px. 8).

On May 19, 2015, Petitioner presented to Loyola Medicine clinic for an initial evaluation with Dr. Troy A. Buck, MD. (Px. 22). Dr. Buck, an anesthesiologist, provided Petitioner with information regarding the placement of the stimulator, and advised Petitioner to return "in a month." (Px. 22). During the interim, Petitioner was directed to watch the informational dvds and obtain further medical records for Dr. Buck's review. (Px. 22). Further, that Petitioner would need to be psychologically evaluated in order to be approved for the stimulator. (Px. 22).

On December 03, 2015, Petitioner returned to Dr. Buck for further evaluation. Dr. Buck evaluated Petitioner with a resident, Dr. Zaidi Arslan. Petitioner was again found to be a candidate for a spinal cord stimulator, and was again referred for psychological referral. (Px. 26).

Petitioner continues to receive treatment with Dr. Sather. On January 21, 2016, Petitioner returned for further evaluation. (Px. 27). Dr. Sather noted that Petitioner continued to hope for the placement of the spinal cord stimulator with Dr. Buck, noting that "This has been a

prolonged wait with approval over 6 months and a couple specialists." Petitioner continued to suffer from depression and anxiety. (Px. 27). Petitioner's medication was updated again, to include Baclofen, Celexa, Gabapentin, Hydrocodone, Norcoc, Hyddroxyzine Pamoate, Lorazepam, vitamins, Oxycodone extended release tablets, Trazadone, and Lyrica. (Px. 27).

Dr. Sather noted that Petitioner was not approved for aquatic therapy. (Px. 27).

4. Evidence Regarding Petitioner's Medical Charges.

During arbitration on March 30, 2016, both Parties submitted updated pharmacy billing records.

The Petitioner submitted updated IWP billing records. (Px. 28). The bills indicate that between January 21, 2013, and December 08, 2015, IWP generated a total pharmacy bill of $86,561.19. Further, that between January 21, 2013, and December 08, 2015, the Respondent paid $16,775.86 towards that balance, leaving a remaining outstanding balance of $69,785.33. (Px. 29). The Respondent made no payments between December 02, 2014, and February 2, 2016. (Px. 29).

Pages 16 through 21 of the IWP reimbursement worksheet reveals that the Respondent did not make any payments to IWP for any dates of service after December 2, 2014, until February 5, 2016. (Px. 29) On February 5, 2016, IWP received payment for outstanding pharmacy charges with dates of service ranging from July 31, 2014, through December 5, 2015. (Px. 29) The February 5, 2016 payment totaled $19,768.47. (Px. 29). As a result, the Respondent paid a total sum of $36,544.33, leaving a total outstanding balance of $50,016.86. (Px. 29).

The Respondent submitted its own payment report, dated March 29, 2016. Page 5 of the payment report indicates that the Respondent began to receive billing from IWP during February of 2013. Between February 18, 2013, and February 3, 2016, the Respondent paid $36,544.86 towards IWP pharmacy charges. Px. 29). The Respondent also submitted explanation of review reports, summarizing the amount billed and payment amount allowed. The amount of payment was based on the medication's average wholesale price. Utilization review was included.

At arbitration, counsel for the Petitioner objected to the introduction of utilization review evidence and submitted a memorandum of law in support of her position. (Px. 32) Petitioner stipulated to the admission of the payment history contained within the paperwork for purposes of providing evidence as to what bills were paid, and agreed that the Respondent should be provided credit for any payments made to IWP as the date that the payments were made. (Px. 32). However, Petitioner objected to introduction of the utilization review evidence submitted through the billing records, as expert testimony of the person conducting the utilization review was not solicited nor timely disclosed. Petitioner further objected that the utilization review evidence provided for reimbursement according to the average wholesale price rate as opposed to the usual and customary rate. (Px. 32).

5. Petitioner's Attempts Obtain Approval of the Spinal Cord Stimulator, Aquatic Therapy, and Coverage of His Medical Bills, Including His IWP Pharmacy Bills.

At arbitration, Petitioner submitted extensive correspondence exchanged between the law firms of Shay & Associates, counsel for the Petitioner, and Knell, O'Conner, & Danielewicz, counsel for the Respondent. (Px. 18).

On August 08, 2014, Timothy Shay, counsel for Petitioner, requested that the spinal cord be approved by the Respondent, as contemplated by IME physician Dr. Ghanayem. (Px. 18) Brian Wojcicki, attorney from the Respondent, stated that Dr. Ghanayem's office had been "delayed" in responding to the requests, and that his adjuster had changed. (Px. 18).

On August 26, 2014, attorney Shay reiterated his request for the approval of the spinal cord stimulator. Wojcicki responded that Dr. Ghanayem would not perform the spinal cord stimulator, but that Dr. Troy Buck, an associate at Loyola, was willing to do so. (Px. 18)

On October 29, 2014, attorney Noll again contacted Wojcicki, requesting that Petitioner be approved for placement of the spinal cord stimulator. (Px. 18).

On December 2, 2014, Noll sent additional correspondence, and requested that Petitioner be referred to Dr. Troy Buck, neurosurgeon at Loyola, for placement of the spinal stimulator. (Px. 18).

On December 3, 2014, attorney Shay sent a letter to Andrew Fernandez, counsel for the Respondent, advising that a 19(b) petition would be set for arbitration. Shay also requested approval of aquatic therapy. (Px. 18).

On December 09, 2014, attorney Noll sent correspondence to Danielewicz, reminding counsel that Petitioner was in an extraordinary amount of pain due to his condition, and requesting that the stimulator be approved as soon as possible. (Px. 18).

On February 19, 2015, Shay mailed updated treatment records to the Respondent. Shay advised that he had left multiple phone messages in attempts to resolve the matter of the spinal cord stimulator, with no response. (Px. 18).

On March 2, 2015, attorney Noll telephoned attorney Danielewicz, and requested placement of the spinal cord stimulator. (Px. 18).

On March 5, 2015, attorney Shay mailed another letter to Danielewicz, requesting approval of the spinal cord stimulator. (Px. 18).

On April 3, 2015, Thomas Boyd, attorney for the Respondent, e-mailed the law firm of Shay & Associates, stating, "Happy Friday. My client has informed me that we are approving the spinal cord stimulator." (Px. 18). That approval came 400 days after IME physician Dr. Ghanayem's examination. (Px. 18).

On April 6, 2015, attorneys Noll and Shay requested a copy of the written approval for the stimulator, and confirmation of the date of Petitioner's first doctor's appointment. (Px. 18).

On April 10, 2015, Boyd forwarded an email from Zachary Taylor, adjuster for the Respondent, stating that the spinal cord stimulator was approved. (Px. 18).

On April 10, 2015, attorney Shay mailed Petitioner's IWP pharmacy bills to attorney Boyd. Shay requested that Boyd forward the billing to the Respondent for payment. (Px. 18).

On May 20, 2015, attorney Noll sent a letter to Boyd, advising that Petitioner had only been approved for an initial examination with Dr. Troy Buck. (Px. 18). Follow-up treatment was not been authorized. (Px. 18). Noll requested coverage of Petitioner's next appointment, which was scheduled for July 2, 2015. (Px. 18).

On July 1, 2015, Sarah Jones, paralegal at Shay & Associates, e-mailed Boyd, and again warned that Dr. Buck's office had not received confirmation of coverage. (Px. 18). Jones requested coverage immediately, and provided the phone number for the Respondent to call and authorize the appointment. (Px. 18).

On July 1, 2015, attorney Noll requested that a written copy of the approval be faxed to both the law firm of Shay & Associates, and to Dr. Buck's office, to ensure receipt and to avoid cancellation. (Px. 18).

Attorney Danielewicz responded by e-mail, stating that the appointment was approved by adjuster Shannon Casey. (Px. 18). Danielewicz did not provide a copy of the written authorization.

On July 09, 2016, paralegal Jones contacted Boyd and Danielewicz, and stated that Petitioner had not been able to attend his appointment with Dr. Buck. The medical provider had not obtained approval from the Respondent. (Px. 18).

On July 14, 2016, attorney Noll sent correspondence to Boyd and Danielewicz. Dr. Troy Buck's office had claimed that Shannon Casey, adjuster for the Respondent, had informed their office that Petitioner's case had been closed, and that the appointment was therefore cancelled. (Px. 18). Noll provided an office telephone number, and requested coverage. Noll warned that Petitioner could not attend follow-up appointments until authorization was received. (Px. 18).

On August 19, 2015, Noll telephoned and e-mailed attorney Danielewicz, and requested payment of Petitioner's medical bills and approval of the stimulator. (Px. 18).

On August 20, 2015, Noll mailed correspondence to Danielewicz and Boyd, advising that Dr. Buck's schedule was full, and that as a result of the July 2, 2015, cancellation, Petitioner would not be seen until September 29, 2015. (Px. 18). Noll warned that Petitioner could not attend the appointment in September, without prior approval by the Respondent. (Px. 18). Noll

advised that a Petition for Penalties would be filed because the Respondent had not paid Petitioner's prescription costs and had not approved his medical examinations. (Px. 18).

On September 10, 2015, attorney Boyd provided a "Supervisor Review" note dated April 2, 2015, stating that the spinal cord stimulator had been approved. (Px. 18). Boyd also provided a "Contact" note, stating that Casey had telephoned Dr. Buck's office on July 1, 2015, and approved coverage. (Px. 18).

On September 10, 2015, at approximately 4:11 p.m., Noll emailed a response to Boyd. Noll stated that she had telephoned Dr. Buck's office to confirm coverage, and spoken with "Quanita," an assistant who handled the workers compensation claims. "Quanita" advised that on July 1, 2015, adjuster Casey had advised that Boer's case was closed. Further, that no written approval for the September 29, 2015 appointment had been received. As a professional courtesy, Quanita attempted to telephone adjuster Casey in an attempt to obtain coverage. However, approval could not be obtained because adjuster Casey's voice messaging system was "full." (Px. 18).

On September 14, 2015, Noll requested confirmation that adjuster Casey had been directed to fax written confirmation of coverage to Dr. Troy Buck's office. (Px. 18).

On September 1, 2015, paralegal Jones provided a fax number to the Respondent, and a telephone number, to again facilitate written authorization of Petitioner's September appointment. (Px. 18).

On September 29, 2015, attorney Shay advised counsel for the Respondent that Petitioner's unpaid prescription expenses exceeded $50,000.00. (Px. 18).

On September 29 2015, attorney Boyd sent an email, advising, "I realize at this point you have no reason to take my word for it, but I just got off the phone with my adjuster and she is faxing in the written authorization for the spinal cord stimulator to Dr. Buck's provider relations office." (Px. 18).

Later on September 29, 2015, paralegal Jones contacted Loyola, and was again advised that Casey had not faxed approval. Jones emailed attorney Boyd, and advised that she would fax the written approval on the Respondent's behalf. (Px. 18). The appointment was then approved. (Px. 18).

On December 21, 2015, attorney Noll warned that the 19(b) and Petition for Penalties would proceed, because over $50,000 remained outstanding to IWP. (Px. 30). Noll requested that attorney Boyd schedule any evidence depositions that he wished to submit, immediately. (Px. 30).

On January 6, 2016, attorney Boer requested updated IWP bills, with HCFAH 1500 codes. (Px. 18). The billing was provided within twenty minutes of Boyd's request. (Px. 18).

On January 7, and 15, 2016, additional medical records were provided to attorney Boyd. (Px. 30).

On January 21, 2016, attorney Noll telephoned and e-mailed attorney Boyd, requesting proof of payment of the IWP bills. (Px. 30).

On January 22, 2016, attorney Boyd advised that utilization review was not complete, and that he would be unable to attend arbitration. (Px. 30). Attorney Noll advised that arbitration would proceed, due to Petitioner's lack of coverage of medications and the threat that acute withdrawal posed. (Px. 30). Attorney Noll requested a telephone conference with the arbitrator. (Px. 30).

On January 25, 2016, Attorney Noll again requested that Boyd schedule the evidence deposition of any utilization review physicians. (Px. 30). Noll again agreed that a telephone conference should occur with the arbitrator. (Px. 30).

On January 26, 2016, Attorney Noll provided updated prescription information to attorney Boyd. (Px. 30).

On February 1, 2016, attorney Boyd accused attorney Noll of "doing little to nothing to facilitate" the process of coverage. (Px. 30). In response, Noll confirmed that the prescriptions had been faxed directly to the pharmacy in question, and that Dr. Sather had hand-walked the prescription to the pharmacy. (Px. 30).

On February 2, 2016, paralegal Jones provided attorney Boyd with Petitioner's pharmacy information, including the phone number, address, and email to the pharmacy manager at Walgreens. (Px. 30).

On February 2, 2016, attorney Boyd requested that Petitioner utilize CVS in Mahomet, Illinois. (Px. 30) Noll and Petitioner agreed, but requested confirmation that the prescriptions were available to be picked-up, as the pharmacy was located two hours from Petitioner's home. (Px. 30).

On February 2, 2016, attorney Noll wrote to Arbitrator Lee, and cc'd attorney Boyd. Noll requested that arbitration proceed. (Px. 30). On February 2, 2016, attorney Boyd emailed Arbitrator Lee, stating that the "prescriptions as ordered have been authorized and were waiting for pickup." (Px. 30).

On February 3, 2016, attorney Boyd emailed attorney Noll at 7:21a.m., and advised that the prescriptions had been filled and were located at the CVS in Mahomet. (Px. 30).

However, on February 3, 2016, at 11:01a.m., attorney Boyd sent an email requesting that Petitioner's prescriptions be delivered to the CVS in Mahomet, Illinois. (Px. 30). An additional e-mail dated February 3, 2016, indicates that the prescriptions were driven to the CVS at or about 7:50 p.m. (Px. 30).

After arbitration was held on February 3, 2016, attorney Noll agreed to re-open evidence. (Px. 30). On March 09, 2016, attorney Noll provided Dr. Sather's contact information to attorney Boyd, to facilitate prescription coverage. Noll also offered to provide an updated HIPAA form in order to expedite review. (Px. 30). Noll advised that Petitioner could not continue to cover the costs of his prescription and was in danger of losing his home. (Px. 30).

On March 11, 2016, attorney Noll provided Mr. Boyd with Petitioner's updated prescriptions, which include Baclavan, Hydrocodone, Lorazepam, Oxycodone, Topiramate, and Citalopram (Celexa). (Px. 30). A HIPAA authorization was also provided on March 14, 2016. (Px. 30).

CONCLUSIONS OF LAW

Issue A, B, and C: Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, and was there an employer-employee relationship? If so, did an accident occur that arose out of and in the course of the employment relationship?

The Petitioner's testimony, that he was employed by the Respondent, Cross Country Construction, is undisputed. Moreover, the Respondent's continued payment of temporary total disability benefits, and some pharmacy and medical provider billing, is indicative of coverage. By all accounts, Petitioner injured his lumbar spine while using a sledgehammer to place poles in a center tower. For these reasons, the Arbitrator finds that the Respondent was operating under and subject to the Illinois Workers' Compensation Act, while acting as an employee of the Respondent.

Issue D: What was the date of the accident?

The Arbitrator finds that the date of the accident was January 30, 2012. This finding is based upon the uncontroverted testimony of the Petitioner, accompanied by the ongoing temporary total disability benefits provided by the Respondent.

Issue E: Was timely notice given to the employer?

The Arbitrator finds that timely notice of the accident was provided to the Respondent, based upon the uncontroverted testimony of the Petitioner, accompanied by the ongoing temporary total disability benefits provided by the Respondent.

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

The Arbitrator does find that the Petitioner's current condition of ill-being, specifically including Petitioner's L5-S1 post-surgical findings of epidural fibrosis around the S2 nerve root, and Petitioner's anxiety and depression, are causally related to the injuries sustained on January 30, 2016. In so finding, the Arbitrator relies upon the Petitioner's various treating physicians and independent medical examiner, together with Petitioner's various medical records.

The Arbitrator relies on evidence that, on May 24, 2013, Dr. Hyunchul Jung, MD, reviewed Petitioner's post-operative MRI, and opined that the films L5-S1 post-surgical findings with epidural fibrosis around the S1 nerve root. Dr. Jung opined that Petitioner's pain stemmed from the epidural fibrosis around the left sided S1 nerve root. Further, that if epidural injections were ineffective, the spinal cord stimulator trial and implantation would be the "next option." (Px. 3). Dr. Jung's final impression was of post-laminectomy syndrome and epidural fibrosis. The Arbitrator finds this evidence to be credible.

The Arbitrator notes that Dr. Alexander's February 27, 2014, Dr. Alexander Ghanayem, an independent medical examination resulted in diagnoses that were almost identical to Dr. Jung's assessments. Dr. Ghanayem opined that Petitioner suffered from significant post-operative changes at the L5-S1 level, including scar reaction/formation at the operative level. Dr. Ghanayem assessed failed back syndrome, and also recommended placement of a spinal cord stimulator, with a primary goal of "getting him <Petitioner> off of pain his significant pain medication." (Px. 1). The arbitrator finds this opinion to be credible.

On June 5, 2014, Dr. Carl Sather, MD, also wrote a letter on behalf of the Petitioner, recommending placement of the spinal cord stimulator with hopes of obtaining better pain control. (Px. 2). Dr. Sather related his need for further treatment to Petitioner's work injury, stating "We have worked as indicated through escalated standard medical and surgical care, abiding with recommended workman's compensation practices but not been able to manage his chronic pain nor improve his functional limitations after his injury." The Arbitrator notes that Dr. Sather has treated Petitioner for several years' time, and is in a better place to evaluate and examine Petitioner's functional limitations than any other witness. The Arbitrator finds Dr. Sather's opinions as to Petitioner's ongoing pain and depression to be credible.

On May 19, 2015, and December 3, 2015, Dr. Troy Buck, MD, surgeon at Loyola Medical Center, also reviewed Petitioner's medical records and found that Petitioner was a candidate for spinal cord stimulator placement, referring Petitioner to psychological placement. (Px. 22, 26). The Arbitrator finds Dr. Buck's treatment recommendations to be consistent with the other physician's assessments.

Taken as a whole, the Arbitrator finds that the overwhelming evidence suggests that Petitioner's ongoing lumbar pain is causally related to his January 20, 2012 spinal injury. In particular, the Arbitrator finds that Petitioner's post-operative changes at the L5-S1 operative area, and epidural fibrosis at the S1 level, occurred as a direct result of Petitioner's laminotomy. The Arbitrator notes that Petitioner had zero complaints or treatment for back pain prior to the 2012 injury, and that the radiological films taken after Petitioner's surgical intervention directly support the conclusions made by Dr. Jung, Dr. Sather, and Dr. Ghanayem.

The Arbitrator also finds that Petitioner's depression and anxiety are causally related to the January 20, 2012 spinal injury. Dr. Carl Sather's October 29, 2012 correspondence to the Respondent, explaining that Petitioner's depression was causally related to his chronic pain situation, is highly compelling. (Px. 8). Petitioner's treatment records indicate that Petitioner walks with a cane, leaks urine at night and is unable to work or engage in significant activities of daily living. This state of living would certainly cause mental health issues to manifest.

Therefore, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to his work injury.

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

J(1) Petitioner's medical services were reasonable and necessary.

The Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary. In so finding, the Arbitrator notes that IME physician Dr. Ghanayem specifically found that all medical treatment, to date, had been medically reasonable and necessary. (Px. 1). Dr. Ghanayem wrote that surgical intervention for Petitioner's radicular symptoms was manifestly warranted, and that the unfortunate post-operative changes, in particular the epidural scarring located at the S1 spine, impinging on the nerve root, was an unfortunate result of the surgery. Dr. Ghanayem also stated that ongoing medical care, including evaluation for a spinal cord stimulator, was appropriate.

Therefore the Arbitrator also finds that Petitioner's evaluation for spinal cord stimulator, under the medical care of Dr. Troy Buck, is reasonable and necessary. In so finding, the Arbitrator notes that the Respondent has provided zero evidence to the contrary.

The Arbitrator finds that Petitioner's anti-depressant and anti-anxiety medications were reasonable and necessary. Dr. Sather's testimony and correspondence regarding the use of such medication, to be highly credible. Dr. Ghanayem's report specifically stated that the goal of the spinal cord stimulator was to reduce Petitioner's ongoing and debilitating pain, in order to reduce Petitioner's reliance on pain medication.

The Arbitrator puts zero credence on any utilization review evidence referenced by the parties. Expert testimony of the apparently numerous persons conducting the utilization review was not solicited through expert deposition at any time over the past four years. Further, no experts were disclosed in a timely manner. There is no showing that any of the individuals performing the utilization review ever examined the Petitioner, or what records, if any, the reviewers relied upon when conducting their evaluations.

In contrast, Dr. Sather's testimony was clear that Petitioner's pain and antidepressant medications were necessary and causally related to Petitioner's chronic pain condition.

Therefore, the Arbitrator finds that the medical services provided to Petitioner were reasonable and necessary.

J(2) The Respondent has not paid all appropriate charges for the reasonable and necessary medical services.

The Arbitrator finds that the Respondent has not paid all appropriate charges for the reasonable and necessary medical services. The Arbitrator hereby directs the Respondent to pay all medical charges issued by the health care providers in Petitioner's Exhibit 19, in accordance with the medical fee schedule, with the exception of Petitioner's Pharmacy bills, which is addressed, below.

The Arbitrator hereby also orders the Respondent to pay all of the pharmacy charges issued by the IWP as delineated in Petitioner's Exhibit 29, pursuant to the usual and customary rate, and not the average wholesale price.

In so holding, the Arbitrator notes that the evidence is uncontroverted that IWP is an Illinois licensed pharmacy. The Respondent did not dispute or object to that evidence.

As of June 28, 2011, Section 8.2(a-3) of the Act states that each prescription filled and dispensed *outside* of a licensed pharmacy shall be reimbursed at or below the average whole sale price (AWP) plus a dispensing fee. However, because the IWP is a licensed Illinois Pharmacy, reimbursement continues in accordance with the usual and customary rate.

The Commission has advised:

> However, prescriptions filled by a licensed pharmacy will continue to be paid at the usual and customary rate.
>
> http://www.iwcc.il.gov/faqmed.htm

The Respondent did not object to the introduction of the Petitioner's pharmacy bills, or object to the reasonableness of the charges at arbitration. The Respondent stipulated to the introduction of Petitioner's Exhibit 29. The Respondent did not raise an objection to the introduction of IWP's HCFAH forms or reimbursement worksheets, which provided a history of the dates that pharmacy charges were issued, and the dates of payments made by the Respondent. (Px. 29).

In contrast, the Petitioner did object to any of the Respondent's utilization review evidence that provided for reimbursement according to the average wholesale price. The arbitrator notes that the utilization review documentation was not provided to Petitioner's counsel until one day prior to arbitration. Further, that no evidence depositions were taken by the Respondent, despite the Petitioner's ongoing requests that the same be conducted. The utilization review advocating for reimbursement based upon wholesale price must be disregarded.

Therefore, the Arbitrator finds that the reasonable and necessary medical charges were not paid. (Px. 29)

K. The Petitioner is entitled to prospective medical care, including placement of the spinal cord stimulator after proper presurgical clearance, coverage of

aquatic therapy as referred by Dr. Sather, and coverage of his prescription medication.

The Arbitrator holds that the Petitioner is entitled to placement of, the spinal cord stimulator, following pre-surgical and other medical clearance as ordered by Petitioner's treating physicians, including but not limited to Dr. Troy Buck's ongoing recommendations. The Respondent is directed to continue to provide coverage of Dr. Buck's medical appointments, and his pre-surgical referrals, to facilitate resolution of the claim.

Petitioner is also entitled to coverage of his antidepressant medication and pain management medication as prescribed by Dr. Carl Sather, until such time as Petitioner receives the spinal cord stimulator. The Arbitrator reserves further ruling on the necessity of Petitioner's pain management and anti-depressant medications, after placement of the spinal cord stimulator occurs. The Parties are given leave to re-open the issue as to what pain management and mental health medications continue to be necessary, after the spinal cord stimulator has been placed, and after the treating physicians have re-evaluated Petitioner's health and disability status.

M. Penalties should be imposed upon the Respondent.

The Arbitrator finds that penalties should be imposed upon the Respondent. In so finding, the Arbitrator notes that treating physician, Dr. Hyunchai Jung, opined that evaluation for a spinal cord stimulator should occur as early as May 24, 2013. Independent medical examiner, Dr. Alexander Ghanayem, recommended evaluation for the spinal cord stimulator on February 27, 2014. Dr. Carl Sather, MD, wrote a letter to the Respondent on June 5, 2014, advocating for the placement of the spinal cord stimulator.

However, the Respondent did not appear to approve that evaluation April 3, 2015. At that time, attorney Boyd, e-mailed the law firm of Shay & Associates, stating, "Happy Friday. My client has informed me that we are approving the spinal cord stimulator." (Px. 18). That approval came 400 days after IME physician Dr. Ghanayem's examination. (Px. 18). After Petitioner's first evaluation with Dr. Troy Buck, on May 20, 2015, the Respondent failed to provide further coverage for several months' time. This was true, despite Dr. Buck's treatment record, advising that Petitioner should return in a few weeks' time. (Px. 27).

Similarly, the Respondent failed to make outstanding pharmacy payments until February 3, 2016, the date on which arbitration under Sections 16 and 19 of the Act were scheduled to be heard. At arbitration on March 30, 2016, counsel for the Respondent, Thomas Boyd, stated that he did not appear on February 3, 2016, because the Respondent had issued outstanding pharmacy payments that morning.

Q. Why didn't the Respondent show up for the hearing?

A. The Respondent did not appear for the hearing because they had paid approximately $19,700.00 on the morning of February 3 to the Injured Workers Pharmacy.

(Tr. vol. 2. p. 5)

Taking that as true, the Arbitrator finds that penalties are necessary.

In reviewing Petitioner's Exhibit 29, it is obvious that the Respondent was aware that IWP was acting as Petitioner's pharmacy, and simply quit paying for all prescriptions after the December 2, 2014 date of service. (Px. 12). The Arbitrator finds that no further payments were made until February 5, 2015, at which time a payment of $19,768.47 was issued, and apparently received by IWP on February 5, 2016. (Px. 29) Further review of Petitioner's Exhibit 29, specifically page 14 of the reimbursement worksheet, reveals that some pharmacy charges with dates of services as early as July 31, 2014, remained unpaid until February 05, 2015. (Px. 29).

Attorney for the Petitioner, Timothy Shay, began mailing the outstanding IWP pharmacy bills to attorney Boyd on April 10, 2015. Shay requested that Boyd forward the billing to the Respondent for payment. (Px. 18). On August 19, 2015, Noll telephoned and e-mailed attorney Danielewicz, and requested payment of Petitioner's medical bills and approval of the stimulator. (Px. 18). On September 29, 2015, attorney Shay advised counsel for the Respondent that Petitioner's unpaid prescription expenses now exceeded $50,000.00. (Px. 18). On January 21, 2016, attorney Noll telephoned and e-mailed attorney Boyd, again requesting proof of payment of the IWP bills.

No explanation for the nonpayment was provided by the Respondent until January of 2016, when attorney Boyd responded that utilization review was not complete. (Px. 30).

The Insurance Claim Forms contained within Petitioner's Exhibit 29 all indicate that the Respondent, Cross Country Construction, was named as the employer in question, and that the Respondent's workers compensation insurance provider, Applied Risk / Underwriters, was always named as the insured's name to whom billing should be directed to. (Px. 29).

This Arbitrator finds that the nonpayment of the pharmacy charges warrants penalties.

(1) Section 16 penalties.

The Worker's Compensation Act states that whenever the Commission shall find that an employer has been guilty of delay or unfairness towards an employee in the adjustment or payment of benefits due, or has been guilty of unreasonable or vexatious delay, or has engaged in frivolous defenses, the Commission may assess all or any part of the attorney's fees or costs. For the reasons stated above, the Arbitrator finds that the Respondent has been guilty of unreasonable and vexatious delay.

Petitioner's counsel is hereby awarded 20% of all amounts awarded herein.

(2) **Penalties pursuant to Section 19(k) of the Act.**

Section 19(k) of the Act provides:

> In cases where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. When determining whether this subsection (k) shall apply, the Commission shall consider whether an Arbitrator has determined that the claim is not compensable or whether the employer has made payments under Section 8(j). 825 ILCS 305/19(k). (Emphasis provided)

This arbitrator finds that the Respondent failed to pay the pharmacy bills with dates of services from December 2, 2014, onward, until February 3, 2016. No reason for the delay was provided by the Respondent at arbitration, who waited until the morning of arbitration to submit payment. This resulted in a 428 delay in payment of the December 2, 2014 pharmacy bill, and lesser delays in each subsequent charge. The arbitration finds this to be frivolous, unreasonable, and vexatious delay over matters that that do not present a real controversy.

The arbitrator orders that $ 50.016.86, as issued in Petitioner's Exhibit 29 be paid to IWP, and that an additional $ 25,08.43 be awarded to the Petitioner due to the Respondent's failure to pay IWP pharmacy bills.

(3) **Section 19(l) Penalties.**

> Sec. 19(l) If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have *14 days after receipt of the demand to set forth in writing the reason for the delay.* In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). *In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day* for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, *not to exceed $10,000.* A delay in payment of 14 days or more shall create a

rebuttable presumption of unreasonable delay. 825 ILCS 305/19(l). (Emphasis provided)

As noted above, this arbitrator finds that the Respondent failed to pay the pharmacy bills with dates of service from December 2, 2014, onward, until February 3, 2016. Correspondence provided by the Petitioner reveals that Petitioner, through his attorneys, began to demand payment of the outstanding pharmacy charges on April 10, 2015, and continued to demand payment through the date of arbitration, February 3, 2016. This resulted in a 299 day delay in payment. Applying a $30 per day penalty, the Petitioner is hereby awarded $8,970.00. The Respondent did not provide written explanation for the delay within 14 days of Petitioner's demands.

N. The Respondent is due credit for IWP pharmacy payments made.

The Respondent is hereby given credit for payments previously made pursuant to Petitioner's Exhibit 29.

0. The Arbitrator finds that notice of arbitration was proper.

The Arbitrator hereby finds that the Respondent was provided notice of arbitration, in accordance with the Workers Compensation Act. Counsel for Petitioner provided the required petition for immediate hearing, notice of motion and order, and request for hearing, to the Respondent by certified mail, as required by law, which was properly set for January 26, 2016. Counsel for Petitioner made oral motion to proceed with arbitration on January 26, 2016, when counsel for Respondent failed to appear. Counsel was aware of the motion, and the Order to proceed to arbitration, because of a telephone conference between the Parties and Arbitrator on that same date. Moreover, Petitioner provided a copy of Arbitrator Lee's signed notice of motion and order, setting the case for trial certain, as required by the regulation.

Therefore, arbitration proceeded with appropriate notice.

It is hereby ordered.

Edwd Lee
Arbitrator

6/4/16
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

JOHN JOYCE,

Petitioner,

vs. NO: 12 WC 18298

GARDA,

17IWCC0377

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent, herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical, temporary total disability (TTD), permanent partial disability (PPD), evidentiary issues, and prospective medical, and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission affirms, in part, the Decision of the Arbitrator including the finding of causal connection of the left hip. The Commission, however, modifies the Arbitrator's denial of prospective medical treatment relative to the left hip. The Commission finds that Petitioner's request for a left hip replacement is premature. Petitioner's claim for prospective medical is premised upon Dr. Domb's opinion that Petitioner will, more likely than not, need a total hip replacement in the future. While Dr. Domb's opinion establishes that Petitioner may need a left hip replacement in the future, the Commission finds no indication in the record that Joyce is in need of a left hip replacement at this time. Thus, the issue of prospective medical is premature.

17IWCC0377

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 11, 2016, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $557.33 per week for a period of 71-3/7 weeks, April 17, 2012 through August 30, 2013, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that petitioner is entitled to have from the respondent the reasonable and necessary cost for decompression of his left L5 nerve root. His request for the reasonable and necessary cost for a total left hip replacement is premature.

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: JUN 22 2017

MJB/tdm
O: 5-2-17
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

JOYCE, JOHN
Employee/Petitioner

Case# **12WC018298**

17IWCC0377

GARDA GARGE
Employer/Respondent

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:

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

2965 KEEFE CAMPBELL & ASSOC LLC
JOSEPH D'AMATO
118N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

JOHN JOYCE
Employee/Petitioner

Case #12 WC 18298

V.

GARDA GARAGE
Employer/Respondent

17IWCC0377

An *Application for Adjustment 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 23, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On April 16, 2012, 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 $43,472.00; the average weekly wage was $836.00.
- At the time of injury, the petitioner was 62 years of age, married with no children under 18.
- The parties agreed that the respondent paid $27,554.17 in temporary total disability benefits and $103,098.43 in medical expenses.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 71-3/7 weeks, from April 17, 2012, through August 30, 2013.

ORDER:

- The petitioner's request for the reasonable and necessary cost for a total left hip replacement is denied. The petitioner is entitled to have from the respondent the reasonable and necessary cost for a decompression of his left L5 nerve root.
- 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 8, 2016
Date

APR 11 2016

FINDINGS OF FACTS:

The petitioner, an armored truck driver, sustained injuries on April 16, 2012, after slipping while exiting his truck. He received care with Dr. Rajeev Khanna at Advanced Occupational Medicine Specialists and reported his foot slipped while holding the door with his right hand, bracing himself with his left arm, slipping again and landing on the ground mostly with his left leg. He complained of left shoulder and abdominal wall pain, greater on the left side. Dr. Khanna noted mild left shoulder pain with the crossover, O'Brien's and biceps tests. The petitioner denied left knee pain but lateral and medial joint line tenderness was noted for both knees. The doctor noted tenderness to palpation along the midline and the left upper and lower quadrants of his abdominal wall. The diagnosis was abdominal muscles, left knee and left shoulder strain. The petitioner was given lifting and sitting work restrictions. He reported continuing symptoms on the 19th. On the 26th, he complained of a burning pain in his left knee and pain in his left hip. Dr. Khanna's impressions on April 26th included his prior diagnosis and an additional assessment of degenerative disc disease L4-5 and L5-S1 and lumbago. On May 3rd, Dr. Khanna noted that the petitioner's left shoulder, left thigh, abdomen, left hip and back pain was unchanged. Two weeks of physical therapy was prescribed for the petitioner's lower back and left shoulder. An abdominal CT scan on May 9th revealed a small umbilical hernia containing fat. An MRI of his left shoulder on May 23rd showed bursal surface fraying of the supraspinatus tendon but no full thickness tears, a probable SLAP-type tear of the superior labrum, degeneration of the posterior glenoid, thinning of articular cartilage and subchondral osseous edema or cyst formation of posterior glenoid with possible degeneration, fraying or tearing of the posterior labrum and an inferiorly

projecting AC arthrosis. He reported increasing symptoms to Dr. Khanna at follow-ups in May.

On June 21, 2012, the petitioner saw Dr. Kevin Tu at G&T Orthopaedics, who opined that the MRI revealed partial-thickness rotator cuff and labral tears, for which he recommended a left shoulder surgery. On July 5th, Dr. Khanna's work status report indicated a diagnosis of umbilical hernia, left shoulder glenoid/labrum tear, left knee sprain, lumbar strain and left hip pain. On July 14th, Dr. Heilizer performed a laproscopic ventral and umbilical hernia repair with mesh. An MRI of his left hip on August 22nd revealed anterosuperior and superior labral tears, gluteus minimus insertional tendinosis and an aspherical femoral head with osseous convexity at the lateral femoral head/neck junction suggesting Cam morphology. Dr. Khanna's assessment at a follow-up on August 9th was the same. On September 25th, Dr. Tu performed an arthroscopic subacromial decompression, debridement and distal clavicle excision. Dr. Khanna's assessment did not include lumbago at follow-ups from October 15th through November 29, 2012.

On December 13, 2012, the petitioner saw Dr. Benjamin Domb at Hinsdale Orthopaedics for his left hip. The doctor's assessment was left hip labral tears, a Cam morphology, a slight acetabular retroversion and minimal degenerative changes, and a left lumbar spinal radiculopathy for which he felt was likely responsible for lots of the petitioner's buttock pain. Dr. Domb opined that a left hip injection confirmed the petitioner's anterior and lateral hip pain was coming from his hip joint and that his posterior pain was from his spine. He recommended hip surgery and a lumbar MRI. A lumbar MRI on January 10, 2013, revealed mild left foraminal stenosis at L3-4, severe discogenic degeneration at L4-5 with mild-to-moderate bilateral foraminal stenosis and

severe discogenic degeneration at L5-S1 with mild-to-moderate left and mild right foraminal stenosis and a small extruded left paramedian disc fragment. On May 9, 2013, Dr. Tu noted that the petitioner reported improvement with continued left shoulder pain and difficulty with sleeping and overhead activities. Dr. Tu opined that the AMA impairment rating for the petitioner's left shoulder injury was 11% upper extremity and 7% of the whole person.

On May 24, 2013, Dr. Domb performed a left hip arthroscopic removal of loose body, a labral repair, an acetabuloplasty, femoroplasty, a removal of bone cyst of the femur and a capsular release. On July 16, 2013, the petitioner reported doing well and that his hip was sore and he was sore all over. Dr. Domb noted that the petitioner was ambulating with a cane. He noted a left antalgic gait, and positive log roll and anterior impingement tests and a Faber sign. The petitioner reported more improvement on August 29th.

Dr. Bryan Neal opined after a Section 12 examination on September 18, 2013, that the petitioner's left lower extremity radicular symptoms were secondary to a left herniated lumbar disc in his lumbar spine and did not concur with the recommendation of a total hip arthroplasty. On October 8th, the petitioner complained of a sharp increase in hip pain after standing and a really stiff hip. A lumbar MRI on November 6th disclosed diffuse disc degeneration and spondylosis, most severe at L5-S1 with bilateral foraminal stenosis and an osteophyte/disc complex abutting both nerve roots. On November 19th, the petitioner saw Dr. Julie Morgan at Hinsdale Orthopaedics for his left hip and reported difficulty with walking short distances and arising from sitting.

On December 19, 2013, the petitioner saw Dr. Lorenz at Hinsdale Orthopaedics and related groin and left buttock pain, occasional radiation down his left leg at the L5-S1 distribution to his heel and the lateral aspect of the dorsum of his foot, a pain level of 7/10, increased pain with positioning and ambulation and discomfort with prolonged sitting. Dr. Lorenz noted no Waddell's signs, a good lumbar range of motion, left buttock pain with forward bending, an antalgic gait, a positive straight left leg raise, left dorsiflexion weakness and difficulty with left heel walking. Dr. Lorenz's diagnosis was degenerative disc disease with possible radiculitis of his left lower extremity. An EMG/NCV study on January 15, 2014, was consistent with a left L5 radiculopathy. On February 12, 2014, Dr. Lorenz noted complaints of low back pain radiating into the left hip and left neck pain radiating into his middle three fingers. His assessment was left L5 radiculopathy and neck pain with radiculopathy. On March 27th, Dr. Bardfield gave the petitioner a left L5 nerve root transforaminal lumbar epidural injection. The petitioner reported on April 14th that the injection was not beneficial. On May 23, 2014, the petitioner was re-evaluated pursuant to Section 12 of the Act by Dr. Babak Lami, who opined that his low back pain was due to degenerative changes and no longer related to the April 16, 2012, injury and that surgery would not improve his radicular pain. On July 7th, Dr. Lorenz recommended a decompression of the L5 nerve root on the left side and opined that there were mild degenerative changes of the cervical spine with no radiculopathy. Also, Dr. Lorenz opined that the petitioner had only minor degenerative changes in his left hip that do not contribute to any considerations for a total hip replacement.

On July 10, 2014, Dr. Domb recommended a posterior-approach total left hip replacement. On November 4th, Dr. Lorenz testified that the petitioner likely had some quiet degenerative lumbar changes that were aggravated by his work accident and recommends decompressive surgery of the L5 nerve root. On March 31, 2015, Dr. Domb testified that the petitioner's work accident was a cause or contributing factor to his left hip pathology and that more likely than not he will need a hip replacement at some point in the future. On September 8, 2015, Dr. Neal testified that that the petitioner did not require a hip replacement. A work status report by Dr. Lorenz on January 20, 2016, indicated light sedentary work restrictions and no truck driving for the petitioner.

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 his current condition of ill-being with his left knee, left shoulder, lumbar spine, left hip and umbilical hernia is partially causally related to the work injury. The petitioner failed to prove that his current condition of ill-being with his cervical spine is causally related to the work injury. The petitioner did not complain of cervical symptoms when he sought care with Dr. Khanna on the day of his accident or to any of the multitude of medical providers he saw prior to his first complaint of neck pain to Dr. Lorenz on February 12, 2014.

It is noted that the petitioner did not report low back or left hip symptoms at his initial medical care or at a follow-up with Dr. Khanna on April 19, 2012. The reservation caused by the lack of immediate low back and left hip symptoms is compounded by the absence of any medical notes of the cause and the duration of the petitioner's low back and left hip symptoms in Dr. Khanna's treatment records a week later on April 26, 2012.

However, slipping off his truck with most of his weight on his left leg, as noted in Dr. Khanna's records, should increase the traumatic forces through the petitioner's left hip and back.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that a total left hip replacement recommended by Dr. Domb is reasonable medical care necessary to relieve the effects of the work injury. Dr. Neal testified that that the petitioner did not require a hip replacement and Dr. Lorenz opined that the petitioner had only minor degenerative changes in his left hip that do not contribute to any considerations for a total hip replacement. The petitioner's request for the reasonable and necessary cost for a total left hip replacement is denied.

The petitioner proved that a decompression of the left L5 nerve root recommended by Dr. Lorenz 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 decompression of his left L5 nerve root.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Gianola,
Petitioner,

v. Case No. 13 WC 12155

Illinois Tollway Authority,
Respondent.

ORDER

This matter comes before the Commission on Petitioner's Petition to Reinstate his case following its January 27, 2017, dismissal for want of prosecution. Due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on May 19, 2017, in Geneva, Illinois. For the reasons set forth below, the Commission dismisses the Petition to Reinstate.

1. On January 27, 2017, the arbitrator dismissed this case for want of prosecution.
2. At the May 19, 2017, hearing on Petitioner's Petition to Reinstate, Petitioner's attorney agreed that notice of the arbitrator's ruling was sent out on January 31, 2017, and received by him. Respondent's counsel represented that she received the notice of ruling on February 6, 2017.
3. Petitioner offered into evidence a letter, dated February 16, 2017, purportedly sent to the Commission. (Exh. 1). The letter directs the reader to enclosed copies of Petitioner's notice of motion and petition to reinstate, but no such documentation was presented at the May 2017 hearing.
4. Petitioner's attorney represented at the hearing that the February 16 letter was not sent via certified mail and that he did not receive a response from the Commission indicating that the letter or referenced motions had been received or filed. The letter presented at the May hearing is not accompanied by any envelope or other proof of service.
5. Respondent's counsel stated at the hearing that she received a copy of Petitioner's February 16 letter and an unfiled copy of the motion, but never received a filed copy. Respondent's counsel further noted that the letter and motion included no proof of mailing.
6. On April 18, 2017, Petitioner's attorney sent to the Commission a letter substantially similar to the February 16 letter. (Exh. 2). Attached to the April 18 letter, and offered into evidence, were a notice of motion and Petitioner's Petition to Reinstate Case. (Exh 3).

7. The Commission returned a file-stamped copy of motion accompanying the April 18 letter, and Petitioner's attorney agreed he received the file-stamped copy on May 5.
8. At the May 2017 hearing on the Petition to Reinstate, Petitioner's attorney agreed that, for whatever reason, the February version of the petition had not been filed, and he argued that the mistake should not lead to prejudice to his client.

"When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a Petition to Reinstate the cause onto the Arbitration call." 50 Ill. Adm. Code § 9020.90. The Appellate Court has characterized this 60-day limit as "jurisdictional." See *TTC Ill., Inc. v. Ill. Workers' Comp. Comm'n*, 396 Ill. App. 3d 344, 354 (2009) ("Although the 60-day limit for filing a petition to reinstate a case after it has been dismissed by an arbitrator for want of prosecution is jurisdictional in nature"). Thus, the Commission has no authority to waive or alter the it.

Here, Petitioner's case was dismissed for want of prosecution on January 31, 2017, and his Petition to Reinstate was filed on April 18, 2017, at the earliest. Under any conception of the date of notice, Petitioner's Petition for Reinstatement was filed outside the 60-day window in which the Commission was empowered by rule to accept it. For that reason, the Commission must dismiss Petitioner's Petition to Reinstate.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition to Reinstate is dismissed.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,000.00. 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: JUN 26 2017

r-06/12/17
TJT/knc

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

JEFFERY MORGAN,

Petitioner,

vs.

NO: 13 WC 37932
14 WC 23170

CTA,

Respondent.

ORDER

Petitioner, on October 27, 2016, caused to be filed with the Commission a Motion for Fees and Penalties and for payment of outstanding medical bills. On January 12, 2017, with both parties represented by counsel, Commissioner Kevin W. Lamborn presided over the proceedings pursuant to Petitioner's motion. At issue is whether Respondent is liable for the unpaid medical expenses under the Lump Sum Settlement Contract the parties entered into.

Petitioner filed an Application for Adjustment of Claim with the Commission on February 18, 2014, alleging that he sustained injuries to his back, neck, and right shoulder/arm while working for Respondent on November 12, 2013. A second Application for Adjustment of Claim was filed with the Commission on July 8, 2014, for alleged injuries sustained to his right arm and lumbar spine on July 4, 2014. The parties agreed to settle both claims by entering into a single Lump Sum Settlement Contract.

At a date uncertain, the parties agreed to a provisional draft of a Lump Sum Settlement Contract. On September 25, 2014, counsel for Respondent, Andrew Zasuwa, signed a Lump Sum Settlement Contract and forwarded this contract via email to counsel for Petitioner, Mr. Edwin

Reyes, at 10:01 a.m. the following morning. In the email, Mr. Zasuwa wrote, "Hi Edwin, attached please find a signed settlement contact with one slight proposed change to the terms." The change Mr. Zasuwa referred to in said email modified the pertinent language of the contract from "Respondent agrees to pay reasonable and necessary related medical bills" to "Respondent agrees to pay reasonable and necessary related bills for dates of service thru 3/12/14." Next to the inserted language was written Mr. Zasuwa's initials. On September 26, 2016, both Mr. Reyes and Petitioner signed the Lump Sum Settlement Contract that contained the changes Mr. Zasuwa had alluded to in his email to Mr. Reyes. Neither Petitioner nor Mr. Reyes initialed next to the changed language of the Lump Sum Settlement Contract. The executed Lump Sum Settlement Contract was approved by Arbitrator David Kane on September 30, 2014.

At the time the Lump Sum Settlement Contract was signed by the parties, $28,936.11 in medical charges related to Petitioner's August 12, 2014, lumbar facet arthropathy remained outstanding. That amount remains outstanding despite Petitioner's demands for Respondent to pay those charges and is the reason for Petitioner's motion.

The Commission finds in the transcript of the proceedings before Commissioner Lamborn that Mr. Zasuwa indicated that Mr. Reyes drafted the original Lump Sum Settlement Contract and that he modified it before returning it to Mr. Reyes. As Mr. Zasuwa modified the language of the Lump Sum Settlement Contract that he originally received, the Commission construes the modified Lump Sum Settlement Contract to be a counteroffer to Mr. Reyes' original offer. Mr. Zasuwa indicated before Commissioner Lamborn that Mr. Reyes did not contact him concerning the changes to the original Lump Sum Settlement Contract but signed it and had Petitioner sign it before presenting it to Arbitrator Kane for approval. Mr. Reyes did not contest Mr. Zasuwa's recitation of the events. Mr. Reyes actions are seen as acceptance of Mr. Zasuwa's counteroffer.

The Commission could find reason to quibble over the assertion that Mr. Zasuwa made in his email to Mr. Reyes that the proposed change was "slight." Quantitatively, Mr. Zasuwa added only a few words to the Lump Sum Settlement Contract. Qualitatively, the added words are substantial. Even if the Commission finds Mr. Reyes had reasonably relied on Mr. Zasuwa's claim that the change to the Lump Sum Settlement Contract was "slight," the Commission finds Mr. Reyes had an obligation to find the change in the contract or, failing to find the change, contact Mr. Zasuwa to ascertain what that change was. Mr. Reyes' statement before Commissioner Lamborn that Mr. Zasuwa "didn't point out what the change was" is inconsequential. Mr. Reyes was put on notice that a change to the Lump Sum Settlement Contract had been made in no uncertain or ambiguous terms. His responsibility was to learn what the change was before accepting the terms of the modified Lump Sum Settlement Contract. That the changed language of the Lump Sum Settlement Contract was handwritten and stands out from the remainder of the Lump Sum Settlement Contract that is typewritten should have made it apparent to Mr. Reyes.

The Commission will not consider whether the modification of the Lump Sum Settlement Contract was invalid under any contract formation theory in the absence of any such assertion being made.

IT IS THEREFORE ORDERED BY THE COMMISSION THAT Petitioner's Motion for Penalties and Fees under Section 19(k), Section 19(l) and Section 16 of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION THAT Petitioner's Motion for Payment of Medical Bills is denied.

JUN 29 2017

DATED:
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tamara Davidson,
Petitioner,

vs.

NO: 13WC 009757

University of Illinois,
Respondent,

17IWCC0402

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, 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 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.

JUN 27 2017

DATED:
o060817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAVIDSON, TAMARA
Employee/Petitioner

Case# **13WC009757**
14WC000012

UNIVERSITY OF ILLINOIS
Employer/Respondent

17IWCC0402

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:

2333 WOODRUFF JOHNSON & PALERMO
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

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

0522 THOMAS MAMER & HAUGHEY
KENNETH REIFSTECK
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61820

1073 UNIVERSITY OF ILLINOIS
OFFICE OF CLAIMS MANAGEMENT
100 TRADE CENTER DR SUITE 103
CHAMPAIGN, IL 61820

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

AUG 9 - 2016

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

17IWCC0402

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

- [ ] 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

Tamara Davidson
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # 13 WC 9757

Consolidated cases: 14 WC 00012

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Urbana**, on **June 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] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

17IWCC0402

FINDINGS

On **January 23, 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 **$2,100.55**; the average weekly wage was **$525.14**.

On the date of accident, Petitioner was **45** years of age, *single* with **1** dependent child.

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

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

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

Respondent is entitled to a credit for all medical benefits paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on January 23, 2013 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being in her right shoulder is causally related to her employment or her accident of January 23, 2013. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

August 8, 2016
Date

ICArbDec p. 2

AUG 9 - 2016

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner has been employed by Respondent since 2001 as a cook preparing food for students attending the University of Illinois.

Petitioner submitted her medical records from Carle Foundation Hospital/Carle Clinic into evidence as PX 2. No records prior to January 1, 2013 were submitted.[1] However, based upon a review of PX 2 it appears that Petitioner was diagnosed with chronic migraines in 2012 and had some bilateral hip and back pain symptoms in August and September of 2012. (PX 2)

According to time records (RX 2, dep. ex. 4), Petitioner had accumulated 40 hours of work between January 9, 2012 and Friday, January 13, 2012. She then didn't earn any further hours until December 12, 2012. Petitioner worked December 12, 13, 14, 16,17,18,19, and 20, 2012. She didn't work again until January 13, 2013. She then worked that day and the 14th followed by the following: January 16, 17, 18, 19, 20, and 21, 2013. Petitioner then worked from 8:00 a.m. through 10:38 a.m. and 11:06 a.m. through 2:30 p.m. on January 23rd. Petitioner took a sick day on January 24, 2013. (RX 2, dep. ex. 4)

On January 24, 2013, Petitioner was evaluated by Dr. Bruce Kaplan at Carle Family Medicine. Petitioner provided a history that her body had been aching for the past three days, primarily in her shoulders. She further reported that moving her arms aggravated her pain and that she had been doing a lot of stirring and lifting at work as a cook for Respondent. She also complained of left neck pain and a headache. Dr. Kaplan's assessment was chest wall pain, migraine headache, elevated blood pressure, and left-sided neck pain. Petitioner was taken off of work and told to follow-up with her primary care physician. (PX 2)

Petitioner worked eight hours on January 25, 2013. (RX 2, dep. ex. 4)

Petitioner worked eight hours per day on the following dates: January 30, 2013; January 31, 2013; February 1, 2013; February 2, 2013; and February 3, 2013. She did not work on February 4, 5, or 6th, 2013. (RX 2, dep. ex. 4)

On February 6, 2013, Petitioner was seen by Dr. Natalie Renee Sessions at Carle. At that time, Petitioner reported ongoing bilateral hip and pelvic pain. She also reported shoulder and neck pain which was made worse when she was working as a cook for Respondent. She indicated that she did a lot of stirring as well as lifting of heavy baskets and she felt this exacerbated her symptoms. Petitioner advised that her pelvic pain continued to bother her most when she went to change positions such as lying down at night and then going to sit up or getting out of car. When standing Petitioner felt a throbbing in her left leg and pelvis. It was

[1] See authorization signed by Petitioner (PX 2, pp. 3-4)

also noted that "Since her last visit[2], she also now reports pain involving the area from her elbows to her hands bilaterally with numbness in her hands. This occurs mostly at night and will wake her up." Petitioner was assessed with myalgia and myositis, unspecified, along with pelvic and thigh pain, back pain, an unspecified vitamin D deficiency, and obstructive sleep apnea. (PX 2)

Petitioner worked on February 7, 8, 9, 10, 12, 13, 14, 16, and 17, 2013. (RX 2, dep. ex. 4)

On February 20, 2013, Petitioner was evaluated by Dr. Charles Liang at Carle Convenient Care. Petitioner complained of right shoulder pain after lifting pasta at work. She had been seen by Dr. Kaplan on January 24, 2013. She was previously given Demerol for her migraines and her shoulder pain got better until the 24th when she noticed, while pushing off a chair, that she experienced a sharp pain in her right shoulder. The shoulder pain was made worse when letting her arm hang at her side. Dr. Liang's assessment was pain in joint, shoulder region and migraine. Petitioner was instructed to follow-up with her primary care physician for her shoulder pain and to work on range of motion shoulder exercises. (PX 2) Petitioner did not work that day. (RX 2, dep. ex. 4)

Petitioner worked on February 21, 22, 23, and 24th. (RX 2, dep. ex. 4)

Petitioner completed a First Report of Injury on February 24, 2013. Petitioner indicated that she sustained an injury while working at "Penne Lane" on January 24, 2013. Petitioner indicated "shoulder pain and something popped." She stated "everytime I lift that pasta basket and the pain get worse and mixing food in the pot make it hurt more and picking up basket or pushing heavy carts." Petitioner identified "Keith and Carrie" as witnesses. She also advised that she had been taken off work at Carle for three days. (RX 2, Depo exhibit 1).

Petitioner returned to Dr. Kaplan on February 26, 2013 with continued complaints of right shoulder pain. Petitioner reported that the right shoulder pain began four days after she was last seen by Dr. Kaplan. She "believe[d] hurt it at work." Petitioner explained that she worked for Respondent and cooks with increased lifting at work and stirring. Petitioner reported repetitively lifting and pouring contents into a pan. She estimated that baskets of pasta weighed about 15 lbs. On examination, Petitioner's right shoulder was tender and abduction of her right upper extremity to 130 degrees caused pain. Petitioner could abduct her left shoulder to 160 degrees. Dr. Kaplan's assessment was right shoulder pain with a question of a rotator cuff injury on the right. Dr. Kaplan recommended Methocarbamol and that Petitioner be seen by the Division of Physical Medicine & Rehab. Petitioner was instructed to follow up with Dr. Kaplan in four weeks. She was also put on restrictions of no lifting, pulling or pushing greater than 5lbs. for the next four weeks. (PX 2)

[2] Not a part of the record.

Petitioner underwent a right shoulder x-ray on February 26, 2013. It revealed minimal degenerative changes of the AC joint with slight irregularity of the articular surface of the clavicle. Dr. Kaplan reviewed the film and left instructions for Petitioner to be notified that the x-ray showed "a little arthritis" and that she should continue with the treatment plan they had previously discussed. (RX 4)

Petitioner was not working as of February 26, 2013.

Petitioner filled out a second First Report of Injury on February 27, 2013. At that time, Petitioner indicated that she had an injury to her right shoulder on January 23, 2013. She also indicated that she was not sure of the time of the accident. She stated that she used the date of January 24, 2013 because that was when she first saw the doctor. She reported that she felt some popping in her right shoulder when she would pick up baskets or pull anything that was heavy or stir the pots. (RX 2, dep. exhibit 3).

On March 1, 2013, Petitioner was evaluated by Dr. Jian Li at the Carle Division of Physical Medicine & Rehabilitation for her right shoulder pain. Petitioner reported that she was required to put pasta into a big basket and put the basket into hot water and then bring it up and pour it into a pan. She indicated that she performed that repetitively from 4:00a.m. to 8:00a.m. and that the pasta basket weighed between 15-20 lbs. She further reported that she felt a pop in her right shoulder when she was picking up a basket of pasta on January 23, 2013 and that she had been having pain in her right anterior shoulder since that time. She also reported tingling in her right hand with occasional numbness. Dr. Li reviewed the x-ray from February 26, 2013 which showed minimal degenerative changes of the AC joint in the right shoulder. Dr. Li's impression was right shoulder sprain/strain/rotator cuff syndrome. Petitioner was advised to undergo a course of physical therapy and instructed to use over-the-counter medications like Ben Gay topically as well as heat to help the pain. Petitioner was instructed to return in five weeks after she finished her course of physical therapy. (PX 2)

Petitioner was next evaluated by James Berkes, PA-C.[3] at the Carle Division of Orthopedics on March 4, 2013. By history, Petitioner had previously undergone a reconstruction of her ECU tendon sheath of the right wrist per Dr. Sobeski. Petitioner was presenting with an unrelated issue on the 4th as she was now experiencing numbness and tingling in her right hand which would awaken her at night. She indicated that all the fingers on her right hand were going numb. On examination, Petitioner had a positive Tinel over the median nerve, a positive median nerve compression test, a positive Phalen's test, a positive Tinel over the ulnar nerve at the elbow, and a positive elbow flexion test. The ECU tendon was not giving her too much trouble and it appeared to have healed nicely. Mr. Berkes indicated that Petitioner likely had a carpal tunnel and cubital tunnel in her right upper extremity. Petitioner was advised to try night splints and a pad at the elbow. Petitioner was instructed to follow-up in 6-8 weeks.

[3] Dr. Sobeski's PA-C.

Petitioner was fitted for right elbow pads, one which was to be worn during the day and the other at night. She was also given a cock-up splint for her wrist at night. (PX 2)

On March 6, 2013, Petitioner was evaluated by Dr. David Zeman at the Carle Orthopedic Department. Petitioner provided a history of right shoulder pain which she attributed to "pasta." Petitioner reported that she returned to work in December and that her shoulder pain has been hurting since then. She also reported some pain and swelling at her sternoclavicular joint while she was in the shower at home around February 26, 2013 but no other injuries had occurred. On examination, Petitioner had diffuse tenderness over the shoulder and impingement maneuvers were painful. Dr. Zeman's assessment was subacromial bursitis and he provided Petitioner with an injection of Depo-Medrol into the subacromial bursa. Petitioner was instructed to resume her physical therapy. (PX 2)

Petitioner presented for physical therapy at Carle on March 11, 2013 per Dr. Li. Petitioner reported burning and throbbing pain in the medial /anterior region of her right shoulder. Aggravating factors included driving and lifting. Decreased use of the shoulder and heat helped. Petitioner reported difficulty sleeping due to pain. The therapist noted Petitioner's right shoulder active range of motion and strength decreased by pain. All provocative testing was positive indicative of diffuse soft tissue involvement. Petitioner was noted to be limited in her ability to perform activities of daily living. Petitioner was to attend therapy two times a week for 6-8 weeks. (PX 2)

Petitioner attended physical therapy on March 18, 2013 and March 21, 2013. Her complaints focused on her right shoulder blade and included a burning and numbness sensation. On the 18th Petitioner mentioned a "new onset" of numbness and tingling in her right hand since the shoulder pain began. Lifting things, housework, and picking up her grandchild were most bothersome. (PX 2)

On March 21, 2013 Petitioner signed her Application for Adjustment of Claim in case # 13 WC 09757. She alleged that she was "injured at work" on January 23, 2013 sustaining injuries to her "right shoulder and body." (AX 2)

Petitioner worked for thirty minutes on March 28, 2013. (RX 2, dep. ex. 4)

Petitioner returned to Dr. Kaplan at Carle Family Medicine on March 29, 2013. At that time, Petitioner continued to complain of shoulder pain unrelieved by the recent injection. She reported "increase carrying of objects." The office note further states, "Patient told she needs to work everywhere in kitchen without restrictions if works." He also noted, "increased stirring at work." Dr. Kaplan's assessment was a right shoulder soft tissue injury. Dr. Kaplan encouraged Petitioner to keep her appointment with Physical Medicine & Rehab and restricted her from working until the end of April 2013. (PX 2)

Petitioner attended physical therapy on March 29, 2013 reporting that her shoulder pain had "flared up" but she didn't know why. She had seen her doctor earlier that day "and states job won't let her work with restrictions." The therapist noted that all exercises that day continued to give Petitioner pain in her anterior shoulder and numbness down into her right hand. (PX 2)

On April 2, 2013, Petitioner returned to Dr. Li. Petitioner reported ongoing pain in her right anterior shoulder which sometimes radiated to the dorsal aspect of her right wrist with associated pain in her hand with numbness. Dr. Li's impression was right shoulder sprain/strain/rotator cuff syndrome. Petitioner was advised to undergo an MRI of her right shoulder. Dr. Li was interested in whether Respondent would accommodate her restrictions. Petitioner indicated that she has not been able to work in the last month and that she was trying to apply for disability. (PX 2)

Petitioner attended physical therapy on April 4, 2013 reporting an upcoming MRI and noting that when she woke up in the morning her shoulder would be "really killing her." During passive range of motion exercises Petitioner noted popping in her clavicle. She continued to have pain with all exercises and described a burning sensation down her arm. (PX 2)

Petitioner underwent physical therapy on April 8, 2013 reporting her sleep was continuing to be disturbed and that she was unable to work. Petitioner asked about her right clavicle being higher than her left and the therapist noted it did appear more prominent. Petitioner related pain with all exercises. (PX 2)

On April 8, 2013 Petitioner called Dr. Li's office to inquire whether or not he had received a letter from Respondent regarding her disability. Dr. Li was subsequently given the paperwork. (PX 2)

Petitioner met with Physical Therapy on April 10, 2013 for an evaluation due to right shoulder pain. Petitioner reported occasional radiating pain down into her hand. She continued with poor posterior glenohumeral mobility and had not tolerated strengthening well. The therapist suggested further medical evaluation to rule out cervical pathology. She was to be seen two times a week for 4-6 weeks. (PX 2)

Petitioner returned to physical therapy on April 11, 2013 reporting her "whole body" hurt. Petitioner described pain with all movements. She was scheduled to undergo an MRI that afternoon. (PX 2)

Petitioner underwent her right shoulder MRI later that same day (April 11, 2013). The radiologist's impression revealed no evidence of a full thickness rotator cuff tear, mild degenerative tendinopathy related to the rotator cuff, and some mild hypertrophy of the AC joint and spurring of the distal acromion. (PX 2)

On April 12, 2013 Petitioner was contacted by Dr. Li's office and notified that Respondent would not process her disability request unless she had been off work for 61 days or more. Petitioner advised she would reach that point near the end of the month and that Respondent had recommended that she apply. Petitioner was also told that the doctor's office had received information in the form of a job description without any specific questions for the doctor to complete. (PX 2)

Petitioner attended physical therapy on April 15, 2013 reporting no change in her shoulder pain. The therapist noted that Petitioner continued to demonstrate symptoms suggestive of cervical pathology including burning/tingling down to her hand. (PX 2)

According to a medical note dated April 15, 2013 Nurse Skaggs (Dr. Li's office) spoke with Tricia Rothermel from Respondent's HR Department that day regarding an update on Petitioner's work status. Ms. Rothermel advised that currently it had a note from Dr. Li that Petitioner was to remain off work through the end of April but she also had another note from the doctor sating that Petitioner had to be off work because she reported that Respondent didn't allow her to work with restrictions. Ms. Rothermel wished to clarify the situation as Respondent was willing to try and accommodate restrictions but it needed to know what the specific restrictions were. A job description had been sent to the doctor to advise him of Petitioner's job duties so restrictions could be specified. Ms. Rothermel also reported that Petitioner would not qualify for disability until she had been off work for at least 61 days. Dr. Li subsequently issued a note on April 16, 2013 outlining restrictions. (PX 2)

Petitioner returned to physical therapy on April 18, 2013 reporting her shoulder was still the same and that the doctor thought she had biceps tendonitis. Petitioner was to undergo ultrasound and ionto to her shoulder. Wall push-ups were discontinued due to pain. (PX 2)

Petitioner returned to work for Respondent on April 22, 2013 with restrictions. She worked April 22, 23, 25, and 26th. (RX 2, dep. ex. 4)

Petitioner worked April 29 and 30, 2013. (RX 2, dep. ex. 4) Petitioner worked May 1, 2, and 3, 2013. (RX 2, dep. ex. 4)

On May 6, 2013, Petitioner returned to James Berkes, PA-C. at Carle Orthopedic Department. Petitioner reported ongoing numbness and tingling in her right hand, mostly in the ring and small finger. On examination, she had a positive Tinel over the ulnar nerve, a positive Tinel over the median nerve at the wrist, and a positive median nerve compression test. Petitioner was advised to undergo a nerve conduction study and to return to Dr. Sobeski after the study. (PX 2)

Petitioner worked May 6, 7, and 8, 2013. (RX 2, dep. ex. 4)

On May 8, 2013, Petitioner underwent an EMG with Dr. Khosrowshahi at Carle Physicians Group. By history, Petitioner reported numbness and tingling of the fourth and fifth digits for two months after shoulder injury. Dr. Khosrowshahi's impression was a normal electrodiagnostic study of the right upper extremity with no evidence of ulnar or median entrapment neuropathy or other abnormalities. She reported numbness and tingling of digits 4 and 5 for two months post shoulder injury. (PX 2)

According to a May 10, 2013 Physical Therapy Discharge Note Petitioner was certified for shoulder therapy from May 10, 2013 through June 9, 2013. (PX 2)

Petitioner worked 7.4 hours on May 10, 2013. She then began her seasonal lay-off. (RX 2, dep. ex. 4)

Petitioner returned to see Dr. Sobeski on May 20, 2013. Dr. Sobeski reviewed the EMG, summarizing it as unremarkable. Petitioner indicated that she did not want to do anything further about it and Dr. Sobeski concurred. Petitioner was instructed to follow-up if needed. (PX 2)

On June 11, 2013, Petitioner was re-evaluated by Dr. Li at the Carle Division of Physical Medicine and Rehabilitation. At that time, Petitioner indicated that physical therapy had not really helped her shoulder pain. She indicated that she had been off work since the middle of May and was wondering if her restrictions would continue when she went back to work in the middle of August. She further indicated that she was able to do her job but it still hurt when she did things with her right arm, especially sweeping and mopping. Petitioner refused a cortisone injection. Dr. Li recommended additional physical therapy and a possible functional ability evaluation regarding her restrictions. Petitioner was instructed to follow-up at the beginning of August. (PX 2)

Petitioner underwent a physical therapy evaluation at Carle Therapy Services on July 9, 2013. In conjunction with the evaluation Petitioner completed a Penn Shoulder Questionnaire. By history, Petitioner reported ongoing right shoulder pain since January. Petitioner stated that her pain began with picking up pasta baskets at work repetitively. Petitioner described right-sided clavicle pain, "feels like it is on fire." The burning sensation was deep in the shoulder and along her right collar bone. She also reported elbow and wrist pain (carpal-tunnel like symptoms) which she felt unrelated to her current shoulder pain. Petitioner reported her shoulder pain had remained unchanged since her last therapy sessions in April stating that it "did help but it didn't." Petitioner also reported daily migraine headaches and periodic neck pain. Petitioner reported being able to perform activities of daily living albeit with pain. She was limited with heavier lifting due to pain and subjective weakness. Washing the bathtub out was painful and she would wake up during the night due to pain in her shoulder. Petitioner was noted to be employed by Respondent in food services which required repetitive lifting and carrying at waist level or above. On examination Petitioner was noted to have decreased cervical range of motion. The therapist noted concern for cervical pathology given the cervical

and right arm symptoms and the fact therapy had not previously helped Petitioner's symptoms. Petitioner was advised to undergo additional skilled physical therapy to address her ongoing complaints of right shoulder pain. (PX 2)

Petitioner underwent physical therapy on July 11, 2013 reporting she was doing fine with the ionto patch but it would fall off due to sweating. Petitioner reported constant numbness and tingling in her right 4th and 5th digits, more so at the end of the day. Petitioner also reported that her elbow would hurt when her fingers would go numb. The therapist noted Petitioner had cervical segmental hypomobility and symptoms suggestive of a nerve root or peripheral nerve root issue. Past EMG studies had been negative for ulnar or median nerve problems. It appeared unclear to the therapist whether Petitioner's shoulder symptoms were a separate issue or possibly being exacerbated by a cervical pathology. Ultrasound was performed to the biceps tendon area that day as she reported pain and tenderness in that region. (PX 2)

Petitioner attended physical therapy on July 19, 2013. She reported sleeping on her right side the night before resulting in a "really sore" shoulder with numbness and tingling down to her hand. Petitioner didn't feel ultrasound was very beneficial but found relief with the ionto patch; however, it didn't stay on due to sweating. Despite therapy that day, Petitioner's pain remained unchanged. (PX 2)

Petitioner reported to physical therapy on July 22, 2013. Her shoulder complaints remained and mid-afternoon and evening numbness and tingling was also noted. (PX 2)

At her July 25, 2013 physical therapy session Petitioner reported right shoulder pain but no numbness or tingling except in the mid-afternoon and evenings. With some of her exercises she did notice a decline in the frequency of her numbness and tingling. Over all, Petitioner felt therapy had been slightly helpful, but not significantly. The therapist noted Petitioner was not responding well to ultrasound so it was deferred at that session. Her symptoms were noted to be reproduced by cervical motions, including right side bends and right side bends with flexion/extension. Petitioner also had a positive Spurling's sign on the right. (PX 2)

On July 25, 2013 Petitioner's physical therapist called Dr. Li's office reporting on Petitioner's p.t. progress. She specifically noted that Petitioner had poor tolerance with ultrasound and increased cervical pain. She further noted that cervical motion caused an increase in Petitioner's pain so the therapist was uncertain whether Petitioner's pain was shoulder or neck related. The therapist further noted some neurological symptoms in Petitioner's right hand and wanted Dr. Li's thoughts. Dr. Li subsequently replied that the therapist could look at his notes and the EMG report. He would discuss the matter with Petitioner at their next appointment. (PX 2)

Petitioner returned to physical therapy on July 29, 2013 reporting ongoing shoulder pain. The therapist noted, "She states she was cuddling with her grandchild and had onset of increased [right upper extremity] numbness and tingling, along with pain." The therapist also

noted Petitioner continued to demonstrate neural tension in supine position that was most affected by cervical position. (PX 2)

Petitioner underwent physical therapy on August 5, 2013 reporting posterior shoulder pain. The therapist noted, "States she helped her daughter move over the weekend and she kept yelling at her to stop carrying things." Petitioner also reported seeing the doctor on Wednesday and would find out if she could return to work "or with modified lifting." (PX 2)

On August 7, 2013, Petitioner returned to Dr. Li. At that time, Petitioner reported that physical therapy was helping but that she still had pain in her right shoulder. Petitioner further indicated that she was returning to work on August 16, 2013 and wanted to discuss restrictions with the doctor. Dr. Li's impression was right anterior shoulder pain and he recommended Petitioner undergo a functional ability evaluation and follow-up with Dr. Zeman. Petitioner remained on a 10lb. weight restriction. (PX 2)

At Petitioner's August 8, 2013 physical therapy session, the therapist noted Petitioner had experienced fair to poor tolerance with ultrasound and was reporting increased pain, at times, with treatment. Petitioner was also unable to tolerate many of the scapular exercises. Petitioner reported pain averaging "6/10" in the right anterior shoulder. She was also reporting numbness and tingling in the 4th and 5th digits of her right hand and right elbow pain. Spurling's test was positive. Petitioner also had a positive ULTTA, and a positive response to cervical distraction, more consistently suggesting radiculopathy v. nerve compression or a true shoulder impingement of RTC issue. Further medical examination and inquiry was suggested. Additional therapy for the shoulder wasn't felt to be beneficial due to lack of progress. Petitioner was to undergo an FAA for functional assessment for return to work. (PX 2)

Petitioner resumed working for Respondent on August 16, 2013. She worked that day followed by August 19, 20, and 21. (RX 2, dep. ex. 4)

On August 21, 2013, Petitioner was re-evaluated by Dr. Zeman for ongoing right shoulder pain. Dr. Zeman's assessment was right shoulder impingement. Petitioner was advised to undergo additional therapy, including rotational strengthening for her right shoulder. (PX 2)

Petitioner worked August 22 – 26, 2013. (RX 2, dep. ex. 4)

At her August 27, 2013 physical therapy visit Petitioner reported having returned to work and noticing increased pain with work activities (repetitive lifting and draining of pasta baskets). Petitioner had been given updated orders to continue skilled physical therapy with a focus on strengthening. Pain with using her arm cross body and overhead was also noted. Petitioner reported numbness and tingling of her 4th and 5th digits of her right hand mostly at night which "comes and goes." (PX 2)

Petitioner worked August 29 through September 2, 2013 and September 5 – 9th . (RX 2, dep. ex. 4)

Petitioner attended physical therapy on September 10, 2013 reporting anterior-superior shoulder pain with good days and bad days. On a good day at work she felt her pain was a "5/10." On a bad day at work it could increase to "8/10" if lifting the pasta basket. (PX 2)

Petitioner worked September 12, 2013 and then September 19 through the 23rd. (RX 2, dep. ex. 4) During this time Petitioner took some time off for funeral leave. (RX 2, dep. ex. 4)

When Petitioner returned to physical therapy on September 24, 2013 she reported ongoing shoulder pain. (PX 2)

Petitioner attended physical therapy on September 25, 2013. The therapist noted Petitioner had only completed two visits in the past month. She was progressing well with her exercise progressions although her pain remained relatively unchanged. Petitioner reported that work activities continued to exacerbate her pain as she had returned to work and now her shoulder hurt again. Petitioner noted less numbness and tingling as it only occurred at night. The goal was to continue transitioning Petitioner to an independent program over the coming weeks. Petitioner reported her worst pain (8/10) with lifting pasta baskets at work. (PX 2)

Petitioner worked September 26 through the 30th, October 3rd and October 5 through October 7. (RX 2, dep. ex. 4)

Petitioner returned to physical therapy on October 8, 2013 reporting she was now in a different position at work and no longer working on the pasta line anymore. She was now in the soup station which required her to open many cans with a large can opener and it required a "repetitive rotary motion" on her shoulder at waist height. She was feeling a little better at the new station but still noticing pain. (PX 2)

Petitioner worked on October 10th and 11th. (RX 2, dep. ex. 4)

At her October 10, 2013 physical therapy session Petitioner reported speaking with her boss at work in an attempt to get a different position other than the pasta bar because every time she went back to work her pain worsened. Petitioner's hand numbness was getting better until two nights earlier when she woke up with bilateral hand numbness. Petitioner noted she had not done anything different the day before except for work. (PX 2)

Petitioner worked October 13th and 14th. (RX 2, dep. ex. 4)

Petitioner attended physical therapy on October 16, 2013 reporting she was still working at the "new position" at work and not lifting as much. She was feeling a little stronger. Petitioner

continued to report "burning" pain with exercises and bilateral numbness and tingling. She was advised to follow up with her provider regarding these symptoms. (PX 2)

Petitioner worked October 17th through the 21st and October 24 through the 26th. She also worked October 27th. (RX 2, dep. ex. 4)

On October 29, 2013, Petitioner attended physical therapy and was discharged from same. Petitioner reported that she was getting a little stronger and was doing better at work because she didn't have to lift the pasta buckets the same way. Petitioner reported performing her home exercises. From July 9, 2013 to October 29, 2013, she had completed fifteen sessions of physical therapy. At that time, it was determined that Petitioner had reached her maximum functional potential and that her job description had changed allowing her to avoid the aggravating activity of lifting pasta baskets which helped reduce her pain. Her pain level remained a "5/10." Petitioner was discharged to an independent home exercise program. (PX 2)

Petitioner's time records show she worked November 2 – 4th and November 14th – 19th. She also worked November 21 - 22 and December 1 and 2nd. (RX 2, dep. ex. 4)

After her discharge from physical therapy on October 29, 2013, Petitioner had no further medical care until she returned to Dr. Zeman on December 4, 2013 complaining of a burning pain in her right shoulder with symptoms going down into her forearm and hand. Petitioner was still working but finding it difficult to open cans and handle objects weighing more than 10lbs. On examination, she had good internal and external rotational strength and no instability with anterior or posterior stressing of the shoulder. Dr. Zeman's assessment was right shoulder pain which had been refractory despite extensive physical therapy and anti-inflammatory measures. Dr. Zeman released Petitioner with permanent restrictions against lifting more than 10 lbs. with her right upper extremity. Petitioner was discharged from his care. (PX 2)

Petitioner worked on December 4, 2013. (RX 2, dep. ex. 4)

Petitioner called Dr. Zeman's office on December 5, 2013 reporting that the doctor had seen her the day before and given her a note stating she could not lift more than ten pounds on a permanent basis. He had dated the note and Petitioner believed it looked like that would be the date her restriction ended. She needed an undated slip stating she had a permanent work restriction of 10 lbs. (PX 2)

Petitioner worked on December 5th and 6th. (RX 2, dep. ex. 4)

On December 7, 2013 Petitioner presented to the emergency room at Carle Clinic regarding hand pain. According to the history, Petitioner noted hand pain which had started two hours earlier while at work and "every time she was dipping vegetables at work [she] was getting shocking pain from [her] right hand to [her] elbow." Petitioner explained that she was experiencing intermittent numbness aggravated by repetitive motion. She reported right hand

numbness and waking up at night with numbness in the 4th and 5th digits of her right hand. Petitioner also reported some shooting pains up the right forearm. She denied any specific injury. Petitioner denied any history of carpal tunnel syndrome. On examination Petitioner had positive Tinel and Phalen signs in the right hand. The physicians' assistant believed Petitioner probably had carpal tunnel syndrome. Petitioner was given a wrist splint and released to modified work/school activity and told to avoid repetitive motion (5 or more per minute) of the right hand. (PX 2, pp. 4-10)

Petitioner worked on December 8, 2013. (RX 2, dep. ex. 4) On December 8, 2013, Petitioner filled out a First Report of Injury. Petitioner stated that she sustained an injury to her right hand on December 7, 2013 in the kitchen at IKE. Petitioner further stated that she was dipping up the veggies and got a sharp pain going from her hand to her elbow. (PX 6)

Petitioner worked on December 9, 2013. (RX 2, dep. ex. 4)

On December 11, 2013, Petitioner was evaluated by James Berkes, PA-C. at the Carle Hand Surgery Orthopedic Department. Petitioner indicated that she was having ongoing trouble with her right upper extremity, including associated numbness and tingling in the ring and small fingers which would awaken her at night. She also stated that she found doing any type of repetitive use with her right arm caused a shocking pain up to her elbow and even into the shoulder at times. On examination, Petitioner had a positive Tinel over the median nerve at the wrist, a positive median nerve compression test, a positive Phalen test, and a positive Tinel over the ulnar nerve at the elbow. Mr. Berkes indicated that her exam and symptoms were consistent with carpal tunnel and cubital tunnel syndrome, that Petitioner had failed conservative treatment and that she was ready to proceed with surgical treatment. Petitioner was scheduled for surgery with Dr. Sobeski. (PX 2)

Petitioner worked on December 12, 13, 14, 15, and 16th, 2013. Petitioner did not resume working for approximately one more year. (RX 2, dep. ex. 4)

On December 17, 2013 an office note was entered indicating Petitioner was ready to schedule surgery. (PX 2, p. 65/106) A subsequent message stated that if Petitioner was pursuing workers' compensation she needed to speak with June Bryant in the office. Petitioner subsequently phoned back advising that she was scheduled for surgery with Dr. Sobeski on January 17, 2014 and was going to use her personal insurance as workers' compensation had denied her claim. Petitioner was later contacted and told a note with restrictions of "left hand work only" could be picked up. Petitioner then phoned back and stated "no longer work comp." (PX 2, pp. 64-65/106)

On December 30, 2013 Petitioner signed a new Application for Adjustment of Claim in case #14 WC 000012. Petitioner alleged an accident date of December 7, 2013 and claimed she was "injured at work" sustaining injuries to her "right hand, right arm and whole body." (AX 4)

Petitioner underwent a pre-operative exam at Carle on January 13, 2014. She was cleared for surgery at that time.

PA-C. Berkes examined Petitioner on January 15, 2014 in regard to Petitioner's left elbow. He noted she was scheduled for surgery in the near future (right side). In light of her positive findings on the left side Mr. Berkes noted she probably had left carpal tunnel and cubital tunnel syndrome as well and might need surgery on that side too. She declined an injection for the left wrist. (PX 2)

On January 17, 2014, Petitioner underwent a right carpal tunnel release and right cubital tunnel release with subcutaneous ulnar nerve transposition per Dr. Sobeski at Carle Foundation Hospital. The pre-operative and post-operative diagnosis was right carpal tunnel syndrome and right cubital tunnel syndrome. Intra-operatively, Dr. Sobeski noted that there were no abnormalities visualized within the median nerve. (PX 2, p. 18)

Petitioner returned to James Berkes, PA-C. , on January 29, 2014. At that time, Petitioner was 12 days status post right carpal tunnel release and right cubital tunnel release. Petitioner reported that she was doing very well and the numbness and tingling in her hand was improved. Petitioner inquired about physical therapy and Mr. Berkes indicated that Petitioner could contact them if she was interested in that option. Petitioner was restricted to left hand work only and was instructed to follow-up in four weeks. (PX 2)

Petitioner telephoned PA-C. Berkes' office on February 17, 2014 requesting that an order for right elbow and hand therapy be put in line. An order was entered the next day. (PX 2, p. 73/106)

At the referral of Dr. Sobeski, Petitioner underwent a physical therapy evaluation at Carle Therapy Services on February 20, 2014. Petitioner reported ongoing achiness in her hands and stabbing elbow pain post-surgery. Petitioner was instructed to undergo skilled physical therapy 2-3 times a week for 4-6 weeks to work on scar massage, desensitization, and strengthening. (PX 2)

The February 25, 2014 Occupational Therapy note indicates Petitioner's overall pain complaints were rated "6/10." She was having difficulty brushing her hair and teeth. Petitioner reported elbow pain and marked hypersensitivity at the incisional sites for her wrist and elbow. (PX 2)

Petitioner attended occupational therapy on February 27, 2014 reporting her arm would hurt quite a bit at night. She described stiffness and achiness. "She states that at night if her body gets chilled, the chill goes to her arm and then it gets warm almost like there is a fever in it." Objectively, Petitioner had good range of motion of her elbow, wrist and forearm although she described ongoing pain and sensitivity. (PX 2)

Petitioner attended occupational therapy on March 6, 2014 reporting that her symptoms were unchanged since her last visit. Petitioner reported both hands were bothering her and the pain was worse at night. Petitioner had good range of motion and expressed the belief that if her elbow pain would go away she would be pretty happy. (PX 2)

Petitioner called Dr. Sobeski's office on March 11, 2014 regarding when she could return to work and under what restrictions. As of January 29, 2014 Petitioner had been limited to left hand work. The March 4, 2014 office note did not mention work or work restrictions. P.A. Berkes advised Petitioner that she could return to work if she wished. When the nurse notified Petitioner of the foregoing, Petitioner advised the doctor's nurse that she did not wish to go back to work until after completing her occupational therapy and seeing the doctor. A note was left for her to pick up. (RX 4; PX 2, p. 74/106)

According to the March 13, 2014 Occupational Therapy note for her hand, Petitioner was reporting pain in her shoulder that would "come and go." If she wrapped it up and had some compression on it, it felt better. Petitioner reported that she was seeking disability because of a right shoulder injury that occurred before she had surgery on her arm. According to Petitioner she was on a ten pound permanent lifting restriction and because of that she wouldn't be able to return to her job. (PX 2)

Petitioner presented for occupational therapy on March 20, 2014 in regarding to her elbow and hand. Petitioner reported that driving bothered her medial epicondylitis and her hands. (PX 2)

Petitioner presented to Occupational Therapy on March 21, 2014. Petitioner reported being off work due to a ten pound lifting restriction. Petitioner wished to get back to work. Petitioner was to be seen 2-3 times a week for three weeks. (PX 2)

Petitioner returned to Occupational Therapy on March 25, 2014 reporting the inability to lift a bottle of bleach or gallon of milk with her right upper extremity. Petitioner expressed concern about her scars' appearance. (PX 2)

According to the March 27, 2014 Occupational Therapy report, Petitioner's overall pain complaint score ("6-7/10") remained unchanged. Her pain was reportedly worse at night and the night before she felt like someone was stabbing her in the arm. (PX 2)

At her occupational therapy visit of April 3, 2014 Petitioner reported distal symptoms 75% of the day and increased pain when lifting grocery bags. Strengthening exercises were limited that day. (PX 2)

Petitioner again went to occupational therapy on April 7, 2014 reporting increased pain when pulling wet clothes out of the washer. She described the worst pain when sleeping as it frequently awakened her. Petitioner did not think her pain medication was working. (PX 2)

Petitioner telephoned PA-C. Berkes' office on April 11, 2014 requesting that her Norco be increased to 7.5 mg and that an order be put in place for left arm therapy. The medication request was denied and the therapy request would be addressed at their next visit. (PX 2, p. 76/106)

On April 16, 2014, Petitioner was re-evaluated by James Berkes, PA-C. Petitioner reported that she was still having pain at the medial aspect of her right arm. Mr. Berkes indicated that she could either continue the physical therapy or transition into a home exercise program. He kept Petitioner off of work and instructed her to follow-up in six weeks. (PX 2)

On April 17, 2014, Petitioner returned to Dr. Zeman at Carle Orthopedics Department. Petitioner indicated that Respondent had sent her back to Dr. Zeman to confirm the restrictions. Petitioner reported ongoing right shoulder pain. On examination, Petitioner had maximum pain and tenderness in the area of her right acromioclavicular joint. Dr. Zeman's assessment was refractory chronic right shoulder pain with early acromioclavicular arthropathy. Petitioner was referred to Dr. Bane for a surgical evaluation. (PX 2)

On April 29, 2014, Petitioner was discharged from physical therapy. At that time, she had completed approximately one month of physical therapy. She reported ongoing pain in her elbow with marked hypersensitivity at the incisional wrist and elbow scars. Petitioner was instructed in a home exercise program of nerve gliding and stretching. (PX 2)

On May 8, 2014 Petitioner was diagnosed with a closed fracture of the middle or proximal phalanx or phalanges of a hand. (PX 2 – identified periodically in Petitioner's "Problem List")

Petitioner was examined by PA-C. Danny McFarlin[4] on May 12, 2014 upon the referral of Dr. Zeman due to right shoulder pain described as a burning sensation mostly up over the anterior and superior aspect of the shoulder. Petitioner reported suffering an injury to her shoulder a little over a year before while working for Respondent. Petitioner stated she had to lift noodles, with her arms extended, out of the cooking apparatus and she injured her right shoulder doing so. Petitioner had undergone therapy and had received an injection by Dr. Zeman into the subacromial space. That had been some time ago. Petitioner noted she had some improvement in pain but then more recently underwent carpal tunnel and cubital tunnel syndrome with Dr. Sobeski and since then she had noticed increased pain in her shoulder area. Petitioner also complained of a little bit of pain on the opposite side with some occasional neck pain, again described as a burning sensation. Petitioner reported difficulty sleeping at night due to right shoulder discomfort. Hydrocodone was effective at taking the edge off and she was taking Lyrica for her fibromyalgia. She denied any left arm numbness or tingling. On examination Petitioner had some mild tenderness on palpation over her lower cervical spine and upper thoracic spine with mild tenderness on palpation of the right trapezius muscle. She

[4] Dr. Bane's PA-C.

had anterior tenderness very specifically over the long head of the biceps tendon. She also had pain at the upper ends of each range of motion exercises and pain with flexion at the elbow against resistance over the anterior portion of the upper arm and shoulder. X-rays did not show significant arthritic changes. The AC joint looked a little wide. Her April 11, 2013 MRI showed mild hypertrophy of the AC joint and very mild tendinopathy. The biceps tendon and rotator cuff appeared normal. PA-C. McFarlin's impression was right shoulder pain possibly coming from the biceps tendon. He also questioned if some of her pain was cervical in nature especially since she described burning pain. He recommended a cortisone injection over her biceps tendon which she was willing to try. If she saw no improvement McFarlin suggested a referral to Dr. Bane to determine if she had a shoulder v. neck issue. The cortisone injection was given. If she saw no improvement in two weeks, she was to call for an appointment with Dr. Bane. (PX 2)

Petitioner was examined by PA-C. James Berkes of the Hand Surgery Division of Orthopedics on May 28, 2014. Petitioner was being re-examined for a recheck of her right arm and right finger. Petitioner reported her ring finger was doing much better although she still had a little stiffness in the PIP joint. X-rays showed no subluxation so she was advised to keep working on range of motion. No instability of the finger was noted. With regard to her arm, PA-C. Berkes noted Petitioner still had some tenderness about the medial aspect of her elbow where her scar was located. She had already been to therapy but didn't want to do that again. Her numbness and tingling had resolved. The only thing still present was "a bit of pain and she does not feel like she has gotten all of her strength back yet." She was told to keep working on it and remain on her 10 lb. lifting restriction for the right arm. She was to return as needed. (PX 2)

Dr. Bane examined Petitioner on June 16, 2014. According to his office note Petitioner initially had an injury on January 23, 2013 while picking up a pasta basket weighing 15 to 20 lbs. to pour into water. She had undergone physical therapy and been treated by Dr. Zeman for subacromial bursitis. Petitioner had also undergone an injection. Dr. Zeman didn't feel Petitioner needed surgery based on Petitioner's MRI and recommended physical therapy. As of December 4, 2013 he imposed a permanent ten pound lifting restrictions and "Once those were placed her job was terminated." The doctor thought, based upon Petitioner's history to him, that she then continued on with her shoulder and her symptoms improved a little just with the rest from not working. Petitioner then had surgery with Dr. Sobeski and saw Dr. Zeman once more at which point he referred her to Dr. Bane. She also saw Dr. Bane's assistant, PA-C. McFarlin on May 12, 2014 and he injected her shoulder which helped for a couple of weeks. Petitioner's May 12, 2014 x-rays showed no changes. He didn't have a new MRI to review. Dr. Bane felt her MRI showed some rotator cuff tendinopathy and some AC arthritic changes. Her exam was positive for tenderness over the bicipital tendon region and AC joint but no evidence of a frozen shoulder. She was uncomfortable with forward flexion and abduction. Dr. Bane wrote, "At this point [Petitioner] has been having a problem with her shoulder that seemed to start initially as a work related accident in January of 2013." He felt her permanent restriction was premature as he recommended arthroscopic surgery. He added, "I think she most likely sustained a strain of her rotator cuff at that time [the accident] that has triggered a bout of subacromial bursitis we have not be able to get better with conservative care. I think that

likelihood of success is reasonable and I do not think it would be fair for her at the age of 46 to simply put limitations on her at this time, without attempting this procedure." Petitioner wished to proceed and was going to use her regular insurance as it sounded like the "work comp aspect of this is still open." (PX 2)

On July 15, 2014, Petitioner underwent a pre-operative exam at Carle. At that time, Petitioner was cleared for surgery. (PX 2)

Petitioner was examined by Dr. Dru Hauter on July 21, 2014 at the request of Respondent. By history, Petitioner reported that she was working the pasta line and started noticing some pain in the right shoulder after dunking the 20lb. basket of pasta into the hot water at the food line. She further stated that the pain would come and go with lifting or with certain positions. Dr. Hauter reviewed several medical records and listed those in his report. Petitioner underwent a physical examination with Dr. Hauter. Dr. Hauter's impression was right shoulder hypertrophic degenerative disease causing impingement syndrome. He opined that there was no evidence of an acute injury and that her problem was degenerative and not a cumulative trauma condition. He opined that surgery was indicated but that the surgery was unrelated to her work for Respondent. Dr. Hauter further stated that the restriction of no above shoulder work was unrelated to Petitioner's work or an injury with Respondent. (RX 3)

Nurse Christine Manuel spoke with Petitioner on July 25, 2014. Petitioner reported being approved for her disability on June 19, 2014 but it had now been terminated as the company doctor stated she should be able to return to work until she had surgery on the 5th. She was trying to appeal the decision. Petitioner was wondering if Dr. Bane could issue a note on her behalf stating that she could not return to work before her upcoming surgery because she couldn't work with her arm. Dr. Bane replied to the inquiry stating, "there has been a lot of confusion on her case. Apparently Dr. Zeman put her on permanent restrictions and she was unable to work with that. All I can say is she has a 10 lb. lifting limit at this time and she should not do repetitive use of her shoulder or work over head. She will be having surgery on 8/5. Hopefully within 3-4 months post-op she would be able to return to regular work duties. I can't say she simply cannot work. I can say the above limitations and that if her employer is unable to accommodate them then she cannot work." Petitioner later called back needing clarification regarding the 10 lb. permanent v. short-term restriction. Petitioner was off work and had been told by "M Fitch" to call the doctor's office regarding a note indicating that she should remain off work as it could not accommodate her restrictions. Petitioner felt it made no sense to stop disability for one week and then restart it again after surgery. Nurse Manuel subsequently called "Melanie Fitch" and notified her of the doctor's position. Ms. Fitch stated nothing could really be done "but send her to a Functional capacity testing and by the time she get's [sic] scheduled for it, she will have had her surgery." Not much could be done except to let her undergo her surgery and re-apply for short-term disability. (PX 2, pp. 94-96/106)

Petitioner underwent right shoulder surgery on August 5, 2014. Petitioner underwent a right shoulder arthroscopy with subacromial decompression, distal clavicle resection, and

debridement of supraspinatus and superior labrum with Dr. Robert Bane. Dr. Bane's pre-operative and post-operative diagnosis was right shoulder partial thickness supraspinatus tear, a type 1 superior labral tear, and impingement and AC arthritis. (PX 2)

On August 12, 2014, Petitioner underwent a physical therapy evaluation at Carle Therapy Services for her right shoulder. As part of the process Petitioner completed a Penn Shoulder Questionnaire. Petitioner reported that she no longer had the burning pain she had been experiencing in her shoulder. At that time, Petitioner was instructed to undergo a course of skilled physical therapy two times a week for six weeks to address her right shoulder pain, range of motion, and strength. (PX 2)

Petitioner reported for physical therapy on August 14, 2014, noting her shoulder was hurting that day and she had taken some pain medication before coming. She was pretty tired after the last session. (PX 2)

On August 15, 2014, Petitioner returned to Dr. Bane. Petitioner reported that she was still fairly stiff and sore; however, her shoulder looked good clinically. Dr. Bane opined that Petitioner's shoulder problem was probably from her work-related exposure and he thought that her ultimate prognosis was good. Dr. Bane indicated that Petitioner would be off of work for approximately three months and instructed Petitioner to return for follow-up in four weeks. (PX 2)

Petitioner went to physical therapy on August 19, 2014. (PX 2)

Petitioner again reported to physical therapy on August 21, 2014 reporting that her right shoulder pain ("8/10") was affecting her sleep and waking her up at night. She wasn't taking any pain medication before her therapy session so she could drive. (PX 2)

At her August 27, 2014 therapy session Petitioner reporting a high level of shoulder pain that was still affecting her ability to sleep. She had also been doing more housework that had increased her pain. (PX 2)

When Petitioner went to therapy on September 3, 2014 she reported her scar was still sensitive and she was in moderate to increased pain depending on the day. She was continuing to notice a burning sensation in her shoulder. Functionally, she was able to do her hair. (PX 2)

That same day the therapist called the doctor's office indicating additional therapy would be appropriate as Petitioner's strength was still lacking. (PX 2, p. 98/106)

Petitioner attended therapy on September 10, 2014 reporting increased pain due to rain for the preceding last two days and difficulty sleeping. She was performing her home exercises as instructed. Petitioner remained functionally limited in lifting objects or carrying a gallon of milk. (PX 2)

Petitioner was examined by Danny McFarlin, PA-C., at Carle Orthopedic Department on September 12, 2014. Petitioner continued to complain of pain in her right shoulder. Mr. McFarlin's assessment was status-post arthroscopy of the right shoulder with ongoing pain. Petitioner was told to continue with her physical therapy. She was encouraged to decrease her medication intake. She was instructed to follow-up in six weeks. (PX 2)

Petitioner was seen in therapy on September 24, 2014 reporting that her exercises were going "okay" and her pain, while a "6-7/10" was going down. She had some trouble stirring while cooking the day before and had to be able to lift 25 – 30 lbs. for work as she could not perform light duty at work. She still complained of a burning sensation in her shoulder and reported difficulty holding her arm up to do her hair or lifting things around in her house. The therapist recommended decreasing the number of sessions per week to allow for the shoulder pain. (PX 2)

On October 8, 2014, Petitioner was discharged from physical therapy regarding her right shoulder. At that time, she had completed 9 sessions of physical therapy and had "no showed" for her last two appointments. She was discharged due to the physical therapy attendance policy. (PX 2)

Petitioner returned to Mr. McFarlin on October 24, 2014. Petitioner's Lyrica was refilled and she was instructed to return in four weeks. (PX 2)

Petitioner was examined by P.A. Swartz on November 17, 2014 in regard to hypertension and chest pain. Petitioner, who was familiar to P.A. Swartz as she had previously treated her for a number of years, was noted to have a long history of headaches, fibromyalgia and neuropathy in her legs. Petitioner advised the doctor that she had been recently going to see Dr. Hampton but wished to transfer her care back to the clinic. Petitioner was supposed to be on Lyrica but has issues getting it covered with her insurance. They discussed her blood pressure and heart issues with Petitioner reporting she couldn't get in to see Cardiology until January. She also mentioned straining her back doing some lifting about a week earlier. Back pain and leg tenderness was noted on exam. Blood pressure medication was prescribed and lab work ordered. (PX 2)

PA–C. McFarlin re-examined Petitioner on November 28, 2014 regarding her right shoulder. He noted she has "struggled with pain" which she described as a burning sensation over the anterior portion of her arm and shoulder. Petitioner related a history of neuropathy in her feet having once taken Lyrica with good results. Gabapentin caused headaches. A cortisone injection was offered but Petitioner declined it. On examination Petitioner had pain over the anterior portion of her shoulder and fairly good range of motion with flexion and abduction. Internal rotation was limited to the beltline. She was slightly decreased in flexion and in abduction due to pain but could get to 160 degrees, albeit uncomfortably. He noted no swelling. PA –C McFarlin recorded that "they" were trying to get Lyrica cleared for her. He felt she was getting

better and should continue to improve. He felt her restrictions should remain in effect. He wished to see her again in six weeks. Petitioner was to apply ice or heat to her shoulder as needed. (PX 2)

On December 8, 2014, Petitioner called Dr. Bane's office indicating that she was scheduled to return to work on December 9, 2014 but was requesting a note to keep her off of work since her shoulder continued to give her a lot of pain. Mr. McFarlin indicated that Petitioner could return to work with restrictions. (PX 2, p. 21/97)

Petitioner resumed working on December 9th and 10th of 2014. (PX 2, dep. ex. 4)

Petitioner was contacted by Dr. Bane's office on December 15, 2014 regarding the off-work slip previously requested. Petitioner reported she was back to work within her restrictions but still hurting really bad. (PX 2, p. 21/97)

Petitioner returned to PA –C. McFarlin on January 9, 2015. Petitioner indicated that she was getting a little bit better. She was back on the Lyrica which helped. She was also back to work with restrictions which he felt was also helping. On examination Petitioner had some pain at the upper ends of range of motion but improving. She had nearly full range of motion in flexion and abduction. She still reported pain on palpation over the anterior portion of her shoulder. He observed no swelling or pain on palpation to her neck or paraspinal musculature. PA-C. McFarlin advised Petitioner to get back into physical therapy since it had previously stopped because it was causing her more aggravation. Petitioner's light duty restriction of lifting no more than 10 lbs. was continued and she was instructed to return in six weeks. He gave her a script for Norco and told her to use it as infrequently as possible. (PX 2)

Petitioner worked January 18 - 21, 2015. (RX 2, dep. ex. 4)

Petitioner worked January 24 – 28, 2015. (RX 2, dep. ex. 4)

Petitioner underwent another physical therapy evaluation at Carle Therapy Services on January 27, 2015. Petitioner's complaints included ongoing shoulder pain which was aggravated by repetitive motions of cooking, combing hair, and putting on and taking off upper body garments. Due to difficulty sleeping Petitioner was sleeping on her right side with her right shoulder flexed more than 90 degrees and with her right wrist close to her right ear. Petitioner was instructed to undergo a course of skilled physical therapy two times a week for four weeks. Petitioner was working light duty with restrictions. (PX 2)

At her January 29, 2015 physical therapy session Petitioner reported right shoulder pain described as "10/10." (PX 2)

Petitioner worked January 31 and February 1, 2015. She also worked February 2 -4 and February 7 – 11, 2015. (RX 2, dep. ex. 4)

Petitioner attended physical therapy on February 6, 2015. (PX 2)

Petitioner was examined by P.A. Swartz on February 6, 2015 regarding bilateral foot pain, especially on the bottoms of her feet. Petitioner reported pain when waking up in the morning or if she has been sitting or standing. Petitioner had recently returned to work from a medical leave so she wasn't used to standing like that. Petitioner was also reporting bilateral hand pain and swelling. On examination Petitioner's hands displayed generalized swelling but no loss of strength. Her feet were tender to palpation on the bottom of both feet from her heels to the balls of her feet. She was diagnosed with plantar fasciitis, bilaterally, and instructed in the use of ice, stretching, and the need to refrain from going barefoot. Medication was given. (PX 2)

Petitioner worked February 14, 15, 16, and 18, 2015. (RX 2, dep. ex. 4)

On February 16, 2015 Petitioner returned to physical therapy reporting pain of "7/10." (PX 2)

Petitioner took a vacation day on the 17th (RX 2, dep. ex. 4)

On February 18, 2015 Petitioner again went to physical therapy with no changes being reported. (PX 2)

Petitioner was examined by PA-C. McFarlin on February 19, 2015 regarding her right shoulder. Petitioner reported no improvement from her physical therapy. Petitioner had good range of motion regarding flexion and abduction with pain being noted only at the upper ends. External rotation remained slightly decreased as was her range of motion internally with her arm behind her back. Petitioner also voiced pain over the anterior superior aspect of her shoulder. McFarlin suspected "a little adhesive capsulitis" possibly. Again, they discussed a Cortisone shot which Petitioner declined. Continued physical therapy was recommended as was the possibility of another MRI to make sure nothing was being overlooked. Petitioner wished to proceed with the MRI. Another possibility was a referral to a pain clinic for management of her chronic pain. He noted the Meloxicam, Ibuprofen, and Lyrica weren't helping her with the pain. (PX 2)

Petitioner worked from February 22, 2015 through February 24, 2015. (RX 2, dep. ex. 4)

Petitioner worked February 27 – March 4, 2015. (RX 2, dep. ex. 4)

Petitioner underwent a right shoulder MRI on March 5, 2015 that showed supraspinatus tendinosis with no evidence of rotator cuff tears and post-operative changes related to her prior surgery. (PX 2)

That same day, PA-C. McFarlin left a note for the office to contact Petitioner regarding her MRI. He stated, "Please notify the patient that there is no evidence of a rotator cuff tear. There is

some tendonitis of the rotator cuff. There is nothing else we can offer for treatment. She has refused cortisone injections." Petitioner was advised and inquired into a pain clinic. PA-C. McFarlin issued the referral. (PX 2, p. 37/97)

Petitioner worked March 7 – 11, 2015. (RX 2, dep. ex. 4)

On March 12, 2015, Petitioner was seen by Dr. Shabeera Rauther at Carle's Interventional Pain Department. Dr. Rauther noted he had last seen Petitioner in 2012 for hip pain. Petitioner reported pain on a scale of "7/10." She primarily hurt over her right shoulder and had previously undergone surgery which made her pain worse. She described a burning and throbbing sensation that didn't radiate anywhere into her arm or neck. Petitioner reported right shoulder pain which made it difficult for her to sleep and work. At work, Petitioner has to lift pans of food, "etc." and was finding that difficult. Petitioner related that physical therapy had helped "to some extent." She was doing home exercises as recommended. Lyrica wasn't helping very much. Hydrocodone had helped in the past. On examination Petitioner had some tenderness to palpation along the anterior aspect of her shoulder joint. Range of motion of the joint was noted to be fairly unremarkable. Petitioner had some weakness with abduction of the shoulder. Dr. Rauther's impression was right shoulder supraspinatus tendinitis. Dr. Rauther noted he was not an expert in shoulders but his review of the recent MRI was fairly unrevealing. He recommended a drug screen as Petitioner assured him she would only take the Hydrocodone as needed and not daily. She was planning on establishing general care with Dr. Hussain the next day. Dr. Rauther indicated that Petitioner should do so and discuss a small dose of Hydrocodone with him. They also discussed cortisone injections which Petitioner declined. (PX 2)

Petitioner worked March 14 and 15, 2015. She resumed working March 17 – 19, 2015. (RX 2, dep. ex. 4) Petitioner also worked: March 28 – 31; April 1; April 4 – 9; April 12 – 15; and April 18 – 22. (RX 2, dep. ex. 4) She worked April 23 and April 25-26 as well as April 27 (4.1 hours)

On April 28, 2015, Petitioner was examined by Dr. Jeffrey Coe at Occupational Medicine Associates of Chicago at the request of her attorneys. Petitioner provided Dr. Coe a history of working for Respondent as a cook in the Dietary Department for 40 hours per week for the past 15 years. Petitioner further reported that her work required relatively constant, forceful use of both upper extremities. Petitioner also reported that her customary work required lifting food, pots, and other materials frequently, cutting, and awkwardly stirring. She further reported that she was frequently assigned to the pasta station in which she lifted, reached, and pulled up baskets of pasta and stirred using a large paddle. Petitioner reported that she was required to work in particularly awkward situations due to her stature of 5 foot 3 inches. Dr. Coe provided an extensive chronology of the medical records he reviewed. An examination of Petitioner was completed at that time as well. Dr. Coe opined that Petitioner suffered repetitive strain injuries to her right dominant upper arm in her work as a cook for Respondent. Dr. Coe further opined that the repetitive strain injuries were a factor causing the development of Petitioner's right shoulder subacromial impingement (both acute and chronic shoulder pain) as well as her right

carpal tunnel syndrome and cubital tunnel syndrome. Dr. Coe further opined that Petitioner was in need of permanent work restrictions of no lifting more than 10 lbs. and limitation in the use of her right arm to shoulder height or below. (PX 1)

Petitioner worked on April 29, 2015. (RX 2, dep. ex. 4)

Petitioner worked May 2 – 6, 2015. She also worked May 10 – 14, 2014. (RX 2, dep. ex. 4)

Petitioner underwent a complete physical with P.A. Swartz on May 15, 2015. She was still experiencing foot pain despite wearing inserts. Her cough had improved. No shoulder or upper extremity complaints were noted. X-rays of Petitioner's feet were ordered and she was prescribed Lyrica for her foot pain. (PX 2)

On May 20, 2015, Petitioner returned to Dr. Rauther with ongoing pain in multiple areas but especially in her right shoulder and neck. Patient reported that she has continued to take Hydrocodone about three times a day as needed. Petitioner tried to cut back on her good days and when around her grandchildren. She denied getting pain medication from anyone else. On examination Petitioner was tender to palpation over multiple fibromyalgia points. There was some diffuse tenderness to palpation along the paraspinal muscles of the cervical and lumbar spine. Dr. Rauther's impression was right shoulder supraspinatus tendinitis and myofascial pain and fibromyalgia. Dr. Rauther refilled Petitioner's prescription for Hydrocodone and instructed her to follow-up in five weeks. Petitioner also mentioned an annoying and persistent cough despite being treated for it with so many things. No recommendations were made regarding the cough. (PX 2)

Petitioner was re-evaluated by PA-C. McFarlin on May 27, 2015. Petitioner reported that she felt her shoulder was getting better but the pain continued to persist particularly after working all day long. McFarlin was concerned that Petitioner was developing adhesive capsulitis. Petitioner was working with restrictions of no lifting over 10 lbs., no overhead work, and no repetitive use of her arm. She was "pretty much" performing her normal activities but noting a difficult time lifting anything "really heavy." Petitioner felt her shoulder was getting better but the pain persisted. Norco seemed to be taking the edge off and she was reportedly only taking it as needed. Her exam was consistent with her previous one in February. Petitioner's work restrictions were continued although the weight was increased to fifteen pounds and she was instructed to return in eight weeks. He again recommended the possibility of an MRI. (PX 2)

Petitioner worked May 27, 28 and 29, 2015. Petitioner also worked on June 1, 3, 4, and 5, 2015. Petitioner worked on June 9, 2015. Petitioner was then on seasonal lay-off. (RX 2, dep. ex. 4)

On/about June 15, 2015 Petitioner contacted PA-C. McFarlin's office regarding clarification of her work restrictions. Petitioner requested a new note stating she had a 15 pound weight

limit and no overhead work. Petitioner advised that Respondent was not letting her work with the repetitive use of her right arm and she had been doing that since returning to work in December. She needed the note by June 16, 2015 at 10:00 a.m. or she would lose her work hours. PA-C. McFarlin issued a note stating she could not lift more than 10-15 lbs., engage in overhead work, and should have limited repetitive use of her right arm. The restrictions were to remain in effect for eight weeks. (PX 2, pp. 54-55/97)

Dr. Rauther re-examined Petitioner on June 24, 2015 in the Carle Pain Center. Petitioner reported pain complaints regarding her low back and right shoulder which had been made "somewhat worse" after tending to her sister who had some surgery. She rated her pain at "8/10." Petitioner was taking the Norco three times a day as needed. On examination some slight tenderness to palpation over the right lumbar paraspinal muscles and over the iliac crest on the right were noted. Muscle strength was 5/5 in both her bilateral upper and lower extremities. Petitioner's diagnosis remained unchanged and Dr. Rather refilled her prescription for Hydrocodone. Petitioner was to return in a month for a routine medication check-up. (PX 2)

Petitioner worked June 28th and 29th for 8 hours. (RX 2, dep. ex. 4) She also worked 5.5 hours on July 2 and July 5th. Petitioner continued to work off and on during July of 2015. (RX 2, dep. ex. 4)

Petitioner was last seen by PA-C. McFarlin on July 23, 2015. At that time, Petitioner reported ongoing pain but positive progress with decreasing pain. She was working with restrictions and it seemed to be working out "pretty good" for her. Her exam remained unchanged, including continued pain with impingement testing, especially with internal rotation. Petitioner had limited range of motion trying to reach behind her back. McFarlin continued Petitioner's light-duty restrictions and instructed her to follow-up in eight weeks. Mr. McFarlin also noted that he had some concern that "some of this" could be coming from Petitioner's neck and at some point a cervical spine x-ray might be appropriate. (PX 2)

Petitioner did not follow up with Dr. Bane or PA-C. McFarlin within 8 weeks as ordered.

Petitioner also presented to Dr. Rauther on July 23, 2015 regarding her pain management. Petitioner was complaining of right shoulder pain as well as bilateral foot and leg pain. Petitioner was noted to have fibromyalgia and diabetes. She reported that her blood sugars were "fairly very well controlled." She was taking Lyrica at bedtime and Hydrocodone up to three times a day if needed. Petitioner reported the medications were helping. Petitioner also reported "having a lot of heavy duty work to do lately." Physical findings on examination of Petitioner included some tenderness over her right shoulder joint line and pain with range of motion testing in her right shoulder. Dr. Rauther's diagnoses were right shoulder supraspinatus tendinitis, myofascial pain and fibromyalgia, and diabetes with possible diabetic neuropathy. He refilled her Hydrocodone for another six weeks. He also added Cymbalta to help with the fibromyalgia and diabetic neuropathy. Petitioner was to return in six weeks. (PX 2)

Petitioner worked some in early August of 2015. (RX 2, dep. ex. 4) She also worked August 17 – 20 and August 22 – 24, 2015. She worked August 26, 2015. Petitioner next worked on September 1, 2015. (RX 2, dep. ex. 4)

Petitioner returned to see Dr. Rauther on September 3, 2015 reporting bilateral hip pain and fibromyalgia pain. Petitioner had driven all the way to Dallas and back and secondary to the temperature changes, etc. she had noticed a lot of pain, especially in her feet, radiating to her legs. She had also been diagnosed with strep throat recently and wasn't doing very well. Petitioner told the doctor she had done well on 30 mg. of Cymbalta but couldn't tolerate a higher dosage. Dr. Rauther refilled her prescriptions. She was to return in four weeks. (PX 2)

Petitioner periodically worked in September of 2015. (RX 2, dep. ex. 4)

As instructed, Petitioner presented to Dr. Rauther on October 1, 2015. She reported multiple areas of pain, especially the right side of her low back. Petitioner had undergone a renal duplex exam on September 19, 2015 due to issues with hypertension and had been experiencing back pain ever since. She rated her overall pain as an "8/10." Petitioner was taking her hydrocodone and Lyrica but could no longer tolerate the Cymbalta. Dr. Rauther's examination was limited to Petitioner's low back. Her diagnoses were modified to include back pain. He recommended lumbar spine x-rays and cessation of the Cymbalta. He increased her hydrocodone to 7.5 mg. Petitioner was to return in four weeks. (PX 2)

Petitioner worked the following dates in October: 3 - 6; 7; 9 -13; 14; 17; and 19 – 21st. (RX 2, dep. ex. 4)

Petitioner returned to Dr. Rauther's office on October 29, 2015 regarding her low back and left hip pain. Her overall pain score remained the same as at her last visit. Petitioner was only taking the hydrocodone maybe once a day. Dr. Rauther examined her low back. He had her undergo a drug screen. In his office note he mentioned that Petitioner's lumbar spine x-ray showed minimal disc degeneration with minimal discs. She was to bring in her remaining pain pills to verify the count against her reported use. (PX 2)

Petitioner worked October 31 – November 4, 2015. (RX 2, dep. ex. 4) She also worked November 9 – 11, 2015. (RX 2, dep. ex. 4) Petitioner worked November 15 – 19, 2015. (RX 2, dep. ex. 4)

Petitioner again presented to Dr. Rauther on November 24, 2015. At this visit she had low back pain complaints. She reported that she had called the doctor's office reporting that some of her pain pills had been stolen as she had had a "get together" at her place and thereafter some of the pills were stolen. She reportedly kept them in her room and had locked her room but "somehow they still disappeared." She had filed a police report. Her previous drug screen was negative for hydrocodone. She brought her pills with her and she had 9 left over. Petitioner was complaining of a lot of discomfort in her low back and right lower extremity for which Dr.

Hussain had ordered an MRI. Her exam was limited to the low back. Dr. Rauther explained to Petitioner that the fact the pain medicine did not come up positive on the drug screen was a "big red flag" and very concerning. Since she filed a police report he was willing to excuse her. However, he advised her he would discharge her from care if there were any further discrepancies. He wished to see her in four weeks. (PX 2)

Dr. Rauther again examined Petitioner on December 22, 2015. At this visit she complained of low back pain and numbness in the lower extremity along with some right shoulder pain. The insurance company didn't approve the MRI without first attempting therapy for her back. That had been ordered and was to begin in January. Petitioner's low back was examined but not her shoulder. Her hydrocodone was refilled. (PX 2)

Petitioner presented to PA –C. McFarlin on January 7, 2016 regarding a complaint of left shoulder pain. Petitioner had been referred by Dr. Hussain[5]. She denied any injury but reported the pain had begun two months earlier. She described it as a burning sensation primarily located over the AC joint. Petitioner had been off work over the winter break and the pain had improved to some degree. Petitioner had a history of a similar problem on the right side for which she had undergone surgery. Petitioner reported some ongoing right shoulder pain but feeling much better since surgery. Petitioner also reported some back issues with radiation down her right leg. She was to begin physical therapy for that and was being treated by Dr. Rauther. She denied any numbness or tingling in her upper or lower extremities or neck pain. Petitioner reported taking hydrocodone for her chronic back pain. Petitioner was working as a cook for Respondent. PA-C. McFarlin's impression was left shoulder acromioclavicular joint pain. He felt she should try some therapy for it. She was also given a cream to use. She did not want injections or surgery. He felt she could continue with the hydrocodone as needed. (PX 2)

Petitioner underwent a physical therapy evaluation on January 8, 2016 at the request of Dr. Hussain. Petitioner was complaining of chronic back pain which was causing difficulty walking, standing, and performing activities of daily living. Petitioner gave an onset date of August as she noticed back pain after work one day which had been progressing ever since. When lying on her right side, Petitioner would notice tingling in her buttocks, radiating down her leg. Petitioner reported problems getting in and out of a chair, difficulty with stairs, and problems lifting objects off the floor. Petitioner was working full duty for Respondent. She was to attend physical therapy two times a week for six weeks. (PX 2)

Dr. Rauther re-examined Petitioner on January 21, 2016. Her presenting complaints included bilateral shoulder pain and back pain with the left shoulder being more painful. Petitioner had undergone one consultation therapy session and one actual session with her right leg going completely numb after the actual therapy session. Her left shoulder and low back were examined. Dr. Rauther noted there wasn't so much tenderness on her right shoulder. Petitioner's hydrocodone was refilled. (PX 2)

[5] Don't believe Dr. Hussain's office note is in the record

Petitioner attended physical therapy on January 28, 2016 reporting she had been in the hospital for two days over the weekend secondary to chest pain. Petitioner reported back pain of "8/10" and that it only radiated when lying down. Petitioner further reported compliance with her home exercise program "when there's time." (PX 2)

Petitioner returned to therapy on February 9, 2016 due to chronic lower back pain. Petitioner reported her pain would "calm down" when she wasn't pushing/pulling at work. Petitioner wasn't taking her muscle relaxers due to the inability to take them when she really needed them. (PX 2)

The deposition of Carrie Anderson was taken on February 19, 2016. Ms. Anderson is the executive chef for Respondent's residential dining. She has held that position for 1 ½ years. Prior to that time Ms. Anderson was the production chef, a position she held for 12 years. Ms. Anderson testified that in 2013 she was a production chef and, as such, she was responsible for all administrative duties as they pertained to production of food in the kitchen. She was assigned to Ikenberry Commons. Ms. Anderson testified that there is one set of dorms, Nugent Hall, connected to Ikenberry. Ms. Anderson further testified that Ikenberry is a multi-venue location with seven different small restaurant concepts contained in the front and a main kitchen located in the back. She was responsible for all the restaurants and the kitchen and would supervise the storekeeper, head cook, cook, snack bar attendant, kitchen helper and food service laborer.

Ms. Anderson testified that Petitioner was a cook in 2013 and she had supervisory responsibility over Petitioner. Ms. Anderson testified that she could not recall if Petitioner ever described an acute injury to her which involved doing something as a cook and hearing her shoulder pop. She also could not recall if she filled out any type of accident or incident report for such an incident. (RX 1, pp. 1-7)

On cross-examination Ms. Anderson testified that she believed she probably oversaw about forty employees back in January of 2013. She did not recall what station or venue Petitioner was working at in January of 2013. She agreed there was a "Penne Lane" in 2013 and that Petitioner possibly worked there during that time. If she did, she would have been required to lift baskets of pasta and push carts; however, she would not be required to stir pasta in a pot if she was at the station. Ms. Anderson acknowledged that there were two 5 gallon kettles in Penne Lane and one might have contained a pasta sauce which would require stirring with a long-handled spoon or whisk. Ms. Anderson further acknowledged that Petitioner might have stirred the pasta sauce as a cook.

Ms. Anderson further acknowledged that she didn't know if Petitioner filled out incident or accident reports for February 24 or 27 of 2013. She did not know how much a basket of pasta would weigh but she didn't think it was 20 lbs. She felt they weighed under 5 lbs., if not 2 lbs.; however, that was just the weight of the basket. (RX 1, pp. 7-11)

The deposition of Keith Garrett was taken on May 24, 2016. (RX 2) Mr. Garrett is Respondent's food service administrator and has been so employed since November of 2002. As such, he oversees the whole dining hall, including 60 full-time employees and as many as 375 student workers. He has been assigned to Ikenberry since the summer of 2010. Mr. Garrett testified that Petitioner was one of the cooks at Ikenberry. He would have been responsible for Petitioner's work schedule which followed the academic calendar and included some "lay-off" periods such as Thanksgiving, winter break, spring break, and summer (mid-May to mid-August). (RX 2, pp. 1 – 6)

Mr. Garrett was shown Petitioner's accident report dated February 24, 2013 that concerned an accident date of January 24, 2013. He recalled Petitioner coming to him to fill out an accident report and that she claimed shoulder pain when something popped while working at "Penne Lane," the pasta destination in Ikenberry Dining Hall. Mr. Garrett testified that he didn't know about the alleged injury before Petitioner reported it on February 24, 2013. (RX 2, pp. 6-9)

Mr. Garrett testified that Respondent has a computerized timekeeping system called "Kronos" that requires employees to swipe their ID card through a machine to monitor time in and out. He identified deposition exhibit 2 as Petitioner's time records for January 20 – 26, 2013. According to it, Petitioner called in sick on January 24, 2013. He further identified deposition exhibit 3 as an accident report dated February 27, 2013, and dated three days after deposition exhibit #1 (the accident report dated February 24, 2013). Deposition exhibit 3 referenced an accident date of January 23, 2013, the day before Petitioner's originally claimed accident date of January 24, 2013. Mr. Garrett recalled that since her dates weren't correct Petitioner was asked to fill out another accident report. He further testified that on the 23rd Petitioner was not working at Ikenberry but she left the accident location as Ikenberry. According to her time records, Petitioner was working at Busey-Evans Hall. (RX 2, pp. 9-12, 17 - 19) Mr. Garrett testified that he didn't ask Petitioner to correct the second accident report even though he knew she wasn't working at Ikenberry on the 23rd. He could not explain why he didn't ask for a further correction testifying, "I believe I passed it on to our HR person." (RX 2, p. 20)

Mr. Garrett acknowledged that he did not witness an accident on January 23, 2013 involving Petitioner. He first learned of her alleged January 23, 2013 accident on February 24, 2013. He was also aware that Petitioner claimed a December 7, 2013 carpal tunnel injury. He first learned of that accident "right when she told him" as she filled out an accident report contemporaneously with the claimed accident. He testified that prior to December 7, 2013 Petitioner never complained to him about either of her hands. Mr. Garrett also testified that they could usually accommodate restrictions. He further identified deposition exhibit 4 as an Excel spreadsheet for employee time and that it showed days when Petitioner worked and didn't work. The time period in deposition exhibit 4 is for January 1, 2012 through November 19, 2015. Mr. Garrett believed that Petitioner began working for Respondent in 2000 or 2001 and that she had always worked as a cook. He did not work with Petitioner prior to Ikenberry. He believed Petitioner was formerly a cook at the Pennsylvania Avenue Residence Hall. (RX 2, pp.

12 – 17) Looking at deposition exhibit 2, Mr. Garrett testified that Petitioner worked full days at Ikenberry on January 20 and 21, 2013. On January 22, 2013 she was "OPP" which meant a work opportunity was attempted but they either couldn't get hold of her or she refused. She did accept six hours on the 23rd. (RX 2, pp. 19-20) Petitioner began working at Ikenberry on December 12, 2012. (RX 2, p. 21) Mr. Garrett testified that Petitioner would have been assigned different stations as a cook based on her restrictions. He testified that she had restrictions in December of 2012 and would have been told not to lift over 15 lbs. He believed her restrictions were related to her shoulder but he didn't know which shoulder. He further testified that the foregoing testimony was to the best of his knowledge as he would really need to review her file and dig through it. Mr. Garrett further testified that Petitioner could have been making soup or working in "Penne Lane" during that time frame. He believed baskets of pasta could weigh up to 25 lbs. Mr. Garrett also testified that Petitioner was always instructed not to "lift out" due to her restriction as there would have been a cook in the next station who could handle that for her. (RX 2, pp. 22-23)

Mr. Garrett testified that he had no independent recollection of any shoulder injury or accident prior to February of 2013 but they might be in her file if there were any. (RX 2, p. 23)

Petitioner's case proceeded to arbitration on June 8, 2016. The disputed issues were accident, causal connection, medical bills, temporary total disability, and nature and extent. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that she started working for Respondent in February of 2001 as a cook. It was her job to prepare food for the students. Petitioner testified that she worked at Ikenberry Dining Hall.

Petitioner testified that she sought treatment with Dr. Kaplan at Carle on January 24, 2013 and that she was complaining of right shoulder pain. She acknowledged giving Dr. Kaplan a history of doing a lot of stirring at work and some lifting at work and it was causing right shoulder pain. Petitioner denied any problems, treatment or work restrictions with regard to her right shoulder prior to January 24, 2013.

When asked to describe the work activities that she was performing in January of 2013 which required her to seek treatment with Dr. Kaplan, Petitioner testified that she was cooking pasta and preheating pasta in a machine that was chest level. She would preheat it, pull it back out of the water, and put it in a pan. She estimated that a basket of pasta weighed 15 to 20 lbs. and she would engage in that activity 5 or 6 times per hour. Petitioner worked an eight hour day for Respondent.

Petitioner testified that Dr. Kaplan took her off work as of January 14, 2013. Thereafter, she continued to follow up at Carle for her right shoulder. She filled out an injury report on February 24, 2013 and included an accident date of January 24, 2013 because her supervisor, Carrie Anderson, had told her to use that date. Petitioner also testified that she returned to Dr.

Kaplan on February 26, 2013 and he put her on light duty/modified duty at that time. Petitioner further testified that she provided her work restrictions to Respondent and it did not accommodate her restrictions at that time.

Petitioner testified that on April 15, 2013 she spoke with "Trish" about going back to work with restrictions and she did so on April 22, 2013.

Petitioner further testified that she began treating with James Berkes at Carle in March of 2013 for right hand complaints and she underwent an EMG on May 8, 2013 which was normal. Thereafter she continued to treat for her right shoulder, underwent an MRI and physical therapy and was eventually referred to Dr. Zeman who injected her right shoulder in August of 2013. As of December 4, 2013 Dr. Zeman had issued permanent restrictions for Petitioner's right shoulder and arm and Respondent accommodated those restrictions.

Petitioner testified that she went to the emergency room on December 7, 2013 complaining of right hand pain and intermittent numbness up into her forearm. She testified that when she cooked for vegetables she had to use a big "tilt skilled" and as she would "dip it out doing the wrist motion back and forth," the handle would hit her hand for some reason and she would get a sharp electric pain from her hand to her elbow. Petitioner estimated she would go through, at least, six cases of vegetables an hour and engaging in that activity at least 10 to 15 times per hour. Petitioner reported the problem to Charlie and Stacie on December 7, 2013 and completed an accident report on December 8, 2013.

Petitioner testified that she underwent right wrist and elbow surgery on January 17, 2014 and that she was taken off of work at that time. Thereafter, she underwent physical therapy and was eventually released from care on May 28, 2014.

Petitioner testified that while treating for her right wrist and hand she continued treating for her right shoulder with Dr. Zeman. She also testified that Dr. Zeman referred her to Dr. Bane and that Dr. Bane took her of work as of June 16, 2014. Petitioner underwent right shoulder surgery on August 5, 2014 followed by physical therapy. She was subsequently referred to Dr. Rauther for pain management.

Petitioner testified that as of July 23, 2015 she was to refrain from lifting more than 15 lbs. and not perform any overhead work. She continues to work for Respondent as a cook and Respondent is accommodating her restrictions.

Petitioner testified that her bills have been paid by her group insurance or Medicaid. She further testified to some out-of-pocket expenses.

Petitioner acknowledged being sent to Dr. Coe by her attorney. She testified to telling him about her work duties and that her description was similar to what she testified to during the hearing.

Petitioner testified that she continues to see Dr. Rauther for pain management on a monthly basis. Dr. Rauther is providing pain management for Petitioner's low back, left hip, and right shoulder. Dr. Rauther has continued to prescribe Hydrocodone for pain management purposes. (PX 2)

Petitioner testified that she continues to experience occasional numbness and a burning sensation in her right shoulder with work activities and activities of daily living. She no longer is able to participate in her family bowling night because of the pain in her right shoulder. Petitioner further testified that she can't keep her right hand above her head for longer than ten minutes because it becomes too painful. This has limited her in her ability to style her hair. She continues to take the Norco that Dr. Rauther has recommended.

On cross-examination Petitioner acknowledged filling out an accident report with Keith Garrett and that there was some confusion regarding the accident date but that January 24, 2013 was the date of a doctor's appointment. Petitioner clarified that she hurt her shoulder on January 23rd and went to the doctor on January 24th. She also acknowledged that she was doing something with pasta when she felt a pop in her shoulder. When asked if that was when her pain began, Petitioner disagreed, explaining that she had been noticing pain and had been telling "them" about it but she thought it would go away and it didn't. Petitioner agreed that it was the popping that made her go to the doctor. She also acknowledged that it occurred while working at "Penne Lane" in Ikenberry.

Petitioner also testified that she only works when the students are in school. Generally, her job ends sometime in May and resumes again in August. She is also off during Christmas for about a month.

Petitioner denied any treatment for carpal tunnel syndrome in the past.

On redirect examination, Petitioner testified that she had been experiencing right shoulder pain for a few weeks before January 23, 2013 and that she noted it while working the pasta station.

The Arbitrator concludes:

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?

Petitioner failed to prove she sustained an accident on January 23, 2013 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being in her right shoulder was causally related to her accident or her work duties for Respondent. It is not entirely clear whether Petitioner is claiming a right shoulder injury due to repetitive

trauma (her job duties as a pasta cook), specific trauma (a pop to her right shoulder) or a combination/hybrid of both.

Assuming that Petitioner is alleging she sustained an accidental injury as a result of her repetitive work activities she must show the performance of her work involves constant or repetitive activity that gradually causes deterioration of an 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." There is no requirement that a petitioner must spend a certain amount of each day on a specific task before a finding of repetitive trauma be shown. *Edward Hines Precision Components v. Industrial Comm'n*, 365 Ill.App. 3d 186, 292 Ill. Dec. 185, 193-94 (Ill. App. Ct. 2005). It is axiomatic that the unique facts of each case must be closely scrutinized. Furthermore, the causation issue in repetitive trauma cases generally requires persuasive and well-informed opinions from medical experts.

Petitioner's testimony regarding the cause of her right shoulder complaints was unclear and inconsistent. While on direct examination (and through a great deal of leading) Petitioner testified that she sought treatment for her shoulder due to stirring and lifting activities associated with making pasta, on cross-examination Petitioner testified that she had been telling "them" about her pain before January 24, 2013; however, it was when she felt a pop in her right shoulder that she sought medical treatment. That history was not provided to Dr. Coe. That history was not provided to Dr. Kaplan on January 24, 2013 or Dr. Session on February 6, 2013 or Dr. Liang on February 20, 2013. When Petitioner was seen by Dr. Liang on February 20, 2013 Petitioner reported improvement in her right shoulder pain until that very day when she "pushed off a chair" and felt a "sharp pain" in her right shoulder. Petitioner then went to Dr. Kaplan on February 26, 2013 and, again, failed to mention a pop. She also failed to mention the chair incident. Instead Petitioner provided, yet again, a new history of onset – ie., that her right shoulder pain "began" four days after her last visit with Dr. Kaplan (which was on January 24, 2013). The Arbitrator then notes yet another different history when Petitioner presented to Dr. Zeman on March 6, 2013 – ie., her shoulder had been hurting since she returned to work in December of 2012. In summary, Petitioner's testimony as to the onset and cause of her right shoulder complaints was in stark contrast to the different histories contained in the medical records. Petitioner never addressed these differing histories in her testimony.

Additionally troubling to Petitioner's repetitive trauma claim is that Petitioner did not work during most of 2012. Her time records (RX 2, dep. ex. 4) show that she did not work between January 13, 2012 and December 12, 2012. Indeed, her earnings as reflected on AX 1 reflect a minimal amount. Mr. Garrett testified, without rebuttal, that Petitioner returned from a leave of absence in mid-December of 2012. That testimony was consistent with Petitioner's time records. Petitioner then worked sixteen days (and not always consecutive days) between December 12, 2012 and January 23, 2013. Petitioner, herself, did not address how many hours she worked per week or her lack of work in 2012. This is significant because Dr. Coe's causation opinion (upon which Petitioner relies for liability) is based upon the premise that Petitioner

worked a 40 hour week. However, she wasn't doing that prior to January 23, 2013. It further appears he had no knowledge regarding her lack of work altogether in 2012. Thus, Dr. Coe's causation opinion is not based upon an accurate understanding of Petitioner's work duties and schedule for Respondent. Petitioner did not establish that she had worked a forty hour week for Respondent since the year 2000.

Dr. Coe also failed to explain how Petitioner's work activities specifically caused her right shoulder impingement and right carpal and cubital tunnel syndromes. He simply stated that she suffered repetitive strains which were a factor in the development of her specific conditions. However, no detailed information was provided by him as to specifically how her anatomy was repetitively strained by lifting and stirring. He did not detail how her job required her to engage in "constant" and "forceful" use of both upper extremities. Dr. Coe also failed to address Petitioner's varying histories to the doctors when she began treatment in early 2013. While his report discusses many medical records pertaining to Petitioner, his discussion/review of them was not that detailed as he only relied upon portions of histories and notes supportive of Petitioner's claim. Dr. Coe did not review or comment upon Dr. Rauther's records or Dr. Sessions' records. Dr. Coe only examined Petitioner once and his exam was done at the request of Petitioner's attorneys.

The Arbitrator is aware that Dr. Bane's office note of August 15, 2014 suggested that Petitioner's "work exposure" "probably" had been a factor in her shoulder condition. However, his opinion was not within a degree of medical certainty and was based upon no detailed and accurate information concerning her job duties for Respondent. Petitioner also wasn't forthright with the doctor regarding her accident or her work status with Respondent as she represented she had been terminated after receiving a ten pound permanent lifting restriction in December of 2013. She further described her work accident as a single act of picking up a pasta basket weighing 15 to 20 lbs. on January 23, 2013.

No treating physicians were deposed and with the exception of Dr. Bane's comment on possible causation addressed above, no other treating doctor expressed an opinion on causation.

With regard to a specific trauma claim, the Arbitrator notes the absence of any persuasive corroboration for Petitioner's testimony that she felt a pop in her shoulder while making pasta at Ikenberry on January 23, 2013. First, she wasn't actually working there that day. Furthermore, there is no corroboration for a history of a specific shoulder pop until March 1, 2013. By then, Petitioner had seen four other doctors and never provided that history.

As an additional reason for denying Petitioner's claim, the Arbitrator finds that Petitioner was not an altogether credible witness. First, there were the inconsistent histories to the medial providers.

Second, the date, location, and description of the accident were all placed in doubt by the testimony of Keith Garrett. Mr. Garrett testified that Petitioner completed an accident report indicating an injury or illness on January 24, 2013. The accident report indicating a January 24, 2013 date of accident was completed by Petitioner on February 24, 2013, when she claimed that she experienced shoulder pain when something "popped" while working at Penne Lane, a station at Ikenberry Dining Hall. The undisputed evidence as shown by Petitioner's time records was that Petitioner did not work at Ikenberry on January 24, 2013.

Mr. Garrett further testified that on February 27, 2013, Petitioner completed a second accident report, this time claiming shoulder pain when she felt something "pop" while working at Penne Lane Station at Ikenberry Dining Hall with an accident date of January 23, 2013. The accident report of February 27, 2013, asserted an accident date of January 23, 2013, and indicated that Petitioner had originally reported a January 24, 2013 accident date because that was the day she first sought medical treatment. However, Mr. Garrett testified that Petitioner was not working at Ikenberry on January 23, 2013; rather, she was working at Busey-Evans Dining Hall. This information was confirmed by Garrett reviewing the timecard system in his deposition exhibit ex. # 2. Petitioner did not rebut this.

Petitioner's credibility was further damaged by her testimony regarding her alleged carpal tunnel syndrome. With respect to her right carpal tunnel syndrome on the right, Petitioner testified that she had never been treated for carpal tunnel syndrome in the past. She further testified that she had never been diagnosed with carpal tunnel syndrome prior to December 7, 2013. The medical records contradict this testimony as she was diagnosed with carpal tunnel syndrome on March 4, 2013. (PX 2) The medical record on that date also indicates "R hand numbness and pain. Last seen 10/27/11 by Sobeski." (PX 2) This history appears in the "history" section of her medical records as early as a February 6, 2013 visit with Dr. Sessions. (PX 2)

Petitioner's credibility was further dampened by her representations to doctors and therapists about Respondent's ability to accommodate her work restrictions. Petitioner misrepresented her employment status to Dr. Bane, stating she had been terminated. Even more striking was her misrepresentation to Dr. Li and therapists that Respondent would not let her work with restrictions. Dr. Li's office note documents Respondent's efforts to correct this inaccuracy. While Petitioner testified to speaking with "Trish" in April of 2015 about returning to work her testimony was a little misleading given the doctor's documentation of what was really going on.

Based upon her review of the medical records, this Arbitrator found repeated efforts on Petitioner's part to try and remain off work as long as possible. Petitioner would tell doctors she wasn't ready to return to work and request off work slips despite evidence to the contrary. Additionally, as noted above, she misrepresented Respondent's ability to accommodate restrictions so that she could be off work. The Arbitrator also noted a tendency on Petitioner's part to initiate treatment for another body part when nearing completion of treatment for a current one. For example, in late 2013 when she was being returned to work for her shoulder,

she then presented for treatment to her hand and wrist. Once that was nearing resolution of treatment, she resumed care for her right shoulder. As her right shoulder treatment lessened, she began having issues with her feet, then her back, and then her left shoulder. Again, all of this suggests a desire to keep from having to go back to work as a cook. This Arbitrator further found troubling Petitioner's tendency to see one set of doctors for her shoulder complaints and another set of doctors for her right upper extremity complaints with no apparent sharing of information between these doctors.

Petitioner's credibility was further diminished by her testimony at arbitration that she continues to treat with Dr. Rauther for her right shoulder. Dr. Rauther's records, as of September 3, 2015, and subsequent thereto, document no major right shoulder complaints or, at best, some isolated complaints given when being seen by the doctor for other more significant complaints. Petitioner also testified that she has restrictions for her shoulder prohibiting her from lifting more than 15 lbs. or engaging in overhead work and that these were given to her on July 23, 2015. The Arbitrator notes that those restrictions, when given in July of 2015, were to remain in effect for eight weeks. Petitioner was to return at that point in time. However, she didn't – at least not until January 7, 2016 at which point she was seeking treatment for a new condition in her left shoulder. Petitioner's lack of follow through to assess her ongoing need for further restrictions after July 23, 2015 is concerning.

Petitioner may very well have experienced some shoulder pain while cooking pasta and/or lifting equipment to do so but she failed to prove that any such pain was caused or aggravated by her job duties. As Petitioner's medical records show, Petitioner suffers from a myriad of medical conditions including diabetes and fibromyalgia, any of which might have explained or contributed to the symptoms Petitioner noticed while working and away from work. Indeed, there was a lot of time when Petitioner was off work and, yet, she continued to report ongoing shoulder pain complaints to her doctors and therapists. One could reasonably infer that if she were avoiding the allegedly offensive job duties, she would no longer have her shoulder complaints. That she continued to do so, suggests perhaps another cause for them. Indeed, many doctors and therapists suggested a possible cervical component to Petitioner's presentation. This was never explored.

In summary, this Arbitrator was not persuaded by the opinion of Dr. Coe nor did she find Petitioner credible. Petitioner failed to meet her burden of proof on accident and causal connection. As such, the Arbitrator concludes that Petitioner failed to prove she sustained an accident on January 23, 2013 that arose out of and in the course of her employment with Respondent or that Petitioner's current condition of ill-being in her right shoulder was causally related to her employment or her accident.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

CHRISTOPHER CELLO,

Petitioner,

vs.

NO: 13 WC 14960

CURRIE MOTORS,

17IWCC0387

Respondent,

DECISION AND OPINION ON §8(a) PETITION

This case comes before the Commission on Petitioner's §8(a) Petition, filed on January 8, 2016, claiming additional medical expenses. A hearing was held on April 18, 2016, before Commissioner Charles DeVriendt in New Lenox, Illinois, and a record was made.

As background, Petitioner's case was initially heard on the issue of nature and extent by Arbitrator Flores on June 3, 2015, and a decision was issued on June 4, 2015. The Arbitrator's decision noted that Petitioner had undergone two lumbar surgeries, underwent a functional capacity evaluation (FCE), and was returned to work with restrictions. Petitioner continued to work for Respondent but in a different capacity with limited lifting and earning less money. Petitioner testified that he continued to take gabapentin three times a day and Zohydro ER, a hydrocodone compound, twice a day, which "has helped him a lot and stabilized his pain through the day although the pain never completely goes away." (Dec. at 2). In addition to temporary total disability, temporary partial disability, and maintenance benefits, which were not in dispute, Petitioner was awarded a wage differential of $297.17 per week. The Arbitrator's decision was not reviewed by either party.

The current issue before the Commission is Respondent's claim that Petitioner's continued use of narcotic pain medication is unreasonable and unnecessary based on the opinion of its §12 physiatrist, Dr. Lanoff. Petitioner claims that the use of Zohydro and gabapentin continues to help his pain and is supported by the opinion of his treating pain management physician, Dr. Abusharif.

At the §8(a) hearing, Petitioner testified that he was taking these two medications at the time of the last arbitration hearing on June 3, 2015, and had returned to work at Respondent but in a different position with limited lifting. Petitioner testified that these medications take the "stabbing pain away and makes me function through the day and do the activities that I need to

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do." (T.4/18/16 at 8). He testified that if he doesn't take them, "the pain is debilitating to the point where I can't move." (Id. at 9).

On cross-examination, Petitioner stated that he was not interested in a weaning program as suggested by Dr. Lanoff. He testified that he was previously on Norco but was changed to Zohydro by Dr. Abusharif because it did not contain Tylenol, which affects the liver. He testified that the Zohydro is time released and controls his pain better. He takes it twice a day, morning and evening, and it helps him sleep through the night. On redirect examination, Petitioner testified that, in addition to his own research, he has discussed the relative risks and benefits of Zohydro with Dr. Abusharif and he still desires to continue with the medication. Petitioner feels it is the only way he can do his daily activities. Petitioner testified that the pain never completely goes away but it takes the stabbing, debilitating pain away.

Dr. Lanoff examined Petitioner one time, on August 19, 2015, and reviewed his records. His report is somewhat confusing. His examination showed some limited range of motion, positive straight leg raising test on the left at 45 degrees, and reproduction of radiating left lower extremity symptoms with FABER and Patrick testing, yet he stated that Petitioner was "objectively negative." He did not find any Waddell signs and stated that Petitioner did not have any nonorganic behaviors, but also stated that Petitioner's complaints "have no medical basis." He opined that Petitioner's subjective complaints were out of proportion to the objective findings and there was no indication for continued narcotic usage. He suggested that Petitioner be weaned from these medications. He agreed with Petitioner's need for light duty restrictions based solely on his surgical history and not on any subjective complaints.

In contrast, Dr. Abusharif's August 31, 2015 record indicates that Petitioner had 3-4/10 pain with medications, which increased when he did not take them. Petitioner had sharp low back pain that radiated into the bilateral buttocks, hips, and lower extremities, left greater than right, with numbness and tingling in the lower extremities. Dr. Abusharif also noted a positive straight leg raising test on the left and tender paraspinal muscles. On December 14, 2015, Dr. Abusharif wrote that Petitioner's pain increases to 7-9/10 without pain medication and depending on his activity level. He stated that Petitioner's pain condition is chronic and permanent and that there are no other treatment modalities other than medications to keep his pain under control. Significantly, Dr. Abusharif wrote, "It would be unquestionable to have the patient refrain from his pain medications as this is the only decent quality of life he can have is with the pain medications. This is not just my opinion as a pain management specialist, but *was also demonstrated when the medications were tapered and the patient's pain levels increased dramatically*." Emphasis added. Dr. Abusharif also stated that, "There is absolutely no indication that he can function and maintain decent quality of life without these pain medication and any physician indicating otherwise is simply speaking out of turn because this patient has been managed by me and I am very comfortable knowing his functional status with and without medications and clearly with medications his function is substantially better."

Although weaning someone off of narcotics is an admirable goal, Petitioner's treating doctor is more persuasive on this issue than Respondent's examining physician. Petitioner has been able to function and continue working in a lighter duty job with the use of these medications. Dr. Abusharif's note also indicates that Petitioner's pain levels increased dramatically when his medications were tapered in the past. Respondent's brief states, "By Petitioner's own testimony he has taken medications for several years with limited effect." (Respondent's brief at 4, unnumbered). However, Petitioner clearly testified that the combination of Zohydro and gabapentin takes away his stabbing, debilitating pain and allows

17IWCC0387

him to function. He also testified that the time-released Zohydro works better than the Norco he was taking previously.

The Commission finds that Petitioner has proven that the medication regimen as prescribed by Dr. Abusharif is reasonable, necessary, and causally related to his work injury. Respondent is hereby ordered to authorize and pay for Petitioner's pain management treatment with Dr. Abusharif.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §8(a) is hereby granted as outlined above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for Petitioner's pain management treatment with Dr. Abusharif.

The party commencing 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: JUN 26 2017

Charles J. DeVriendt

Joshua D. Luskin

Kevin W. Lamborn

SE/
O: 5/17/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CELLO, CHRISTOPHER
Employee/Petitioner

Case# **13WC014960**

CURRIE MOTORS
Employer/Respondent

17IWCC0387

On 6/4/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

5133 ZENITH INSURANCE COMPANY
TINA L DePAUL
500 PARK BLVD SUITE 400
ITASCA, IL 60143

17IWCC0387

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

- [ ] 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

Christopher Cello
Employee/Petitioner

v.

Currie Motors
Employer/Respondent

Case # **13** WC **14960**

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **New Lenox**, on **June 3, 2015**. By stipulation, the parties agree:

On the date of accident, **May 24, 2012**, 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 $**75,179.52**, and the average weekly wage was $**1,445.76**.

At the time of injury, Petitioner was **48** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**48,192.00** for TTD, $**33,876.10** for TPD, $**6,835.14** for maintenance, and $**0** for other benefits, for a total credit of $**88,903.24**.

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

As stipulated by the parties, Respondent shall pay Petitioner temporary partial disability benefits for 81 & 4/7th weeks, commencing May 30, 2013 through December 21, 2014, as provided in Section 8(a) of the Act.

As stipulated by the parties, Respondent shall pay Petitioner temporary total disability benefits for 50 weeks, commencing June 14, 2012 through May 29, 2013, as provided in Section 8(b) of the Act.

As stipulated by the parties, Respondent shall pay Petitioner maintenance benefits for 23 weeks, commencing December 22, 2015 through May 31, 2015, as provided in Section 8(a) of the Act.

As stipulated by the parties, Respondent shall be given a credit of $48,192.00 for TTD, $33,876.10 for TPD, and $6,835.14 for maintenance benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits, commencing June 1, 2015, of $297.17/week until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

RULES REGARDING APPEALS Unless a 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

June 3, 2015
Date

JUN 4 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*
NATURE AND EXTENT ONLY

Christopher Cello
Employee/Petitioner

v.

Currie Motors
Employer/Respondent

Case # **13** WC **14960**

Consolidated cases: **N/A**

FINDINGS OF FACT

The only issue in dispute is the nature and extent of Petitioner's injury. AX1. The parties' dispute regarding permanency centers on whether Petitioner is entitled to continuing wage differential benefits or whether he sustained a loss of use of the person as a whole pursuant to Section 8(d)(2) of the Act.

Petitioner testified that he has been employed by Respondent for 19 years as an automobile mechanic and is a member of the Local 701 Auto Mechanics Union. His duties include repairing and maintaining automobiles.

Petitioner testified that he was paid based on the jobs that he performed utilizing "book time," which is a pre-determined amount of time payable to the mechanic at an hourly rate for each task (e.g., oil change). Petitioner was paid the amount listed in the book regardless of how much actual time it took him to complete the task.

On May 24, 2012, Petitioner sustained an accident. He explained that he had to work on an F550 truck and, after kneeling down all day to complete several tasks, he was working on a wheel and he felt a strain in his back.

Petitioner went to the emergency room at Silver Cross Hospital on June 6, 2012 for low back treatment. PX1. He then came under the care of a pain management physician at Illinois Pain Management, Dr. Yasser Alhaj-Hussein. PX2. Petitioner initially saw Dr. Hussein on June 14, 2012 and later underwent a recommended low back MRI on June 18, 2012. PX2-PX3. The interpreting radiologist noted degenerative changes in the low back from L3-S1, a 2mm disc bulge at L3-4 with bilateral foraminal encroachment and abutting the exiting L3 nerve roots, a 4mm disc protrusion at L4-5 abutting the left traversing L5 nerve root and bilateral neural foraminal encroachment and indentation on the exiting L4 nerve roots, a 5mm disc protrusion at L5-S1 and bilateral neural foraminal encroachment and indentation on the exiting the L5 nerve roots, and a 4cm T2 hyperintense cystic lesion (likely a cortical cyst). PX3. Petitioner underwent a series of three epidural steroid injections as well as physical therapy as ordered by Dr. Hussein. PX2.

Petitioner testified that his low back symptoms did not abate and he continued treatment with an orthopedic surgeon, Dr. Richard Lim at Midwest Orthopaedic Consultants on August 17, 2012. PX3. Dr. Lim recommended a low back surgery which Petitioner underwent on August 31, 2012. Id. Dr. Lim diagnosed Petitioner pre- and post-operatively with a left-sided L4-5 herniated nucleus pulposus and left-sided sciatica. Id. Petitioner attended post-operative physical therapy and had another epidural steroid injection on November 19, 2012. Id. However, with ongoing symptoms, Dr. Lim prescribed a second low back surgery. Id.

Before undergoing that surgery Petitioner underwent an examination with Dr. Jesse Butler on January 14, 2013 at Respondent's request. RX1. Dr. Butler concurred that Petitioner required further treatment including surgery at L4-5 albeit with some disagreement as to the type or extent of surgery. Id.

On February 14, 2013, Petitioner underwent the recommended second surgery with Dr. Lim. PX3. Specifically, Dr. Lim performed a revision open L4-5 decompression and L3-4 open microdiskectomy. Id. Post-operatively, Petitioner underwent additional extensive physical therapy. PX3-PX4.

After physical therapy, Petitioner underwent a functional capacity evaluation on June 21, 2013. PX4. Petitioner returned to Dr. Lim on August 9, 2013 for a final visit and he found that Petitioner had reached maximum medical improvement. Id.

Petitioner testified that he returned to work on May 30, 2013 with work restrictions. *See also* PX4. He explained that he received temporary partial disability benefits each week during this period of time. Petitioner also explained that Respondent accommodated his restrictions and his income eventually stabilized, in contrast with his pre-injury income which fluctuated. He now receives a salary of $1000 per week for mechanical work consisting mostly of diagnostic tasks with limited lifting. Petitioner further explained that his circumstances have changed in terms of income. He testified that he used to earn money whereas he is limited now in his earnings after his injury.

Regarding his current condition, Petitioner testified that he currently and regularly takes medication including Gabapentin three times a day and a pain medication, Zohydro ER, twice a day. Petitioner testified that the Zohydro, which is a hydrocodone compound, has helped him a lot and stabilizes his pain through the day although the pain never completely goes away. He also takes Ibuprofen as needed for break-though pain. Petitioner also testified that he can only engage in activities such as travel in a car for about 40 minutes now, and that the injury at work has changed his personal life.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file.

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 uncontroverted evidence that Petitioner was employed as an auto mechanic at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury. The Arbitrator therefore gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. This fact is not in dispute. Thus, the Arbitrator therefore gives significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the evidence establishes that Petitioner is partially incapacitated from pursuing his usual and customary line of work such that he would have been able to earn $1,445.76 per week, but now earns only $1,000.00 per week due to the restrictions imposed after his accident at work. *See Wood Dale Electric*, 2013 IL App (1st) 113394WC. This evidence is

uncontroverted. Thus, the Arbitrator therefore gives significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of Petitioner's reported disability is corroborated by the treating medical records, and his need for treatment including a revision surgery was indicated by Respondent's Section 12 examiner, Dr. Butler. Thus, the Arbitrator gives significant weight to this factor.

Based on the above factors, considering the permanent partial disability benefits awardable under the Act, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a loss of earnings as a result of his injury at work pursuant to Section 8(d)1 of the Act. Respondent shall pay Petitioner permanent partial disability benefits, commencing June 1, 2015, of $297.17/week[1] until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

[1] The Arbitrator calculates Petitioner's benefits pursuant to Section 8(d)1 of the Act as follows: ($1,445.76 AWW) – ($1,000.00) = $445.76 x 2 ÷ 3 = $297.17.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Owsley,
Petitioner,

17IWCC0366

vs.

NO: 13 WC 16846

Williamson County Sheriff's Department,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, 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 November 14, 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: JUN 16 2017
o6/8/17
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)/8(a) ARBITRATOR DECISION

17IWCC0366

OWSLEY, ROBERT
Employee/Petitioner

Case# **13WC016846**

WILLIAMSON COUNTY SHERIFF'S DEPT
Employer/Respondent

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:

3101 PRINCE LAW FIRM
TYLER N DIHLE
404 N MONROE ST
MARION, IL 62959

2337 INMAN & FITZGIBBONS LTD
DANE KURTH
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

17IWCC0366

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)

ROBERT OWSLEY
Employee/Petitioner

v.

WILLIAMSON COUNTY SHERIFF'S DEPT.
Employer/Respondent

Case # **13** WC **16846**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of Herrin, on **June 16, 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, **October 1, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$51,251.41**; the average weekly wage was **$985.60**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **2** dependent children.

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

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

ORDER

The Petitioner failed to prove that he sustained accidental injury to the left upper extremity that arose out of and in the course of his employment with the Respondent.

The Petitioner failed to prove that his condition of ill being, left cubital tunnel syndrome, is causally related to his employment with the Respondent.

Based on these findings, 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 7, 2016
Date

ICArbDec19(b)

NOV 14 2016

STATEMENT OF FACTS

The Petitioner, a 44 year-old male at the time of hearing, testified that he had been employed by the Respondent as a communications officer since November of 1996. In this job, he answered both incoming 911 and seven digit phone calls and based on these calls would dispatch police, fire, ambulance and other agencies to emergency calls, or would transfer the calls to their proper responders. He also would have administrative phone calls and would work with court paperwork. While he testified that he is right handed and normally uses his right hand with his cell phone, he would answer phones at work with his left hand because that was the side of the desk the phones were located. In his redirect testimony, the Petitioner stated that he spends a significant amount of his workday with his elbows in a flexed position.

Petitioner testified that he would answer at least a hundred calls per day on the general seven digit number for Respondent. The volume of incoming 911 calls varied and could include 7 to 8 on a slow day, or 50 to 60 on a busy day. When receiving 911 calls, Petitioner testified that he held the phone to his ear with his shoulder while using his mouse and computer keyboard to enter call details. Petitioner also used a radio microphone to talk with police officers while muting the 911 callers. Petitioner's 911 call receiver did not have hands-free capabilities, so he answered calls with his left arm given the placement of the phone on the left side of his desk. He would remain on 911 calls for various periods of time depending on the needs of the caller.

Petitioner testified that 90% of his job involved typing, including warrants, orders of protection, and civil paperwork. He would generally sit at the desk with his arms on the desk, and his elbows would sometimes be placed on the edge of the desk and sometimes hang off the desk. He typically ate lunch at his desk, but when he was not on calls he could get up and move around the room. Petitioner testified that his work station had three keyboards and four mouse devices, and that he communicated with officers using both the microphone in the middle of his desk and the telephone. The Petitioner's work station included the general telephone, a 911 call receiver, keyboards, and mouse devices, all of which were depicted in Respondent's Exhibit 2.

Petitioner testified that he initially notified Respondent of his injuries at some point on or after 10/1/12, and alleged a progressive injury involving worsening pain and numbness in his left arm. On 11/15/12, the Petitioner completed the First Report of Injury. (Px5). This document indicated a report of left arm pain and numbness in the hand and last two fingers, alleged to be caused by prolonged exposure of the left elbow and arm to excessive keyboarding and data entry, answering calls and dispatching units. The Petitioner also noted he had not yet sought medical treatment. His symptoms involved pain and discomfort in his left arm and elbow, numbness in his left small and ring fingers and dramatically decreased grip strength. The Petitioner testified that this has continued to worsen since he initially reported it. He testified that answering the phone and typing would make his symptoms worse: "The more I'm at work, the more it increases, the longer hours I work, the more it increases."

Petitioner initially sought treatment with Dr. Young on 12/13/12, and was diagnosed with ulnar neuropathy. Dr. Young recommended ulnar nerve transposition surgery. Petitioner also testified that he was examined at the Respondent's request by Dr. Naam pursuant to Section 12 of the Act. He testified that he could not recall if he described his job duties to either physician or what exactly he may have told them. Petitioner confirmed that he never provided Dr. Young with a written job description or photographs of his work station. He indicated that he wanted to proceed with surgery to stop the worsening of the condition and to avoid permanent problems.

The Petitioner agreed on cross examination that he reported to Dr. Young that his symptoms occurred when his left elbow was flexed, including when he was talking on the phone. He also agreed that at his second visit with

Dr. Young on 12/31/12 he may have reported that his symptoms had been present for six months, or since June 2012.

The Petitioner acknowledged that he had previously treated with Dr. Young for right ulnar neuropathy and had undergone nerve transposition surgery for this, and that it was part of a separate workers' compensation claim.

Also on cross examination, Petitioner agreed that he used to be involved in computer gaming years ago, and that he often has had side jobs in computers outside of his employment with the Respondent.

The Petitioner testified that Dr. Young had never taken him off work or ordered work restrictions. He said that Dr. Young indicated he did not need to see him again until he was ready to have surgery.

On 12/13/12, Dr. Young's physician's assistant noted the Petitioner reported constant numbness and tingling on the left 4th and 5th fingers, and mild (4 out of 10) dull pain. Examination appeared to be relatively normal, and an EMG/NCV was recommended to evaluate the ulnar nerve, noting the Petitioner had previously had right cubital tunnel syndrome and had undergone right ulnar nerve transposition surgery. (Px3).

The 12/21/12 EMG/NCV was reportedly normal. (Px3). At a 12/31/12 follow up, Dr. Young noted Petitioner reported that the numbness in his fingers occurred often when he was on the phone or typing, and "really anything where his elbow is flexed." He noted his symptoms had been present for about 6 months. The Petitioner was splinted and provided with an elbow pad. (Px3).

On 2/12/13 the Petitioner reported he no longer had left elbow pain after using the brace and elbow pad, but that he still had numbness and pain in the hand into the forearm. Noting he might have a false negative on the EMG/NCV, and that this had also occurred on the right side, Dr. Young recommended left ulnar nerve transposition surgery. He also noted that he would seek approval from workman's comp. (Px3). Dr. Naam examined the Petitioner on 2/7/13. (see Rx1, Depo Ex. 2).

On 4/9/13, Petitioner called Dr. Young's office to inform him of Dr. Naam's examination, and he again called in on 4/16/13 reporting increased pain. (Px3). On 4/22/13, Dr. Young noted that Dr. Naam was recommending conservative treatment before surgery, and that Naam was unsure about causation from work. (Px3).

Petitioner completed several questionnaires for Dr. Young at the initial visit of 12/13/12. (Px3). A "Workers' Compensation Information" form noted the condition occurred due to "prolonged work at desk, repetitive motion". He noted complaints of left lower hand and 4th and 5th finger numbness and occasional pain that had been worsening over several months. A "Hand Questionnaire" also noted weakness and some elbow pain sometimes. He noted that he had filed a workers' compensation claim for the same condition on the right. As to his job, the Petitioner reported 95% of his day involved working at his desk with his arms on the desk; 40% of the day was answering the phone with his arms on the desk; 40% of the time talking on the radio; 50% of his day doing repetitive keyboarding and mouse use; and 80% of the day doing data entry. Doing work at his desk with his arms on the desk, whether it was data entry or phone use, would aggravate his symptoms. An intake form completed by Petitioner stated he had the noted symptoms, and when asked how this occurred, he wrote: "Excessive keyboarding/work with elbow and arm on desk, repetitive motion." He reported a history of hypertension and high cholesterol.

Chief Deputy McCurdy testified on behalf of the employer. He testified that Petitioner's job duties involved answering the business line, taking 911 calls, and handling all radio traffic. Additionally, he agreed it involves some clerical work, such as dealing with court paperwork, entering warrants and registering sex offenders. He

testified: "there is a lot of data input that they take care of for us". Chief Deputy McCurdy testified he reviewed several written job descriptions for Petitioner's job (including all of the job descriptions contained in Respondent's Exhibit 1, the deposition of Dr. Naam), and believed they were accurate.

Chief Deputy McCurdy also testified that he tries to get to the dispatch area at least three times per day to bring and pick up paperwork, and so he sees the Petitioner daily and agreed he has to perform multiple activities simultaneously. He testified that Petitioner simultaneously used different equipment while answering phone calls. McCurdy testified that some 911 calls could be lengthy while others might be very brief depending on the nature of the calls. Additionally, the Petitioner could be busy with a lot of calls coming in, and at other times be looking for other things to do. The Petitioner does participate in IT problems. McCurdy also noted that data entry could involve typing, a mouse or a touchscreen.

Regarding the photographs of two work stations in the Communications Division, McCurdy testified that one work station was Petitioner's normal and preferred work station (Rx2a, Rx2b, Rx2c) and the second work station depicted in the photographs in Rx1 (Deposition Ex. 6, 7) was a mirror image of the first with the phone located on the opposite side.

Regarding Petitioner's alleged injuries, Chief Deputy McCurdy testified that Petitioner had been working full duty since he reported the alleged accident. He was unsure when Petitioner first provided notice of his alleged injuries, but Petitioner had made no recent complaints regarding his left arm. He was aware of the Petitioner and his family having a graphic design business at some point, noting at some point that ended, and recalled years prior that he and other officers discussed computer gaming.

Ideally, the Respondent would like to have two communications officers working simultaneously, but it doesn't always work out that way, and the Petitioner spends at least three hours of his workday alone every shift. On cross examination, Chief Deputy McCurdy testified that the Petitioner was a trusted and hard worker, and that he had no reason to dispute the Petitioner's testimony as to the way he used his upper extremity to answer the phone.

Surgeon Dr. Young was deposed on 3/30/15. (Px2). He testified that he diagnosed the Petitioner with left cubital tunnel syndrome, and prescribed ulnar transposition surgery, noting Petitioner had undergone the same procedure on the right side with good results. He noted that the Petitioner had been prescribed bracing and an elbow pad, but that while he reported improvement on 2/12/13, he also noted ongoing pain and numbness. He testified that while he didn't have specific recall of the conversation, the Petitioner stated that he did quite a bit of desk work with his arms flexed on the desk, some phone answering and talking on the radio, and that he believed this discussion took place on 12/31/12. Dr. Young agreed that while he discussed the job duties with the Petitioner, the vast majority of his understanding of the job came from a questionnaire the Petitioner completed for his office. He had no other sources of information regarding the Petitioner's job duties, did not review any written job descriptions and had not seen any depictions of the Petitioner's work station. He testified that his understanding was that when the Petitioner had his elbows flexed and resting on the desk that they would bear weight, and that this activity could have caused or contributed to cubital tunnel. (Px2).

On cross examination, Dr. Young noted that a questionnaire Petitioner completed indicated an onset of several months prior, while a face sheet stated the symptoms began in October 2012. Dr. Young agreed that the EMG/NCV he obtained was within normal limits. While he did not specifically note a diagnosis of cubital tunnel in his records, he testified that the only reason for an ulnar transposition to be prescribed was for the condition of cubital tunnel. He agreed that at one of his visits the Petitioner was 5'6" tall and weighed 310

pounds. It was his understanding that the Petitioner spent about 4 hours per day typing and 3 hours per day on the phone, and, again, that this was based on the information in the questionnaire. (Px2).

The Arbitrator notes that while the Respondent objected to Dr. Young's causation opinion based on a failure to indicate such opinion prior to the deposition, the Arbitrator finds that the opinion is not barred in this regard. In the case of Ghere, the court noted that the key issue is whether the testimony was a surprise to the opposing party. Here, it is clear that the purpose of the deposition was to determine both Dr. Young's knowledge of the Petitioner's job duties as well as whether those duties were causally related to the diagnosis of left cubital tunnel syndrome. In this regard, the Arbitrator notes that Dr. Young indicated on 2/12/13 that he would seek approval of the left transposition surgery via workers' compensation. (Px3). Whether that opinion is valid or credible in this case goes to the weight of the testimony, not its admissibility.

The parties deposed Dr. Naam on 11/10/15. (Rx1). Following his examination on 2/7/13 and review of the Petitioner's medical records, Dr. Naam diagnosed left cubital tunnel syndrome that was not confirmed by the normal EMG/NCV. Dr. Naam testified he would be reluctant to proceed with surgery absent a positive EMG/NCV, and recommended continued conservative care, followed by a repeat EMG/NCV and, if necessary, surgical intervention. (Rx1).

Dr. Naam testified that the Petitioner reported that he developed numbness and tingling in the left hand several months prior to his 2/7/13 examination, and that it may have started before that but that he had gradually worsened over the prior few months with increasing hand weakness and awakening during sleep. Petitioner reported that his job mainly involved receiving 911 and other calls, as well as computer keyboarding, and that he also sat with his elbows flexed on the desk while awaiting phone calls. (Rx1, Depo Ex. 2). Dr. Naam believed that the Petitioner did suffer from left cubital tunnel syndrome, but with regard to causation, he wanted to obtain more detailed information regard the Petitioner's job duties before making a determination. He subsequently reviewed two written job descriptions (Rx1, Depo Ex. 8-9), a Job Demands Analysis (Rx1, Depo Ex. 10), and several photographs of a dispatcher's work space (Rx1, Depo Ex. 6-7).

The Arbitrator reviewed these additional records as well. Deposition Exhibit 8 did not add a lot of detail with regard to the physical aspects of the Petitioner's job. Deposition Exhibit 9 indicated that the job required a lot of multi-tasking in handling multiple phone lines and data entry while also making dispatches of personnel. While the Job Demands Analysis in Deposition Exhibit 10 did not detail the Petitioner's activities in terms of percentages of his day, it did more specifically describe his daily tasks.

Following his review of these materials, Dr. Naam opined that there was no causal connection between Petitioner's work activities and his left cubital tunnel syndrome. He opined that Petitioner's work activities did not require sustained acute flexion of his elbow. While he acknowledged that holding a phone to his ear constituted acute flexion of the elbow, to be causative he testified that the acute flexion must last for continuous periods of 4-6 hours. While Petitioner also did a lot of typing, when he did, he placed his elbow at about 30 degrees of flexion, which was ideal for the elbow. Dr. Naam testified that there was no indication of sustained repetitive flexion and extension of the elbow such as what one might find in jobs involving factory work, cutting meat, or working on dough. Petitioner's job also required no use of vibratory tools. Dr. Naam indicated that sleeping with the elbows acutely flexed could cause cubital tunnel syndrome. He also testified that Petitioner was morbidly obese, and that there is literature linking obesity and cubital tunnel syndrome, although he admitted this was a weak factor. (Rx1).

On cross examination, Dr. Naam again testified that talking on the phone for extended periods of time could contribute to causing cubital tunnel syndrome, but that to be causative such phone usage would have to be

continuous over a 4-6 hour period. Dr. Naam noted this was not the case in Petitioner's job as he simultaneously performed other tasks such as typing, receiving calls, and communicating with emergency responders. Dr. Naam testified that "[Petitioner] was doing lots of activities at the same time, so it [was] highly unlikely that he was sitting with his elbows flexed for 4-6 hours." While he agreed that different doctors could come to different conclusions regarding causation, he testified that any such causation opinion would have to be based on science, and not simply be an opinion that is not based on an application of the facts to the science. (Rx1).

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 he sustained accidental injury to his left upper extremity which arose out of and in the course of his employment with Respondent. The Arbitrator further finds that the Petitioner failed to prove that his left ulnar neuropathy was caused by his work activities.

In many cases involving repetitive trauma claims, such as the case at bar, issues of arising out of the employment and causation are intertwined. Here, the Petitioner has failed to show that his work involved activities which would constitute an accident which arose out of the employment or that such work activities caused cubital tunnel syndrome.

In making this finding, the Arbitrator notes that the opinions of Dr. Naam were more persuasive than that of Dr. Young. First, Dr. Young's knowledge of the Petitioner's job duties was limited. He reviewed the questionnaires that the Petitioner completed for his office, and testified he discussed the Petitioner's work duties with him. That said, the testimony of Dr. Young did not reflect a clear understanding of the frequency of the Petitioner's various job duties.

Dr. Naam provided much more detailed testimony, as noted above, regarding why he did not believe that the Petitioner's work duties were causative of cubital tunnel syndrome. The evidence in the record also indicates that he is a very experienced hand surgeon. His testimony reflected a more thorough review of the evidence in this case in making a causation determination. As an example, Dr. Naam testified that he specifically asked the Petitioner to demonstrate how he used a computer keyboard, and in doing so indicated that he flexed his elbows at 30 degrees, which Dr. Naam opined was optimal for the task, and which the Arbitrator notes would not involve the type of elbow flexion described by Dr. Naam as causative of stretching of the ulnar nerve. The Petitioner did testify that he would lean on his arms on the desk, but it is also accurate that Dr. Young did not indicate detailed knowledge of how the Petitioner performed the task.

While Dr. Young also has solid experience as a hand surgeon, he simply did not explain the basis of his causation opinion very well, and not nearly to the degree of detail as explained by Dr. Naam. The Arbitrator notes that the questionnaire completed by the Petitioner for Dr. Young indicated percentages of his work day that he spent on various activities, but that the total of these percentages was 305%. While the Petitioner's job clearly involved multitasking, this description was simply not specific enough to support an opinion that was more persuasive than that of Dr. Naam. Dr. Young's opinion strongly appeared to be based on simply reviewing the Petitioner's questionnaire as opposed to obtaining more detail from the Petitioner himself.

At one point in the testimony, the Petitioner testified that after he would answer the phone with his left hand, he would transfer the phone to his right hand to talk. At another point he indicated that he would hold the phone between his head and shoulder. The Arbitrator believes it is unlikely that the Petitioner, given the variety of things he had to do in his job, was sitting at his desk with his elbows forcefully flexed for the period of time indicated by Dr. Naam to be causative of cubital tunnel. The evidence also does not support that the Petitioner was repetitively flexing his left elbow to the degree that Dr. Naam indicated would be needed to be a causative factor in his condition.

The Arbitrator finds that the evidence indicates that it is more likely than not that the Petitioner's work duties were not causally related to his development of left cubital tunnel.

WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, and 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 findings with regard to accident and causation, these issues are 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 findings with regard to accident and causation, this issue is moot.

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings with regard to accident and causation, this issue is 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

Michele L. LeMatty (Logsdon),
Petitioner,
vs.

NO: 13 WC 18296

Cassano's Pizza & Subs,
Respondent,

17IWCC0406

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, 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 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.

The party commencing 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: JUN 27 2017
o060817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LeMATTY, MICHELE L (LOGSDON)
Employee/Petitioner

Case# **13WC018296**

CASSANO'S PIZZA & SUBS
Employer/Respondent

17IWCC0406

On 10/18/2016, 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 0.47% 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:

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

1256 HOLTKAMP LIESE ET AL
R KENT SCHULTZ
217 N 10TH ST
ST LOUIS, MO 63101

17IWCC0406

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

Michele L. LeMatty (Logsdon)
Employee/Petitioner

v.

Cassano's Pizza & Subs
Employer/Respondent

Case # 13 WC 18296

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay** , Arbitrator of the Commission, in the city of **Springfield** , on **August 19, 2016.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

17IWCC0406

On **May 8, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$28,080;** the average weekly wage was **$540.00.**

On the date of accident, Petitioner was 37 years of age, ***single*** with one dependent child.

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

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

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

Respondent is not entitled to a credit for any medical bills for which credit is allowable under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on May 8, 2013 that arose out of and in the course of her employment with Respondent or that her conditions of ill-being in her upper extremities were causally related to her accident or her employment with Respondent. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Nancy Lindsay
Signature of Arbitrator

October 13, 2016
Date

OCT 18 2016

Michelle L. LeMatty (Logsdon) v. Cassano's Pizza and Subs - 13 WC 018296

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner presented to Blessing Hospital on May 8, 2013 regarding burning and tingling in her left hand. She denied any known injury and was noted to bc in no acute distress. She reported working in the food industry. There was swelling present in her left hand and she was given a splint. A pain drawing shows only left-sided wrist complaints. The doctor's impression was carpal tunnel syndrome. Prescriptions were given and she was discharged. Petitioner was given informational material on carpal tunnel syndrome. Petitioner was instructed to follow up with a primary care physician of her choice in one to two days. (PX 2, pp. 1-24, 66-73)

That same day, Petitioner was seen by Dr. Thomas Miller of Quincy Family Practice[1]. At that time she reported discomfort in her non-dominant left wrist and hand with a history of approximately six months of swelling and achiness. Petitioner added that it had "started in her back and she had been working with a chiropractor." Her current complaints included discomfort, burning, and tingling in her hand. Petitioner denied any significant trauma and complained of some night pain. It was noted that she worked for Respondent "now." The pain had been so bad that she had to go to the emergency room where she was given a splint and told to come here. On exam, mild diffuse swelling in the left hand was noted when compared to the right hand and any motion was uncomfortable. Provocative testing could not be done as Petitioner reported any motion was uncomfortable. She was given high dose nonsteroidal medication. Petitioner reported having undergone "thyroid testing, etc." in the past six months and being told they were normal. Petitioner was noted to be "a little emotional." It was recommended that she continue to wear the splint and stay off of work until she returned in one week. (PX 8)

Petitioner was off work as of May 8, 2013.

Petitioner returned to see Dr. Miller on May 14, 2013 regarding left hand numbness and tingling as well as neck pain. Petitioner was reporting less pain but ongoing numbness and tingling in her thumb and index, long and ring fingers of her left hand. She had not worked in the last week and had completed most of the medications given to her through the emergency room. Petitioner still reported neck pain. On examination, Petitioner's left hand was slightly more swollen than her right hand and she had decreased range of motion. He also noted some subjective decrease in sensation along the median distribution of the left hand compared to the right and some discomfort with compression of the carpal tunnel. Her neck had "reasonable range of motion" with some discomfort with compression of her head but a negative Spurling's. Petitioner had normal range of motion of her shoulders and elbows. Petitioner was referred for therapy due to her neck problems. Petitioner stated she had been working with a chiropractor for a while but that wasn't necessarily helping her. Dr. Miller also ordered an EMG of Petitioner's left upper extremity as well as an EMG of her left lower extremity. Petitioner was given a work restriction of no jobs requiring fine dexterity with the doctor noting she should use the splint only at night. (PX 8)

[1] Only the records of QFPC subsequent to May 8, 2013 were subpoenaed/requested. (PX 8, p. 1)

Pay stubs indicate Petitioner worked 9.25 hours for Respondent between May 13, 2013 and May 20, 2013. (PX 9)

Pay stubs further indicate Petitioner worked 23.75 hours for Respondent between May 16, 2013 and May 27, 2013. (PX 9; AX 1)

On referral of Dr. Miller, Petitioner was seen by Dr. Crickard, an orthopedic surgeon, on May 28, 2013. (PX 1, pp. 142-143) Petitioner reported left hand numbness and tingling that had started in November and slowly progressed. She reported that in May she was using a reciprocal knife chopping onions when she experienced a sharp pain with numbness and tingling into her hand and she had to quit that activity. On examination, Petitioner had a positive Tinel's and Phalen's over the median nerve and had minimal thenar atrophy present in the left versus right. Dr. Crickard diagnosed left carpal tunnel syndrome and recommended an EMG. Dr. Crickard noted that he had reviewed the literature of workmen's comp and her history and past history and stated in his note that "certainly there is a mechanism at work for overuse of hands. This can lead to carpal tunnel syndrome." (PX 1) Petitioner was released to return to work on May 29, 2013 with restrictions and she was to return to see the doctor after undergoing the EMG. (PX 2, p. 53)

Petitioner signed her Application for Adjustment of Claim herein on May 30, 2013. (AX 2)

Petitioner worked 17.25 hours for Respondent between May 27, 2013 and June 2, 2013. (PX 9)

EMG testing was performed by Dr. Sullivant on June 4, 2013 and was positive for bilateral median nerve compression neuropathy at the wrist (carpal tunnel syndrome) left greater than right. Petitioner's findings were moderate to severe on the left and mild to moderate on the right. (PX 1, pp. 146-147)

Petitioner worked 31.25 hours for Respondent between June 3, 2013 and June 10, 2013. (PX 9)

Petitioner returned to Dr. Crickard on June 11, 2013 and he reviewed the EMG findings. (PX 1, p. 137) Dr. Crickard advised Petitioner that her treatment options including surgery.

Petitioner was seen in the emergency room on June 12, 2013 for generalized complaints of nausea. No upper extremity complaints were noted. (PX 2, pp. 25-44, 74-78)

Petitioner worked 23.25 hours for Respondent between June 10, 2013 and June 17, 2013. (PX 9)

Petitioner worked 21.0 hours for Respondent between June 17, 2013 and June 21, 2013. (PX 9)

Petitioner underwent surgery to her left wrist on June 21, 2013, consisting of a left carpal tunnel release. It was noted that the median nerve showed an hourglass configuration. (PX 2, pp. 55-56) Petitioner was taken off work as of June 21, 2013. (PX 2, p. 54)

There are no pay stubs in the record for the time period between June 23, 2013 and July 22, 2013. From the year to date earnings found in PX 9, it does not appear Petitioner worked during that time.

Petitioner underwent a right carpal tunnel release on July 5, 2013 and the median nerve on that side also showed an hourglass configuration. (PX 2, pp. 120-130)

Petitioner followed up with Dr. Crickard post-operatively on July 18, 2013 at which time she reported having some trouble recovering her full grip bilaterally and limited wrist movement on the right. (PX 1, p. 117-118) Dr. Crickard prescribed occupational therapy which began on the following day. (PX 1, pp. 115-116) He indicated that Petitioner was requesting a return to work with restrictions in a few days and, therefore, she was released to return to work on July 24, 2013 on light duty with restrictions. (PX 1, p. 123; PX 2, p. 54)

Petitioner worked 12.0 hours between July 25, 2013 and July 28, 2013. (PX 9; AX 1)

Petitioner's occupational therapy continued through August 1, 2013. (PX 1, p. 110) The final therapy noted indicated that although Petitioner's range of motion and strength had improved, she had not met her goals for relief of pain. Petitioner was released to return to work without restrictions on that date. (PX 1, p. 122)

Petitioner worked 3.75 hours between July 29, 2013 and August 4, 2013. (PX 9)

On August 12, 2013 Thomas L. Yoss authored an Ergonomic Job Analysis for Petitioner's job as an assistant manager. According to the report, Petitioner had resigned effective July 25, 2013. According to its description, she worked approximately 32-35 hours/week, five days a week, including Tuesday and Saturday from 4:30 p.m. to 11:00 p.m., Wednesday and Thursday from 10:00 a.m. to 5:00 p.m., and Sunday from 9:00 a.m. to 5:00 p.m. It identified her job duties to be 70-80% assistant managerial duties, and 20-30% restaurant duties. It described her managerial duties as assigning employees to various work tasks, providing training for new and current employees, opening and closing the restaurant, counting money from deliveries and restaurant receipts, reconciling daily sales, and making the bank deposits at the end of the shift. It reported that during the three week days she worked, her managerial duties were more than during the weekend, maybe 80-90%. It also described the restaurant duties she would perform. (RX 1)

At the request of Respondent, Petitioner underwent an examination with Dr. William Strecker on August 27, 2013. (RX 3) A written report followed. (PX 9) Dr. Strecker noted that Petitioner provided a history of having begun experiencing numbness and tingling in her hands in January of 2013, more on the left than the right, and also associated with back, neck and shoulder pain. Petitioner noted a burning pain in her left arm when lying down and the same problems with her left leg. Petitioner had initially undergone treatment with her chiropractor. Petitioner further stated that after chopping onions one day with a rocker knife she had a severe increase in pain in the left hand radiating to the elbow. The pain was so severe that she had to go to the emergency room where she was placed in a splint and given Ibuprofen. Petitioner further reported that three days later, her back, neck and shoulder pain had completely resolved. She then went to her family doctor who discontinued her brace. Thereafter she underwent EMG and nerve conductions studies which confirmed bilateral carpal tunnel syndrome and Dr. Crickard subsequently performed releases.

As of the date of Dr. Strecker's exam Petitioner was reporting that most of her symptoms had resolved. She noted occasional numbness on the left side but no night pain or pain to the upper extremity. Petitioner also reported that her right hand was no longer numb although she occasionally experienced a "jittery" feeling. Petitioner told Dr. Strecker that she had worked for Respondent for the last thirteen years as an assistant manager making pizzas, sub sandwiches, and salads. Her duties included food preparation,

chopping onions once a week, proofing and separating the dough, spreading ingredients, saucing pizzas, doing register work, checking receipts, counting money and engaging in clean-up.

Dr. Strecker reviewed Petitioner's treating records since May 8, 2013 and based upon his review of them, along with his examination and discussion with Petitioner, concluded that she had bilateral carpal tunnel syndrome unrelated to her job duties for Respondent under either a causation or aggravation theory. He based his opinion on her description of her job duties. He felt her treatment had been reasonable and necessary in regard to the condition, that she was at maximum medical improvement and that she needed no further treatment but could work full duty. (RX 3 - res. ex. 3)

Deposition of Dr. Strecker

The deposition of Dr. Strecker was taken on September 12, 2013. Dr Strecker testified that he is an orthopedic surgeon and, on average, performs two to three carpal tunnel releases per week. (RX 3, pp. 6-7) Dr. Strecker opined that Petitioner's work activities were not a cause of her carpal tunnel syndrome due to the varied nature of her tasks and lack of use of vibratory tools or abnormal positions of the wrist. (RX 3, pp. 12-14, 17) Dr. Strecker testified that Petitioner had an excellent result from her surgery and could work without restrictions. (RX 3, p. 16) On cross-examination, Dr. Strecker acknowledged that when Petitioner described her work activities as provoking her symptoms that didn't mean they caused or contributed to the condition. He agreed that certain activities would provoke symptoms because the activity is causing some compression of the nerve but the condition is already there. (RX 3, pp. 22-24,28) Dr. Strecker testified that he performs 3 independent medical examinations per week and that 90 percent of those are for employers or their insurance companies. (RX 3, p. 29)

Additional Medical Treatment

Petitioner returned to Dr. Crickard on October 17, 2013 complaining of pain in her right carpal tunnel region. (PX 1, pp 101-102) He also noted that she had left hand swelling and some numbness and tingling. Petitioner also reported pain in her right arm from the elbow down. On examination, Dr. Crickard noted that she had good motion at the elbow and wrist but her Tinel's was mildly positive bilaterally. He recommended some physical therapy and Celebrex, and told her it could take a full year to recover from her prior surgery.

Records show that Petitioner began therapy on October 21, 2013 and continued through November 12, 2013. According to the October 21, 2013 therapy note, Petitioner was working twenty hours per week for Addus Home Care assisting the elderly. Petitioner was complaining of left shoulder, neck, and arm pain as well as leg pain. Petitioner's right wrist range of motion was normal. No notation of any new problems (such as a ganglion cyst on the right wrist) was noted. As of October 31, 2013 Petitioner was performing all tasks with little or no difficulty. At her final appointment, Petitioner felt she was getting worse rather than better and the therapist recommended discharge as she was not progressing with therapy. (PX 1, pp. 79-90)

Petitioner was next seen by Steven Dement, P.A. in the orthopedic department at Quincy Medical Group on November 12, 2013. (PX 1, pp. 75-76) Petitioner reported that her left hand and arm were doing fine but she had persistent vague complaints of pain in the right arm, reporting pain over the dorsum of her wrist, and both medial and lateral epicondyles of her elbow. According to Petitioner therapy had not

improved her strength or function much. P.A. Dement was not clear of her diagnosis and placed her in a splint to follow up with Dr. Crickard in two weeks.

Petitioner was then seen by Dr. Crickard on November 26, 2013, reporting some improvement since her surgeries but some ongoing right wrist pain with minimal numbness and tingling. (PX 1, pp. 72-73) He gave Petitioner a prescription for Celebrex and told her to shoot for a return to work in a month.

Petitioner returned to Dr Crickard on January 7, 2014, reporting continued right elbow to wrist pain and that her arm felt swollen. (PX 1, pp. 59-60) Dr. Crickard did not note any swelling but noted that she was diffusely tender around the elbow and had a little atrophy in the thenar area as she has before. Dr. Crickard recommended a repeat EMG and a second opinion.

In a letter dated January 7, 2014 Dr. Crickard opined that Petitioner's symptoms, given her history, "seem to be exacerbated by her duties at work." He had reviewed her work description and job analysis and spoken with Petitioner about her job several times. "Bottom line is, her symptoms seem to worsen with activities at work." He also noted that Petitioner's history included pain, numbness and tingling starting in November of 2012. She was at work using a reciprocal knife chopping onions when she started having increasing pain, numbness and tingling. It then bothered her afterwards when doing repetitive use of the hands in work. Petitioner was noted to still be in recovery with strength and pain relief type therapy. (PX 4, dep. ex. 2)

On January 8, 2014 Petitioner presented to Dr. Wells/N.P. Kline to establish care and discuss several issues including female-related problems, weight gain, irritable bowel syndrome, and reflux problems. Petitioner had reportedly lost 36 pounds in the previous year, went through a divorce at that time which she was happy about, and has since gained all the weight back. She reported significant issues with reflux which was affected by stress. Petitioner reported a high stress level right now as she was unable to work due to her carpal tunnel issues. Her most recent job had been with home health care. It was noted that Petitioner's wrists were being taken care of by Dr. Crickard. Despite surgery, she felt her hands were still painful. Various treatment suggestions were given although nothing specific regarding her hands/wrists. (PX 5, pp. 79-82)

EMG testing was done on January 27, 2014 by Dr. Hake at Quincy Medical Group. It showed that Petitioner's left median nerve entrapment was improved and her right median nerve entrapment was resolved compared to her previous study. (PX 1, p. 63)

Petitioner returned to Dr. Crickard on January 30, 2014, who noted the EMG results. (PX 1, pp. 56-57) Dr. Crickard indicated that he was referring Petitioner to one of his partners as he did not know what else to do with her. He noted that she was becoming depressed.

Petitioner presented to Dr. Wells/N.P. Kline on February 3, 2014 regarding numerous matters. According to the office note, Petitioner "thinks what has happened the past year has caught up with her – she says she doesn't know if she has anxiety or nervous breakdown – she says she feels like she has had one or something she doesn't know – has carpel [sic] tunnel in both hands had surgery – left side goes numb still she found out she has a lump on her neck and cyst on ovary – is having family issues – she says she was sick for two weeks and finally got over that – she says she is tired and either can't sleep or sleeps all the time – says in 13 years at her job she missed 6 days but had to quit because of things going on." (PX 5, p.

76) Petitioner was described as a single mom who had many things going on in the last year and most of her life. She was "forced" to quit the job she had for 13 years because of being off for carpal tunnel. Dr. Crickard was seeing her for a second opinion on her carpal tunnel syndrome. Petitioner didn't know why she was having right elbow pain. She had undergone a myelogram the previous week and it didn't turn out well. She had also been taking care of her grandfather, her mother had MS and her uncle was causing problems between she and her grandfather. Petitioner was feeling helpless and hopeless. She was prescribed medication for her anxiety and depression and counseled. (PX 5, pp. 76-78)

Petitioner was examined by Dr. Philpott on February 12, 2014 reporting her past bilateral surgeries but ongoing problems of left hand numbness and right hand pain and weakness. Petitioner was offered re-exploration of her left hand for which she expressed interest. Dr. Philpott noted he would impose no work restrictions; however, "she and her lawyer are not happy with this [as] they feel that return to work would be dangerous." She had sensation and, in particular, "SILT", protective sensation. He noted nothing would make that worse. He noted, "I will cancel surgery since I am unsure this will even work, and prefer to help people with prob[lem]s rather than help other claims." Petitioner was advised to follow up as needed. (PX 2, p. 186)

While Dr. Philpott noted in his dictation of February 12, 2014 that surgery was to be cancelled, a handwritten note states that it never was. (PX 2, pp. 185-186)

Petitioner was examined by Dr. Wells/N.P. Kline on February 18, 2014 regarding medications previously ordered for crying spells and anxiety. Petitioner reported a reduction in crying spells but still no motivation. She was scheduled for left carpal tunnel surgery with Dr. Phillpott and was scheduled for a right wrist MRI on the 19th. Petitioner reported she would be having a cyst removed also. Petitioner reported being treated really badly by her manager and being forced out of work and losing her health insurance and "work comp [was] fighting her." Medications to assist with her anxiety and insomnia were adjusted. (PX 5, pp. 73-74)

While surgery was tentatively cancelled, Dr. Philpott did order an MRI of Petitioner's right wrist. That MRI, taken on February 19, 2014, showed a full thickness complex triangular fibrocartilage tear. (PX 1, p. 50)

Petitioner was seen at Dr. Wells' office on March 3, 2014 requesting medications. Petitioner was scheduled for left wrist surgery on March 4th and experiencing some anxiety with the upcoming procedure and some drama in her family. Her prescription for Elavil was increased. (PX 5, pp. 69-71)

Records from Blessing Hospital show that Petitioner underwent a fluoroscopically guided TFCC injection to the right wrist and surgery consisting of an extended median nerve exploration and release in the left wrist on March 4, 2014. (PX 2, p. 214) Her diagnosis both pre- and post-operatively was lack of relief following left carpal tunnel release and a central tear to the triangular fibrocartilage complex on the right.

Petitioner returned to Dr. Philpott on March 10, 2014, reporting much improvement and resolution of her numbness, though she noted some numbness and pain in her right elbow following the injection in her wrist. (PX 1, pp. 42-43) She was directed to maintain her surgical incision and to avoid lifting more than 10 pounds. Petitioner returned again on March 26, 2014 again reporting continued improvement at that her numbness was "mostly resolved". (PX 1, pp. 34-36) On examination she was noted to have no

tenderness, full range of motion, and intact sensation. Her sutures were removed and she was advised to avoid lifting 10 pounds for another 3 weeks, and to then follow up in two months.

On April 11, 2014 Petitioner began working at Pizza Hut.

Petitioner was seen at Blessing Hospital's Emergency Department on April 11, 2014 due to a rash. She had been working out in her yard and was worried about shingles. She was treated for acute urticaria and discharged to home. (PX 2, p. 228)

On April 12, 2014 Petitioner completed a Pain Management Patient Health Questionnaire for Hannibal Regional Medical Group. Petitioner stated she had been referred by "Dr. Kline" due to ongoing pain, numbness and restlessness in her arm and hand along with weakness in her grip. She reported trouble sleeping. Petitioner gave an onset date of December of 2012/ January of 2013. She did not indicate an accident at work; rather, she stated "Pain just began." (PX 3, p. 12) Petitioner also reported that she thought she had a pinched nerve in her back making her hands numb and she started going to a chiropractor. Then, at work, she was chopping onions and she had an enormous amount of pain from her hand to her elbow and went to the emergency room. (PX 3, p. 12) Petitioner stated she wore a brace and that her pain greatly interfered with her activities of daily living. Her pain was worse when attempting activities and trying to sleep. Petitioner filled out a pain drawing (PX 3, p. 14) and noted how her pain was interfering with her activities of daily living. (PX 3, p. 15) Petitioner also acknowledged having taken care of her grandfather with home care. She was a college graduate but not currently working due to her hands. (PX 3, p. 19)

Petitioner returned to see Dr. Philpott on April 14, 2014, reporting that her hand was hurting again since the previous Friday and that it had begun "hurting while picking up boxes at her job." (PX 1, pp. 24-25) She had contacted Dr. Philpott over the weekend reporting that she had started work at a new job at Pizza Hut on April 11 and worked for 2 hours, with increased pain and a pulling feeling in her wrist. Petitioner also reported having pain since Friday night including a feeling like restless leg symptoms in her hand but it had resolved except for the pulling feeling in her dorsal wrist. Petitioner also reported having swelling in her left hand since Friday night. Dr. Philpott pointed out to Petitioner that there was no obvious edema in either hand. Dr. Philpott's examination was negative and he noted that he found no physical cause of her pain. She was referred for assessment of her pain by a pain management doctor. Petitioner was released to full duty. (PX 5, pp. 53-55)

Petitioner presented to Dr. Wells' office on April 15, 2014 requesting pain medication as she had undergone left carpal tunnel surgery six weeks earlier and was experiencing a "restless leg syndrome" of her hand/wrist and couldn't sleep. The surgeon had told her there was nothing he could do for her. She had just tried to work for three hours on the 14th and couldn't do it. Petitioner reported her hand was swollen and shaky all the time. He had tried to get her into pain management but the provider wouldn't take workers' compensation cases. Petitioner was very upset by it all and had experienced an anxiety attack the day before. Petitioner didn't feel her left hand surgery had helped whatsoever as she was continuing to have pain in her palm and wrist. She had worked at Pizza Hut for three hours on the 11th and said she couldn't do the work and was in excruciating pain by the end of her shift and told her employer she couldn't work there. When she started the shift she felt okay. She hadn't been doing her wrist/hand exercises. Petitioner's examination was normal. It was felt Petitioner should go to a pain clinic for a consultation and alternate ice and heat and do her wrist exercises. (PX 5, pp. 65-67)

Deposition of Dr. Crickard

The deposition of Dr. George Crickard III was taken on April 23, 2014. (PX 4) Dr. Crickard is a general orthopedic surgeon with an emphasis on joint replacement. He is not board certified. Dr. Crickard testified to performing 50 to 75 carpal tunnel releases per year. Dr. Crickard testified that he began treating Petitioner on May 28, 2013 with regard to left hand numbness and tingling that she reported began in November of 2012. According to the history Petitioner provided, her symptoms continued to get worse until she was working with a reciprocal knife and chopping onions and she experienced a sharp pain with numbness and tingling into her hand and she had to quit. She went to the emergency room and was diagnosed with carpal tunnel syndrome and treated with a brace and anti-inflammatory medication prior to seeing Dr. Crickard. Dr. Crickard testified that Petitioner related to him that she was having problems at work and had to quit due to numbness and tingling along with daily pain. Petitioner reported less grip strength also. (PX 4, pp. 1- 8)

Dr. Crickard testified that Petitioner was not pregnant or diabetic which ruled them out as risk factors for carpal tunnel syndrome. Her only activity outside of work was tennis but she had only played once that year. His examination was consistent with left carpal tunnel syndrome and he recommended an EMG. Dr. Crickard testified that Petitioner brought up workers' compensation and he reviewed the literature on it and her history. He told her that there was a mechanism at work for overuse of her hands and that could lead to carpal tunnel syndrome; however, they needed to wait for the EMG. Dr. Crickard testified to imposing work restrictions for her left hand. (PX 4, pp. 8-11)

Dr. Crickard further testified that Dr. Sullivant performed an EMG on June 4, 2013 and concluded that Petitioner had bilateral upper extremity median nerve compression at the wrist (carpal tunnel syndrome), left greater than right. Petitioner then returned to see him and he went over the EMG with her and they discussed surgery. Dr. Crickard testified to performing surgery in June and July of 2013. He noted that Petitioner's nerve had the hourglass "squished" position as it came through the carpal tunnel. Petitioner was taken off work completely at the time of her first surgery. Dr. Crickard testified that as of July 18, 2013 Petitioner was examined by his physician's assistant, Steven Dement, who noted she was doing well although she was having trouble recovering full grip bilaterally and had some limited right wrist motion. Occupational therapy was ordered and, as she requested she be returned to work, Dr. Crickard gave her a return to work slip for July 24, 2013. (PX 4, pp. 11 – 16)

Dr. Crickard testified that he next examined Petitioner on August 1, 2013 at which time she denied any pain in her hand unless "she hits it just right." Her numbness and tingling were better. She was to increase her activity and call if she had any trouble. She was released to return to work on August 1, 2013 with no restrictions. Dr. Crickard did not see Petitioner again until October 17, 2013 at which time she was complaining of right wrist pain. She also had some left hand swelling in her palm and fingers, along with numbness and tingling. Her right hand was painful from the elbow down. He ordered physical therapy and Celebrex to address the inflammation in the nerve. She was released to return to work on October 17, 2013. (PX 4, pp. 16- 18)

Dr. Crickard testified that Petitioner returned on October 25, 2013 and was examined by P.A. Dement. She had done "fairly well on the left, but the right ha[d] been problematic" as she described pain radiating from her wrist up to her elbow. P.A. Dement noted that during therapy a lump on the ventral surface of her wrist had been noted and when she pressed in the carpal tunnel area, the lump would increase in size

but it wasn't painful. It was felt she probably had a ganglion cyst that simply needed to be watched. Dr. Crickard did not know her work status at that time. (PX 4, pp. 18-20)

Petitioner, according to Dr. Crickard, returned to see P.A. Dement on November 12, 2013 and she was reportedly struggling with some vague and somewhat wandering arm pain since her right carpal tunnel release. Her left side was fine. She complained of aching, pulling, and stretching pain in the dorsum of her right wrist, over her thumb extensor tendons, and on both the medial and lateral epicondyles of the elbow, worse when she was done working and at night. It was a little better with Celebrex and she was going to occupational therapy. P.A. Dement was unsure of a clear diagnosis as her complaints did not seem nerve related nor did she seem to have a wrist sprain, thumb tendinitis, or epicondylitis. He recommended continued use of the Celebrex and therapy. Petitioner was given a script of no use of the right arm at that time. (PX 4, pp. 20-21)

According to Dr. Crickard, Petitioner returned to the clinic on November 26, 2013. She was reportedly better with only occasional right wrist pain but minimal numbness and tingling. She was to continue the Celebrex which she stated she could get for free from a clinic in Hannibal. Petitioner told the doctor she wasn't "wild about return to work" and they had a long discussion about it. The doctor told her to shoot for a full duty return in one month. In the interim, she had limited right hand use. Dr. Crickard further testified that Petitioner then returned on January 7, 2014 with right elbow to wrist pain and reported it felt swollen. He could find no swelling on exam but noted she was diffusely tender around her elbow. He testified that Petitioner was wearing a wrist splint and had a little atrophy in the thenar area as she had before surgery. Dr. Crickard testified that he wished to repeat the EMG as he felt a second opinion was a good idea as he was stuck regarding further care. She was released to return to work with limited use of the right hand. According to Dr. Crickard a repeat study was performed by Dr. Hake and it suggested her left median nerve entrapment had improved and the right entrapment had resolved. Dr. Crickard testified that he then met with Petitioner on January 30, 2014 and they reviewed the EMG results and he suggested she see one of his partners to determine if he was missing something, Petitioner told him she was beginning to get depressed because she had not worked for Respondent in quite some time, having been there for 13 years before. She had an appointment with a psychologist pending for the next week. Dr. Crickard testified that she had an appointment scheduled with Dr. Philpott, one of their plastic surgeons who specialized in hands, for January 30, 2014 but he had no information concerning the visit. (PX 4, pp. 21-24)

Dr. Crickard acknowledged preparing a report for Petitioner's attorney which was included in the deposition as Exhibit #2. He also identified Exhibit #3 as the letter from Petitioner's attorney which included an ergonomic work study of Petitioner's work activities with Petitioner's own handwritten comments about her work activities. When asked about causation between Petitioner's carpal tunnel syndrome and her work duties for Respondent, Dr. Crickard testified:

> Certainly looking at her job description and in discussions with her of what she does, she certainly does use her hands quite frequently. Although it's not a true repetitive type labor – in other words, doing the same thing minute after minute after minute after minute – it is a

> very hands-on, lifting type of job. That combined with her history of being symptomatic when she's at work and having worsening symptoms a work and after work combine to state that more probable than not her work environment does increase her risk of carpal tunnel syndrome. (PX 4, p. 26)

Based upon the foregoing testimony, Dr. Crickard was of the opinion that Petitioner's work activities were a contributing cause in Petitioner's need for the surgeries the doctor performed. (PX 4, p. 26)

Dr. Crickard was unable to provide an opinion as to the cause of Petitioner's right hand complaints post-surgery. He testified that that was why he wanted a second opinion. He thought maybe it was due to possible overuse or using her hands differently as she recovered from surgery and perhaps she irritated some tendons in her right forearm but he was having difficulty getting a true handle on the symptoms. He further testified that he, himself, never saw evidence of a ganglion cyst and he couldn't state whether it was due to her surgery or not. He did testify that a ganglion cyst at the wrist would not cause Petitioner's symptoms from her elbow to the wrist. (PX 4, pp. 26- 29)

On cross-examination Dr. Crickard testified that he had no explanation as to Petitioner's ongoing symptoms or complaints and any opinion as to causation regarding her right upper extremity forearm pain would be completing speculative. (PX 4, p. 30) Dr. Crickard further acknowledged that as of August 1, 2013 Petitioner was released to full duty and she had no pain unless "she hit it just right." He did not, however, necessarily release her from his care at that time but he didn't have to see her again unless she had problems. She then returned on October 17, 2013 at which time he ordered some additional therapy. When examined by Mr. Dement on October 25, 2013 she reported she was doing well with her left hand but the right hand was problematic. (PX 4, p. 35) Dr. Crickard was of the opinion that Petitioner's right carpal tunnel syndrome that she was originally treated for was not the cause of her ongoing right-sided complaints. He based his opinion on his subsequent clinical findings, the repeat EMG that showed complete resolution of her right median nerve entrapment and her lack of a typical recovery pattern post-surgery. (PX 4, p. 36)

Dr. Crickard testified that in January of 2014 it came to his attention that Petitioner was no longer working for Respondent. He did not dictate anything further regarding her work status after that time. If she worked anywhere else that work could cause or contribute to cause ongoing right hand/wrist complaints. (PX 4, pp. 37-38) Dr. Crickard testified that his causation opinions were based upon the history provided to him by Petitioner as well as the letter her attorney sent him (ex. 3 to the deposition) and Petitioner's version of the ergonomic job analysis. (PX 4, p. 38)

Additional Medical Treatment

Petitioner was examined by Nurse Alison Miller at Hannibal Regional Medical Group on April 25, 2014. She presented with complaints of pain in both arms which had been gradual in onset going back to late 2012, early 2013 and persistent in its symptoms (pain, numbness, restlessness, and weakness). No other information was provided. (PX 3)

Petitioner next presented to Dr. Luvell Glanton at Hannibal Regional Medical Group on April 28, 2014 for pain which she described as gradual in onset (December of 2012/January of 2013) and occurring in a persistent pattern in her bilateral arms and hands for years. Petitioner had undergone surgery bilaterally in June and July of 2013 followed by a repeat surgery to the left hand/wrist in March of 2014. Petitioner reported her hands would hurt and shake with activities of daily living and what she called "restless hand syndrome" at night which interrupted her sleep. She described the pain as moderate and located in her right arm. Dr. Glanton prescribed Lyrica for Petitioner's ongoing pain after carpal tunnel surgery. At that visit Petitioner signed a Patient Medication Management Agreement. (PX 3)

Petitioner presented to Dr. Wells/N.P. Kline on April 29, 2014 reporting she wasn't feeling very well. She thought her depression was worsening and she was having trouble sleeping, problems with migraines, anxiety, insomnia, and irritable bowel. She had seen Dr. Glanton the day before and he wanted to start her on Lyrica but insurance wouldn't cover it. She was seeing a psychiatrist for counseling and was out of medication. Her upper extremity examination was normal. No treatment for the wrists/hands was discussed or mentioned. (PX 5, pp. 61-63)

Dr. Glanton started Petitioner on a Savella Titration Pack on April 29, 2014. (PX 3)

Petitioner returned to see Dr. Glanton on May 1, 2014. No documented history was recorded. She was given a script for Neurontin, 300 mg. (PX 3)

Records show that Petitioner followed up with her doctor, Dr. Wells, at Blessing Physician Services on May 19, 2014, with whom she had also been treating for depression and anxiety. (PX 5, pp. 57-59) Petitioner reported that she had had difficulty with the gabapentin prescribed by pain management as it caused her to snap at people and feel dizzy and tired, so she had stopped taking it. She felt it had helped her pain a little bit. She described pain in her left wrist and noted that an injection in the right wrist had helped for about 3 months and wondered if a similar injection could be given in the left wrist. She was advised to continue with the gabapentin and the plan was to titrate it up more slowly to address the side effects.

Petitioner was seen by N.P. Kline/Dr. Wells on June 25, 2014 requesting a "paper stating what's wrong with her for her records – says she is taking gabapentin 3 times a day – sleeping a lot more naps – right hand is going numb feeling like pins and needles and elbow is hurting again.) Petitioner wished to discuss trying Celebrex as her IBS was acting up again and she hasn't been eating but is gaining weight. Petitioner further reported that 100 mg. of gabapentin was helping bring down her wrist pain to a tolerable level. She was napping a lot and her public aid was to run out at the end of the month as her son was turning 18. She was noted to become tearful when talking about her workmans comp case, stating they had not paid out anything for a year. Her stomach was bothering her and she was told to stop the Celebrex. Despite dietary modification and walking 40 minutes daily, she was gaining weight. Counseling was provided and Petitioner was advised to return in one month to check on her wrist. She was also instructed to keep a food diary and bring it to her next appointment. (PX 5, pp. 48 – 50)

Petitioner returned to Dr. Philpott on July 9, 2014, reporting continued pain in her hand and requesting a repeat steroid shot. (PX 1, pp. 17-18) The doctor noted that she had good improvement following the previous injection and another one was given.

Petitioner returned to Dr. Wells on July 17, 2014, for a recheck on medications. She also reported that the injection in her right wrist had helped, but her left wrist was hurting. Petitioner reported crying spells this week and trouble sleeping. (PX 5, pp. 44-46)

Petitioner was seen by N.P. Kline/Dr. Wells on August 19, 2014 regarding a recent anxiety attack and a bruise on the left side of her neck. Petitioner had gained a large amount of weight and had a break down on Thursday – crying and very upset. Petitioner wondered about changing her medication and getting some blood work done as she had a bruise come up on her neck that was strange although it went away. She was worried about bruising easily and her aunt suggested checking her B12 level. No mention of her upper extremities was made. She was advised to keep her appointment with Dr. Humphrey. Her B12 level was tested and reported as fine. (PX 5, pp. 35- 41)

Petitioner complained to N.P. Kline/Dr. Wells of pain in her left wrist when seeing them on August 27, 2014. Petitioner's primary complaint was pain in her leg and foot with pain from the thigh down on the left side and pain in the left side abdominal area which was very severe the night before. She also reported the right side of her neck hurt in the area of the glands. She also wanted to know what to do with her left hand as she was taking 300 mg. of gabapentin at night. Petitioner had just recently been seen by Dr. Humphrey who had changed some of her medications .Petitioner reported that her leg pain/thigh pain was first noticed while she was sitting in her recliner. She was concerned the discomfort could be related to her nerve problems in her bilateral wrists. She denied any injury to her left leg or foot and denied any consistent exercise program although she had been doing crunches and sit-ups for a while but noticed no difference. Petitioner reported her left wrist was intermittently painful and she had undergone bilateral carpal tunnel surgeries but they only helped for a short period of time and then her symptoms returned worse than prior to surgery. Petitioner reported that Dr. Philpott had done a couple of injections in the right wrist that helped. Petitioner's left neck tenderness was felt to be consistent with cervical lymphadenopathy. She was also diagnosed with insomnia and major depressive disorder. She was told to follow up with Dr. Philpott regarding her left wrist discomfort. (PX 5, pp. 31-33)

Petitioner returned again to Dr. Philpott on September 12, 2014. (PX 1, p. 14) He noted that she was "essentially dismissed from care" following a "well-documented re-exploration of the median nerve of her hand" with an excellent initial result but returning of symptoms. Dr. Philpott's notes indicate that Petitioner had attempted to return to work at Pizza Hut and had gone to the emergency room on her fist day. Dr. Philpott noted that he felt this seemed, in his view, "likely to keep her case open." He also noted that she had contacted him on Sunday when he was off and had been seen by the doctor's nurse practitioner who told her "they" were at the end of the road and she left the clinic. She then called back to the office asking for a steroid injection to her lateral epicondyle and, after an examination, she received one. He noted that she continued to have complaints of pain to her right wrist and a "central TFCC" on an MRI. Dr. Philpott stated that he "cannot help her anymore" and suggest that she see Dr. Bieniek who performed wrist arthroscopy and would be able to minimally invasively debride the tear. He directed his note to be sent to Dr. Bieniek. He concluded by stating that he felt Petitioner was essentially malingering and would not be seen there again. (PX 1, p. 14)

Petitioner returned to N.P. Kline/Dr. Wells again on November 24, 2014 reporting a lot of elbow and wrist pain. (PX 5, pp. 27-29) She reported pain that she was going to go to the emergency room but it "let up". However, that day she was having pain and she had been feeling extremely tired since about four

in the afternoon and she was getting a migraine again but not like before. Petitioner reported bi-weekly headaches rated a "10/10." She described her bilateral wrist pain as a level of "6/10" that was sharp, radiating to the elbow. She reported that her elbow was worse on the right and her wrist was worse on the left. Tenderness and pain with range of motion was noted on examination. Petitioner was taking 700 mg. of gabapentin daily. Petitioner was not working and was going to a free clinic in Hannibal for Effexor, gabapentin, and protonix. She was paying out-of-pocket for other medications. On examination of the bilateral elbows, Petitioner was noted to have tenderness and pain with range of motion. Full range of motion was possible and there was no swelling. Petitioner reported tenderness and painful range of motion on her right and left wrists. Petitioner was diagnosed with: carpal tunnel syndrome, strain of the left quadriceps muscle, fascia or tendon; cervical lymphadenopathy; and major depressive disorder. (PX 5, pp. 27 – 29)

Petitioner was seen at the emergency room at Blessing Hospital on December 5, 2014, complaining of chronic pain for several months in her right wrist. (PX 2, pp. 320 - 322) She reported that ever since her surgery in July of 2013 she had had increased pain. She was diagnosed with right chronic pain syndrome in her wrist.

Petitioner returned to N.P. Kline/Dr. Wells on December 8, 2014, reporting that she had been to the emergency room the previous Friday due to wrist pain and was given Percocet which was helping a lot. Petitioner reported that she was waiting on a medical card so she could see Dr. Bieniek. Dr. Phillpott had reportedly told her there was nothing more he could do for her until her wrist tear was fixed. Dr. Wells discouraged the use of Percocet and urged Petitioner to seek further care with an orthopedic doctor through a medical card. (PX 5, pp. 23-25)

Petitioner presented to Dr. Bieniek on January 27, 2015. (PX 6) Petitioner complained of left hand intermittent numbness nocturnally but not during the day. He noted her past history of 2 left carpal tunnel releases in June 2013 and February 2014. Petitioner also reported some elbow pain extending into her forearm on the left as well. On the right upper extremity, Petitioner reported complaints of ulnar-sided wrist pain and some intermittent infrequent mild numbness and lateral elbow pain. On examination, Dr Bieniek noted tenderness in both elbows along the lateral epicondylar region and reproduction of pain with resistance to wrist and finger extension. He noted tenderness along the ulnocarpal joint in the right wrist. Petitioner's right hand displayed no atrophy and she had a negative elbow flexion test. The left arm had a positive elbow flexion test and tenderness along the lateral epicondylar area of the elbow and pain reproduction with resistance to finger and wrist extension. Dr. Bieniek noted no wrist tenderness of any significance on the left side. He noted that an MRI of the right wrist showed a TFC tear. His assessment was right wrist TFC tear, bilateral tennis elbow and left cubital tunnel syndrome. He injected both lateral tennis elbows, and Petitioner was advised to try and keep her left elbow as straight as practical during the day and avoid compression of the ulnar nerve. He also recommended that she repeat the TFC injection once or twice before considering surgery since it had previously provided relief. She was to return if she wanted any additional treatment to the TFC region. (PX 6) Petitioner did not return.

Petitioner saw N.P. Kline/Dr. Wells on March 9, 2015 in regard to her blood pressure. She was told to quit smoking. According to the office note, Petitioner was seeing Dr. Bieniek for tennis elbow and she was down to ½ pack per day. (PX 5, pp. 19 – 22)

Petitioner had an appointment with N.P. Kline/Dr. Wells on March 17, 2015 regarding problems with migraines. A CT was ordered. (PX 5, pp. 14 – 18; PX 2, pp. 329-330)

Petitioner presented to N.P. Kline/Dr. Wells on March 30, 2015 due to migraines and shaky hands, mostly on the right side. Petitioner wanted her blood sugars checked with regard to the shakiness which was, sometimes, all over. Petitioner reported she couldn't go back to Dr. Beinick for any more injections until she heard from her attorney as the wrist issues were a "workman's comp thing." She reported her elbows felt 98% better but the NSAIDS, naproxen and Celebrex failed to control her pain. She said the steroid injection performed by Dr. Philpott after her surgery worked for a while. She reported not wearing a wrist brace on her right wrist. Lab work was ordered. She was told to call her attorney about getting the right wrist injection. She was encouraged to wear a wrist splint on the right wrist, especially if she was doing housework. She was offered a prescription for one but said she would get an over-the-counter one if she decides to try one as she was concerned with the cost. Petitioner was advised the doctor had very little more to offer her and he discouraged her from undergoing any further wrist surgeries because he didn't feel they would be beneficial. (PX 5, pp. 9-11)

Petitioner presented to Dr. Phan at Blessing Physician Services as a new patient, having been referred by her primary care physician, "Dr. Kline," due to sinus problems. A history of migraines and allergies was noted. (PX 5, pp. 3 – 6)

Petitioner returned to Dr. Wells on March 30, 2015, reporting that the injections in her elbows had caused her elbows to feel 98% better but she needed to hear from her attorney regarding injections to her wrist as those were a worker's compensation issue. (PX 5, pp. 9-11)

Petitioner met with her counselor on April 8, 2015 reporting ongoing struggles with chronic pain. Petitioner was intermittently tearful and didn't feel the Effexor was helping her mood. Her energy had been low recently and she was on two antibiotics. She was advised to continue her current medications. (PX 5, p. 206)

Petitioner met with her counselor on April 20, 2015 at which time they discussed various family and inter-personal issues. Petitioner mentioned that she had some concerns about her pain management, feeling that the lawyer determines when she can go to the doctor. Petitioner was encouraged to make these decisions independent of her counsel, but to review what constituted a medical emergency when she has access to a PCP and Care Coordination team at Palmyra Clinic. (PX 5, p. 205)

Petitioner was seen at the emergency room of Blessing Hospital on April 27, 2015, for chronic bilateral arm pain and anxiety. She reported chronic neuralgic type pain ever since having undergone three carpal tunnel surgeries. On examination, Petitioner was noted to have positive Tinel's signs bilaterally. Petitioner was prescribed Norco for pain. (PX 2, pp. 312-313, 350-351)

Petitioner met with Dr. Humphrey on May 20, 2015 reporting that she had recently gone on vacation and had a good time. Since coming home she had become very anxious and depressed with crying spells, low energy, feelings of worthlessness, and panic attacks. Petitioner was having increased strife with her son and was wishing she could go back to work. Petitioner also reported having migraine headaches and increased elbow pain. Petitioner's medications were adjusted and she was advised to continue with her counselor. (PX 5, pp. 195-196)

Petitioner met with Dr. Humphrey on June 17, 2015 reporting that she was recently married and the ceremony went well and she had a good time. Petitioner noted that not working has affected her greatly as she felt a lot of her independence had been taken away. Her energy level was described as fair. (PX 5, p. 191)

Petitioner met with N.P. Kline on June 29, 2015 for an annual exam. She was smoking 1/3 to ½ a pack per day. She was experiencing sharp, stabbing pain intermittently about twice a week in her right side. The Topamax was helping her headaches and she was "having issues with both elbows and wrists still." (PX 5, pp. 185-188) Petitioner also met with her counselor that day as she had just had a "break down next door" after her session with her care manager, C. Blichan. A number of issues were discussed with Petitioner noting "growing frustration" with not working and the time that was passing regarding her workman's comp case. She had self-referred herself to a physician in Springfield regarding a consultation on her forearm pain which she described as "excruciating and debilitating at times" and that it kept her from activities, further maintaining her depression. (PX 5, p. 184)

At the request of Respondent, Dr. Strecker issued another report, dated July 27, 2015 after reviewing additional records from Drs. Crickard, Philpott and Bieniek. He did not meet or examine Petitioner. Dr. Strecker noted that while Petitioner appeared to be doing very well when evaluated previously on August 27, 2013 Petitioner had returned to see Dr. Crickard for right hand pain and left hand swelling. Repeated nerve conduction studies had been performed on January 30, 2014 which showed normal result on the right side and improvement on the left. He further noted that Petitioner had an MRI in February of 2014 that revealed a central TFC tear and Petitioner had subsequently undergone surgery for a median nerve re-exploration, release on the left and injection into the TFC. Due to ongoing complaints Petitioner had also undergone repeated steroid injections into her carpal tunnel. Her current diagnoses included a TFC tear and bilateral tennis elbow. Dr. Strecker noted that when he examined her on August 27, 2015 [sic] Petitioner denied any elbow pain and had a normal examination without any provocative findings. Her carpal tunnel symptoms had completely resolved and she had no findings referable to a TFC tear. Dr. Strecker was of the opinion that all of Petitioner's complaints and conditions post-dating his earlier examination bore no relationship to her work for Respondent. He felt that, due to the diffuse nature of her complaints, she might benefit from an evaluation for a systemic problem. (RX 4 – res. ex. 2)

Petitioner met with her counselor on July 27, 2015 expressing greatest concern regarding her disability proceedings and frustration at a physician's report that only her tennis elbow was caused by work and not her carpal tunnel. She was contemplating an additional referral. She was noted to become tearful when discussing missing work and she described having been distracted by any symptoms of depression when working, if she even had any, because she was so busy and motivated to work, care for others and keep a clean home. Petitioner was noted to be struggling with her decrease in responsibility and frustration at the limited imposed by her physical injury. When presented with suggestions as to becoming more active and returning to a schedule similar to that before she lost her employment, the counselor noted Petitioner would present barriers to such suggestions. Some interpersonal issues were also discussed. (PX 5, p. 183)

On July 29, 2015, Petitioner sought further care from Dr. Neumeister at the Division of Plastic Surgery at SIU in Springfield. (PX 7) Petitioner was examined by both Dr. Henderson and Dr. Neumeister. According to the office note, Petitioner complained of significant bilateral upper extremity pain, bilateral shoulder pain and bilateral lower extremity pain. Her history was described as "complicated" as involved

a right-sided carpal tunnel release, two left-sided carpal tunnel releases (the last being performed in 2014) and a history of bilateral wrist pain for which she underwent a right wrist MRI that showed a tear. Petitioner knew nothing further about the tear. It was noted that nerve conduction studies in 2014 showed persistent carpal tunnel syndrome. Petitioner also complained of bilateral numbness and tingling in her hands involving all fingers but the small finger, worse on the left than the right as well as bilateral knee and ankle pain with some numbness on the medial aspect of her right foot. Petitioner reported the symptoms were random and there were no elucidating activities. Petitioner's medical history included chronic pain, anxiety and depression. Petitioner was presently unemployed. On examination, Dr. Neumeister noted various areas of tenderness in her right lateral epicondyle extensor wad and wrists, but no tenderness to palpation on the ulnar aspect of her wrist and no Tinel sign with compression of the median nerve at the carpal tunnel or over the pronator or the cubital tunnel. On the left side, Petitioner had a mildly positive Tinel's sign over the median nerve at the carpal tunnel but no intrinsic wasting or thenar wasting. She had severe tenderess to palpation over the pronator, the extensor wad of the radial tunnel and throughout the wrist and forearm with no specific anatomic distribution. In his assessment, Dr. Neumeister noted that Petitioner had severe global complaints of ongoing pain, which he felt might be coming from a systemic issue. He did not recommend further surgery. He set an appointment for her to see a rheumatologist and expressed a desire to review her MRI films and NCV studies. Petitioner was to return thereafter. She did not. (PX 7)

Petitioner met with her counselor on August 10, 2015 reporting decreased symptoms of depression. Petitioner noted action had been taken to continue to pursue treatment of her carpal tunnel syndrome and she has sought a second opinion from an SIU doctor in Springfield. Petitioner expressed issues with finances, family, and anger. (PX 5, p. 179)

Petitioner saw Dr. Humphrey on August 26, 2015 regarding her intermittent bouts of depression and poor energy. Medications were adjusted. (PX 5, pp. 175-176)

Second Deposition of Dr. Strecker

Dr. Strecker was again deposed on September 3, 2015. (RX 4) Dr. Strecker's opinion that Petitioner's condition was not caused, contributed to, or aggravated by her job duties for Respondent remained unchanged. (RX 4, p. 15) On cross-examination the doctor had no objection to any of Petitioner's treatment and he acknowledged that her diminished grip strength could be a residual of her carpal tunnel syndrome. (RX 4, pp. 17-18) Dr. Strecker further acknowledged that he only examined Petitioner on one occasion in August of 2013 (RX 4, p. 19)

On redirect examination Dr. Strecker testified that any altered grip Petitioner might have would not have caused her cubital tunnel syndrome or her lateral epicondylitis. (RX 4, p. 19) He also testified that her subsequent conditions, including the medial nerve re-exploration had nothing to do with her employment with Respondent as she no longer worked there and, furthermore, while the doctor re-released the nerve, her symptoms did not change. (RX 4, p. 20)

Additional Medical Treatment

Petitioner met with Dr. Humphrey, her psychiatrist, on September 29, 2015 reporting that she was doing well and had recently bought a new puppy which was making her very happy. She was sleeping well and

had a good appetite and felt the Wellbutrin had a positive impact on her as she had more energy and less feelings of hopelessness and worthlessness. (PX 5, p. 171)

Petitioner called N.P. Kline's office on October 7, 2015 reporting she needed a referral to a rheumatologist. Petitioner had a referral but it was to a Springfield doctor. Her insurance had switched and she now needed a referral to Dr. Ozment at Quincy Medical Group but her primary care physician had to make the referral. According to the note Petitioner was having more issues with her carpal tunnel syndrome. Petitioner was advised she needed to see Ms. Kline so there could be a reason for a referral to a specialist. Petitioner responded that she had appointment with another provider on Tuesday and would call back and leave word regarding how she wished to proceed. (PX 5, p. 167)

Petitioner returned to see Dr. Crickard on October 13, 2015, reporting bilateral lateral epicondylitis pain and having seen multiple doctors for pain in her wrists and elbows. (PX 1, pp. 10-11) Petitioner reported little relief from cortisone injections. She reported that after her carpal tunnel releases she still had pain in her elbows. On examination, Dr. Crickard noted that Petitioner was experiencing tenderness in her bilateral lateral epicondyles. Dr. Crickard indicated that he would refer her to a "worker's comp specialist". (PX 1)

Petitioner met with Dr. Humphrey on October 27, 2015 reporting difficulty getting disability for her chronic pain. She had stopped smoking cold turkey two weeks earlier and was reporting poor energy and motivation. She mostly sits at home along. Medication was prescribed. (PX 5, p. 163)

Petitioner met with N.P. Kline on October 27, 2015advising Ms. Kline that she had until January of 2016 to get a provider to say that both her tennis elbow and carpal tunnel syndrome was caused by her work. She used to work as an assistant restaurant manager for 13 ½ years at Pizza Hut. She would spread pizza sauce on pizza and do a variety of other tasks as well. According to the office note, "Dr. Crickard stating the carpal tunnel is caused by her work and Dr. Beiniek stating her tennis elbow is caused by her work. States Dr. Crickard wanted Petitioner to see [her] for an opinion. I defer this to orthopedics. She is under a lot of stress regarding the workmans comp." (PX 5, p. 158) Petitioner was encouraged to make an appointment for counseling. (PX 5, p. 160)

Petitioner returned to Dr. Crickard on November 12, 2015 complaining of bilateral wrist and elbow pain. (PX 1, pp. 3-4) He noted that she had an ongoing worker's comp case and that he had tried to refer her to a worker's comp specialist but it had been denied. He noted that from his standpoint there was nothing else that he could do but indicated he was going to refer her to a new plastic surgeon starting at the clinic in December.

Petitioner met with Dr. Humphrey on November 24, 2015 reporting she was continuing to fight for disability and having some marital discord. She feels worthless as she is not working. (PX 5, p. 155)

Petitioner met with Dr. Humphrey on December 22, 2015 reporting some anxiety attacks due to being overwhelmed with numerous stressors in her life. (PX 5, pp. 152-153)

Petitioner sought treatment with Dr. Christian Verry at SLU Care in St. Louis on January 14, 2016. (PX 10, pp. 6-9) Dr. Verry noted that Petitioner complained of bilateral elbow pain, with diffuse pain (lateral to medial), intermittent, and worse with use of her elbow. The doctor had no past medical records to review but Petitioner advised him that she had undergone injections for lateral epicondylitis in the past,

the most recent one having been performed in January of 2014 with short-lived relief of two months' duration. Petitioner denied using any "cho pat" straps but acknowledged a bout of therapy in 2014 without improvement. She also acknowledged undergoing bilateral carpal tunnel releases in 2013 with non-specific shifting pains in her wrists and elbows thereafter. He noted that an MRI in 2014 had shown a full thickness complex tear of the TFCC which had not been repaired. On examination, Dr. Verry noted that Petitioner was tender to palpation over her bilateral lateral epicondyles and medial epicondyles. Sensation was intact to light touch. All else was normal. Dr. Verry diagnosed Petitioner with lateral epicondylitis, noting her history was not "classic" for the diagnosis but the tenderness on exam and relief with prior injections supported the diagnoses. The doctor recommended repeated injections and provided Petitioner with medications and an elbow strap for her right elbow. He prescribed physical therapy. A letter regarding the visit was sent to Dr. Jeffrey Wells in Quincy. (PX 10)

Petitioner saw N.P. Kline on January 19, 2016 regarding an ear problem. (PX 5, p. 145)

Petitioner met with Dr. Humphrey on January 19, 2016 reporting stressors surrounding her family and worry over her grandfather's health. She was continuing to fight anxiety and depression, especially when it came to her own health. Medications were adjusted. (PX 5, pp. 149-150)

Records from Quincy Medical Group show that Petitioner began occupational therapy there on January 26, 2016. (PX 1, pp. 154-158) Therapy orders were for eccentric loading of common extensor tendons in the elbows with manual therapy as well as nerve glides for both carpal tunnels. Petitioner gave a history of the onset of numbness and tingling in her hands while working for Respondent and having undergone bilateral carpal tunnel releases in 2013 as well as a second surgery on her left hand on March 4, 2014, without relief of her symptoms.

Petitioner returned to N.P. Kline on February 17, 2016 for acute sinusitis. She also discussed some inter-family issues and being removed from her own home after an altercation with her son. (PX 5, pp. 141-143)

Petitioner returned to Dr. Verry on February 25, 2016 noting marked improvement in her elbow pain after therapy, though she had mild residual discomfort over the left lateral elbow. (PX 10, pp. 20-23) Petitioner complained of left wrist pain, worth with activity, as well as left hand weakness that would cause her to drop things. She complained of numbness and tingling in her first three digits. Symptoms would awaken her at night. He noted she had a carpal tunnel release in 2013 without improvement. Petitioner also complained of right wrist pain mostly over the radial right wrist into the thumb. She also complained of numbness, tingling and burning, worse with activity. Dr. Verry noted again that Petitioner had had an MRI in 2014 that showed a TFCC tear. Dr. Verry noted that Petitioner had positive Tinels testing bilaterally. He opined that she was suffering from bilateral carpal tunnel syndrome and stated that her symptoms were inconsistent with a TFCC tear. He treated the carpal tunnel syndrome with an injection, night splints and prescribed home exercise (nerve glides). He directed Petitioner to continue therapy. A letter was sent to Dr. Wells in Quincy. (PX 10, p. 24)

Petitioner met with Dr. Humphrey on March 1, 2016 and her medications were adjusted. (PX 5, p. 137)

Records show that Petitioner's therapy continued through March 29, 2016, when she was discharged from therapy. (PX 1, pp. 205-209) Petitioner had attended 15 out of 15 sessions and was reporting relief of her bilateral elbow pain but continued bilateral wrist pain.

Petitioner met with Dr. Humphrey on April 12, 2016 and her medications were adjusted. (PX 5, p. 133)

Petitioner called N.P. Kline's office on April 20, 2016 inquiring about an appointment with an allergist. Petitioner reported having a lump on her neck for at least one year and she was concerned that something was pushing on her voice box or throat as she is hoarse and her throat hurts by the end of the day after talking all day long. She had gone to walk-in clinics and been given antibiotics. Petitioner was later advised that it was Dr. Humphrey who sated she needed to see an allergist and she would need to come in and see N.P. Kline for a referral. (PX 5, p. 132)

Petitioner met with N.P. Kline on April 25, 2016 for her acute laryngitis and folliculitis and contact dermatitis. Petitioner reported having gone to Blessing Hospital for a chest x-ray that was normal and blood work which showed an elevated white count. (PX 5, pp. 127-131)

Thereafter, Petitioner met with her therapist, Ms. Bockhold, on April 25, 2016 regarding personal family issues. Petitioner reported her lack of pain and not having tennis elbow anymore after finding a doctor in St. Louis who referred her to therapy in Quincy. Petitioner was asked about returning to work now that her pain was no longer a barrier and she responded that she didn't feel she could because she is too emotional. (PX 5, pp. 125 -126)

Petitioner met with Dr. Humphrey and her therapist, Ms. Bockhold, on May 10, 2016 regarding personal family issues. There was no discussion of any problems/issues with her upper extremities. (PX 5, pp. 119 – 123)

N.P. Kline met with Petitioner on May 16, 2016 regarding Petitioner's acute laryngitis, chronic hoarseness, and a gynecologic issue. Petitioner was noted to be smoking every day and she was encouraged to stop. (PX 5, pp. 111 - 113)

Petitioner met with her ENT, Dr. Phan, on June 6, 2016 regarding increasing hoarseness and acute laryngitis. (PX 5, pp. 103-108)

Petitioner met with her Ms. Bockhold on June 14, 2016 regarding family and personal issues. There were no references to her alleged work injury. (PX 5, pp. 99 – 102)

On June 21, 2016 Petitioner presented to Dr. Erin Humphrey reporting things had been going "crazy." Petitioner reported she didn't feel independent; however, when the doctor spoke to her about going back to work or school Petitioner made vague excuses not to go back. Her energy was reported as "fair." Petitioner reported feeling stressed and overwhelmed by things at home. She was diagnosed with depression. (PX 5, pp. 95-96) Petitioner also met with Sarah Bockhold a licensed clinical social worker that same day. They discussed the process of going from being single to being part of a marriage and issues between Petitioner, her uncle, and her grandfather. Petitioner reported being unable to work and denying any motivation towards pursuing another position at this time. (PX 5, p. 98)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 18, 2016 by agreement of the parties. The disputed issues included accident, causal connection, medical bills, temporary total disability benefits, temporary partial disability and the nature and extent of Petitioner's injury. Petitioner was the sole witness testifying at the hearing. Petitioner's Application for Adjustment of Claim was amended to reflect Petitioner's married name of "Logsdon."

Petitioner testified that in May of 2013 she was employed by Respondent as an assistant manager. Petitioner testified that she had been employed by Respondent for 13 1/2 years at that point. She testified that her work was as a "working manager" rather than just supervising and she was responsible "pretty much" for everything that needed to be done in the store.

Petitioner described her job duties as including food prep, pizza and sandwich making, cooking, and assistant managerial work. Petitioner testified that on every Wednesday they would chop all the onions needed for the whole week using a pizza cutter, like a rocker one. Food prep consisted of cooking two bags of chicken, cutting onions, shaving ham, cutting mushrooms, coring banana peppers, cleaning lettuce, making pizza sauce, slicing green olives and handling dough every morning. Throughout the day, Petitioner would grind cheese, and at night chop cheese blocks which would be put in a bag and then placed in a walk-in cooler. Pizza making involved putting scoops of pizza sauce on pre-made dough, and moving it around with a ladle. Petitioner testified to putting on ingredients while simultaneously flipping the ingredients, and then putting it in the oven. Petitioner would later scoop the pizza out of the oven and put it onto a pie table before cutting the pizza.

Petitioner went into great detail regarding how pizzas were made. Putting on the pizza sauce involved gripping a ladle with her right hand, holding the pizza with her left hand, and then spinning the pizza around counter-clockwise. Her elbow would be bent and spreading the sauce back and forth with her right wrist. Petitioner further testified that all the ingredients would need to be weighed using a scale located on her left side. She would grab the ingredient with her left hand, put it on the scale in a container located on the scale, weigh it, flip the ingredients out of the scale, and proceed to put them on the pizza. She would use both hands to put ingredients on the pizza. After the pizza was cooked it was scooped out of the oven using a long paddle and cut with a rocker arm knife, which required Petitioner to grip the handles and rockit back and forth with a downward pressure.

Petitioner explained that "sandwich-making" involved getting the bread out and folding it. She would put different ingredients on the bread, including squirting on a sauce per the customer's order. Petitioner would grip the sandwich with tongs and put it in a convection oven. After the sandwich would come out of the oven she would have to slice it. If lettuce and/or tomatoes had been requested as part of the order, she would put it/them on, flip the sandwich over and cut it. Cooking included not only pizza and sandwiches, but also using the stove for making hamburgers and putting food in a fryer.

Petitioner testified that preparing the chicken also involved use of a rocker knife. Cutting onions, mushrooms, olives, and peppers, involved using a knife which she would hold in her right hand. The sauce comes in a big can and she would use a can opener with a big hand crank, which she would turn with her right hand. The sauce would then be put in a bucket which would have to be stirred. Green olives, peppers and pickles come in a jar. The cheese would be cut with a long knife, holding it with both

hands and pushing it down. It would be ground by pushing a grinder level down with her right hand. The pizza dough is taken out of a freezer and then stacked on a board. There would be a board with paper between each piece of dough.

Petitioner further described her assistant managerial duties, which included answering phones and taking orders, operating the register as needed, unloading the delivery truck, counting money, putting away deliveries, training employees, assigning work, opening and closing the restaurant, recording sales, stamping and recording checks for deposit, making deposits at the bank, making kitchen orders, entering tips, and also cleaning (mopping and sweeping) as she went through the day. Petitioner testified that inventory is done the last day of the month which she would do if that were her day.

Petitioner testified that she reviewed the ergonomic job analysis offered into evidence as Respondent's Ex 1. She testified that she was not present when that analysis was done and was not consulted about it. She testified that she had reviewed it when it was sent to her by her attorney and she had written in comments to reflect how she felt that the analysis was inaccurate, which was offered as Respondent's Ex. 2. She testified that as assistant manager she didn't just sit there and tell everyone what to do, but would have to engage in physical hands on work doing everything in the store. Petitioner testified that she was physically active throughout her work day and was using her hands constantly to perform these various activities. Petitioner testified that she would work about 38 ¾ hours per week, sometimes 8 to 6 on Sunday and 4 to 11:30 on Saturday. Petitioner testified that she was paid a salary.

Petitioner testified that on May 8, 2013, while chopping onions for about half an hour or so, she experienced a shooting pain down from her elbows. She testified that prior to that time she had been noticing some pins and needles like numbness in her hands, at times. Petitioner testified that on May 8, 2013 the pain was so bad that it brought tears to her eyes, so she told her boss, Connie, that she was going to the hospital. Petitioner testified that she sought treatment at the Blessing Hospital emergency room where she was given some kind of splint.

Petitioner testified that she followed up with her doctor, Dr. Miller, who referred her to Dr. Crickard who had her undergo an EMG and later performed surgery on her wrists. Petitioner believed that Dr. Miller took her off work for a period of time and then released her for light duty work.

Petitioner testified that she returned to work with light duty restrictions prior to her surgery as well as when released to light duty after her surgery. She denied that her restrictions were adhered to, adding she was taken off her salary and was compensated hourly. Petitioner offered into evidence her paycheck stubs during these periods showing her reduced earnings as PX 9. Petitioner testified that she was released to full duty on August 1, 2013 and returned to work. However, she quit her job about that same time because she couldn't survive on three hours a week.

Petitioner testified that between the time of her release on August 1, 2013 and her return to treatment in October of 2013 she was continuing to experience numbness in her hands and she was still dropping things. Petitioner testified that she was not engaging in any activities to aggravate the symptoms in her hands. She was not working and remained at home.

Petitioner testified that she returned to Dr. Crickard in October of 2013 and he prescribed additional therapy which Petitioner testified didn't help. She went through some additional physical therapy and

electrical studies. When asked if the therapy helped that time, Petitioner replied, "Nope." Petitioner then testified that Dr. Crickard referred her to Dr. Philpott and she underwent an MRI of her right hand/wrist followed by a second surgery on her left hand and an injection to her right wrist because the doctor had found a tear. Petitioner further testified that during this time she went to the emergency room at Blessing Hospital because of hand pain.

Petitioner testified that she attempted to return to "alternative work" in April of 2014 at Pizza Hut but she was only able to work for two hours. During that time she was cutting pizza and noticing excruciating pain just as she had been experiencing before. Petitioner then went to the emergency room and was referred to a pain doctor at Hannibal Regional Hospital and she went to him about three times. However, Petitioner found the pain medication to be too strong and so her family doctor adjusted it.

Petitioner further testified that Dr. Philpott suggested she go to Dr. Bieniek but she was unable to see him until January of 2015 due to lack of funds and coverage issues. Dr.Bieniek injected her elbows. She only saw him one time and he wanted her to come back and perform surgery but she wasn't able to return to see him due to lack of funds and coverage. Petitioner also testified that he wanted her to see a rheumatologist but she couldn't do that due to lack of funds and coverage.

Petitioner testified that she returned to Dr. Crickard in October of 2015 and he attempted to refer her to a new orthopedic doctor at Quincy Medical Group but that doctor would not see her. Petitioner testified that she then went to Dr. Verry in St. Louis and he prescribed some additional therapy that did help her with regard to her tennis elbow. Petitioner added that she had been having pain in her elbow from "day 1." When asked if her problems ever went away during the foregoing time period, Petitioner testified "No, I think it like, I don't know how to explain it. It didn't go away completely, no." Petitioner further testified that her left wrist got worse after Dr. Philpott. She testified that her left wrist is definitely weaker and she drops things.

Petitioner testified that she continues to note numbness and weakness in her hands. It isn't constant but occurs perhaps once a day or "here and there." She doesn't associate it with any particular activities. Petitioner testified that she no longer mows her lawn, no longer gardens and doesn't pick up her two year old grandson. She no longer vacuums and is unable to put a fitted sheet on a bed because she is unable to grasp it and pull it on. She testified that she has difficulty flipping a pan to drain spaghetti. She testified that trying to curl or blow dry her hair is just too much. She testified that these symptoms are worse in her left hand than her right.

Petitioner testified that other than the attempted return to work at Pizza Hut, she had done some home health care for one or two months in September or October 2013, but she had to give that job up when her arm was casted at the elbow per Dr. Crickard's physician's assistant.

Petitioner testified that she not currently under any doctor's care except for going to a therapist who helps her with her anxiety and depression which Petitioner felt "just kind of happened since [she] quit her job." She takes Gabapentin for her arms and hands per Dr. Kline, her current nurse practitioner/family doctor.

Petitioner testified on cross-examination that she was the assistant manager for Respondent during the last four years of her employment. She agreed that she performed multiple tasks every day and also trained employees. She worked Tuesdays, Wednesdays, Thursday, Saturdays, and Sundays averaging about 38

and ¾ hours per week. Petitioner testified that she first began noticing symptoms in November of 2012 or "somewhere around there." She agreed that she only reported left hand and wrist pain initially stating that that was where the pain was "that day." When asked if she remembered having some back pain for which she was going to a chiropractor, Petitioner replied that she wasn't having any back pain; rather, she was having numbness in her hands.

Petitioner agreed that she returned to work on July 25, 2013 but she quit on August 1, 2013. When asked if she was working for Addus performing in-home services about twenty hours per week in October of 2013, Petitioner was not really sure. She testified that all she did at Addus was a little housecleaning and cooking of meals. On further questioning she thought she worked there for about two months in 2013, probably September or October. She further testified that while working there she was still having problems but trying to work and it just got worse. She testified that she would have to ask off work or she had work restrictions and her employer didn't like that so she decided she might as well stop working there. When asked if it was her elbows started developing problems then Petitioner disagreed noting that her wrists, hands, and elbows all got worse. Petitioner testified that she then returned to Dr. Crickard in October of 2013 and he had nothing further to offer her so he referred her to Dr. Philpott.

Petitioner agreed that Dr. Philpott performed an additional surgery on her left carpal tunnel and he injected her right wrist. Petitioner denied telling Dr. Philpott in March of 2014 that her numbness was mostly or entirely resolved. She agreed he released her to return to work with the only restrictions being to avoid submerging her left hand into water without gloves. While Petitioner wouldn't disagree that she returned to Dr. Philpott in April of 2014 "if that's what it says" but she could not recall telling him about an incident at work lifting boxes at her job.

Petitioner believed that Dr. Crickard referred her to Dr. Neumeister and she agreed that when she saw him she was complaining about bilateral hand, elbow, shoulder, knee, ankle and foot problems and he felt she needed to see a rheumatologist. Petitioner could not clearly recall if Dr. Crickard recommended Dr. Verry or if she wanted to see him. She agreed that her elbow complaints resolved with Dr. Verry's treatment.

Petitioner agreed that she explained her job to Dr. Strecker when examined by him.

On redirect examination Petitioner testified that the work for Addus allowed her to care for her 88 year old grandfather who had cancer. She testified that she made breakfast and lunch and did some dusting. She denied doing any vacuuming. She testified that doing that work would bring on pain but it was the same pain that she was feeling before. She testified that the work would flare up her pain and then it would get better. She said that after she left that job, her problems were not any worse than they were before.

Petitioner is right hand dominant (PX 8, p. 2). Up until sometime in 2015 she smoked a pack of cigarettes a day.

Petitioner's medical bills are contained in PX 11.

RX 2 is a copy of the Ergonomic Job Analysis dated August 26, 2013 with Petitioner's comments written thereon. Petitioner noted that she had been working there for five years, not four years. She denied that there was a lunch buffet. She added that her duties included cash count, delivery bags, adding "cc" tickets, entering "cc" tips. She further noted she worked regular hours on Wednesdays and Thursdays and

was the only one in the back (kitchen, oven, pies, phones) with one waitress and one delivery driver. Petitioner corrected her number of hours she worked in a week and noted she worked on Wednesdays an additional half hour and an additional 1 ½ hours on Thursdays. On Tuesdays and Saturdays she worked from 4:00 p.m. to 11:45 p.m. Petitioner disagreed that she cut onions used for salads and onion rings. She believed she cut onions for forty minutes to one hour (not thirty minutes) but agreed it was only one day per week. She would use two hands after the onions were laid out on the cutting board. Petitioner disagreed that the restaurant wasn't busy for lunch during the week, indicating Wednesday lunches were busy. Petitioner also added that when the place was busy she might make the whole pizza and do clean-up. She also prepped in the mornings, cut mushrooms, make pizza sauce, would grind cheese, stock, do inventory and help in the kitchen. (RX 2)

The Arbitrator concludes:

Issues (C) Accident and (F) Causal Connection.

Petitioner failed to prove she sustained an accident on May 8, 2013 that arose out of and in the course of her employment with Respondent or that any condition of ill-being in her bilateral hands, wrists, elbows, and arms was causally connected to her employment duties for Respondent. In so concluding the Arbitrator notes significant credibility concerns regarding Petitioner and the lack of any causation opinions in support of some of Petitioner's alleged physical injuries and an unpersuasive causation opinion of Dr. Crickard regarding Petitioner's bilateral carpal tunnel syndrome. Petitioner further failed to prove that any depression or anxiety was causally related to her alleged accident or employment duties with Respondent.

It is axiomatic that in a repetitive trauma case, such as the one herein, the claimant bears the burden of proof on the issues of accident and causal connection. It is further understood that in a repetitive trauma case the unique facts of each case must be closely scrutinized and that the issues of accident and causal connection are closely intertwined and generally addressed by expert opinion.

First and foremost, Petitioner was not an altogether credible witness. The Arbitrator had the opportunity to observe Petitioner throughout the arbitration hearing and she found her to be somewhat dramatic and, at times, exaggerating, aloof, and misleading in her testimony and demeanor. Petitioner's attitude/response when asked about notes she was reading from was inappropriate. Petitioner was asked about chiropractic treatment and prior back pain on cross-examination to which she denied the latter, claiming she was only having numbness in her hands. Petitioner's testimony on this wasn't credible as the medical histories pre-dating the filing of her claim suggest otherwise. Additionally, if she was going to a chiropractor for hand numbness, one would think Petitioner would have submitted those records into evidence as part of her case. Their absence undermines her testimony. Further credibility concerns include her adamant representation that she had stopped smoking in 2015. Records in 2016 show she had resumed/continued smoking. When she was examined by Dr. Strecker she did not give him an accurate history as she claimed any original back, neck or shoulder complaints she had at the time of her May 8, 2013 emergency room visit completely resolved within three days. However, Dr. Miller's May 14, 2013 office note indicates to the contrary as he specifically referred her to therapy for her neck symptoms. She further told Dr. Strecker that she then went to her family doctor who "discontinued" her brace. That, too, is not correct. Dr. Miller told her to wear her splint at night.

Petitioner's motivation is of great concern. Having reviewed all of the medical records admitted into evidence it is apparent that Petitioner has a multitude of medical issues going on. It is also apparent from many of these records that Petitioner seemed very focused on her belief that she was, and is, unable to work because of her upper extremity complaints and symptoms. As noted by Dr. Humphrey in June of 2016 and prior thereto, Petitioner has frequently been encouraged to go back to work; yet, Petitioner makes excuses not do so. Furthermore, the Arbitrator cannot overlook Petitioner's comments to N.P. Kline on October 27, 2015 wherein she advised Ms. Kline that she had until January of 2016[2] to get a provider to say that both her tennis elbow and carpal tunnel syndrome was caused by her work. Petitioner once again focused on her job duties for Respondent as the cause of her problems even though she had not worked for Respondent in over two years and had worked for other employers she did not even mention. While Petitioner claimed Dr. Bieniek felt Petitioner's tennis elbow was caused by her work that opinion is not found in the medical records of the doctor. Indeed, Dr. Bieniek's office note of January 27, 2015 does not discuss or mention Petitioner's work whatsoever. (PX 6)

Petitioner's testimony about her lack of follow-up with Dr. Bieniek was also not credible. She testified that she was unable to return to see him due to lack of funds and coverage and that he also wanted to perform surgery on her but, again, due to lack of funds and coverage she couldn't proceed. Whether funds and coverage was really an issue isn't clear as Petitioner continued to treat with other providers during the time she was having funding/coverage issues. Furthermore, if Petitioner truly wished to pursue treatment with Dr. Bieniek or others, she had a means to do so under the Workers' Compensation Act. Petitioner didn't pursue this at any time. Additionally, Dr. Bieniek's office note does not state he was recommending surgery. Rather, his note states that they discussed the possibility of surgery if the injections didn't work out but he wished to try a series of them first. Thus, she misrepresented at the hearing exactly what the doctor was recommending for her. The Arbitrator further notes misleading history from Petitioner regarding her alleged ganglion cyst. While P.A. Dement's office note alludes to one being noted during a therapy visit, it was not mentioned in any therapy records admitted into evidence and Dr. Crickard testified he never saw evidence of one.

Similarly, during the hearing, Petitioner denied telling Dr. Philpott that she had injured her hand at a new job picking up boxes or that her complaint of numbness had resolved post-surgery. Petitioner testified, or attempted to testify, that Dr. Philpott made other erroneous entries in his notes. Petitioner took no steps to correct these "erroneous entries" prior to the hearing. She could have deposed the doctor to corroborate her testimony but she did not do so.

Petitioner also failed to be upfront and forthright with her doctors in other ways. Petitioner was released to full duty work as of August 1, 2013. She underwent no treatment between August 1, 2013 and October 17, 2013. When examined by Dr. Strecker during that time she acknowledged that most of her symptoms had resolved. When Petitioner returned to see Dr. Crickard on October 17, 2013 his records reflect the first mention of any elbow pain. Petitioner failed to tell the doctor anything about her employment status – ie., that she had stopped working for Respondent on/about August 1, 2013, that she had never resumed full-time work for Respondent, and that she had been working for Addus Healthcare in September and October of 2013. Despite subjective complaints, EMG testing in January of 2014 showed improved left median nerve entrapment and resolved right median nerve entrapment. Similarly, Petitioner saw P.A.

[2] When her case appeared on the Quincy Docket above the red line.

Dement on November 12, 2013 reporting ongoing complaints "worse when she was done working." Thus, it even appears Petitioner was working somewhere in November of 2013; however, she was not forthright about this at trial.

Focusing on the events of May 8, 2013, Petitioner testified that she was cutting onions for approximately one-half hour on May 8, 2013 when she experienced "shooting pain down her elbows." That testimony was not corroborated by, or consistent with, the medical records generated prior to her retaining counsel and filing her Application for Adjustment of Claim herein. When Petitioner presented to the emergency room on May 8, 2013 she reported no right upper extremity complaints and she did not associate her left hand complaints with any specific activities at work for Respondent. As mentioned above, Petitioner was a very dramatic witness during the hearing and this Arbitrator simply does not believe she would not have mentioned that she was cutting onions at work when she felt this "shooting pain" to the emergency room physicians if, indeed, that is what had happened. Petitioner made no reference to her elbow or "shooting pains" in the ER records. Furthermore, Petitioner immediately went to her primary care physician after being seen at Blessing Hospital's Emergency Room and, again, made no mention of any activities at work that she associated with her left hand complaints. She further added that she had been experiencing swelling and achiness in that hand for approximately six months which had begun in her back and for which she was treating with a chiropractor. Petitioner did not introduce any chiropractic records into evidence as part of her case. As such, the Arbitrator reasonably infers that these records would not have been supportive of her claim.

Petitioner then followed up with her family doctor on May 14, 2013 and, despite not working for a week, she was still experiencing symptoms solely in her left hand. Contrary to Petitioner's representation/history to Dr. Strecker, they did, in fact, discuss issues with Petitioner's neck and she was referred to therapy for her neck, not her hand.

Thereafter Petitioner underwent electrodiagnostic studies of all four of her extremities. Despite never having complained of her right upper extremity or hand, she was found to have electrodiagnostic evidence of right carpal tunnel syndrome. Given the absence of any complaints or symptoms in her right upper extremity prior to that study, the Arbitrator finds the evidence of right carpal tunnel syndrome/median nerve entrapment to be an incidental finding.

As noted above, the first mention of any problems stemming from chopping onions (or any activity associated with work) is found in Dr. Crickard's note of May 28, 2013, only two days before Petitioner signed her Application for Adjustment of Claim herein. The Arbitrator finds the timing of Petitioner's claim and the mention of this history around that same time highly suspicious and troublesome absent any earlier mention. While it appears that Petitioner's job for Respondent was hand intensive in that she used her hands and arms throughout her work day, she did so for a variety of tasks. Furthermore, the job she associated with her complaints (the cutting of onions with the reciprocal knife) was a job she did one time a week for 30 to 60 minutes. Dr. Crickard acknowledged that Petitioner's job duties for Respondent were not the classic repetitive type of labor. His opinion, in turn, was based upon Petitioner's history to him – to wit, she experienced symptoms in her hands when at work. He was completely unaware of her history and treatment for neck issues prior to May 8, 2013 and their possible association with her complaints. Had Petitioner been more forthright in her testimony, had she included treatment records pre-dating May 8, 2013 as part of her case, and had she discussed same with Dr. Crickard at the outset perhaps a different

result might be reached. However, she wasn't entirely credible, her motivation herein was very suspect; and, her presenting histories were inconsistent with her testimony at trial. It is also difficult to conclude that Petitioner's work duties caused or aggravated Petitioner's upper extremities as she has claimed, given her ongoing symptoms and complaints since the initial surgery despite her cessation of work for Respondent and a subsequent nearly normal EMG. No doctor has linked any of Petitioner's ongoing problems to her initial surgery performed by Dr. Crickard. In the end, Petitioner has failed to meet her burden of proof on accident and causal connection.

The Arbitrator further finds that Petitioner has failed to prove that any subsequent conditions for which Petitioner treated after her initial bilateral carpal tunnel surgeries were causally related to her injury or work duties for Respondent. Petitioner proceeded to have problems with her upper extremities and was diagnosed with a right TFCC tear, ganglion cyst, bilateral elbow (tennis) problems, left cubital tunnel syndrome, and repeat bilateral carpal tunnel syndrome. She underwent a re-exploration of her left wrist and an injection to her right wrist for the TFCC tear. Petitioner's medical records also suggest bouts of anxiety and depression Petitioner felt were stemming from her injuries and inability to return to work. Petitioner produced no expert opinion on causation regarding any of these problems and her alleged injury of May 8, 2013. Petitioner treated with various doctors including Dr. Glanton, Dr. Wells (and N.P. Kline), Dr. Philpott, Dr. Bieniek, Dr. Humphrey, Dr. Neumeister, and Dr. Verry. None of these physicians provided a causation opinion with regard to Petitioner's TFCC tear, bilateral tennis elbow and left cubital tunnel syndrome, and/or anxiety and depression. Dr. Crickard reached a point he could not explain Petitioner's symptoms and suggested a second opinion. Dr. Philpott's records suggest something akin to malingering. Dr. Neumeister and Dr. Strecker both thought Petitioner might have a systemic issue. As such, Petitioner failed to prove that any condition of ill-being in her upper extremities (or her anxiety/depression) after August 1, 2013 was causally related to her alleged accident of May 8, 2013.

Finally, the Arbitrator notes that Dr. Strecker gave a very detailed and convincing explanation of why he concluded that Petitioner's bilateral carpal tunnel syndrome was not work-related. He discussed at great length his understanding of her job including what she reported to him and he described the type of occupational exposure that is a causative factor for carpal tunnel syndrome, explaining how it did not exist in her job. He also discussed the non-work related risk factors that Petitioner has/had for carpal tunnel syndrome. Dr. Strecker also credibly testified that all of the subsequent upper extremity conditions Petitioner allegedly sustained after her initial bilateral carpal tunnel syndrome began after he had seen her on August 27, 2013 (at which time most of her symptoms and complaints had resolved) and after her employment with Respondent had ceased.The Arbitrator finds that Dr. Strecker's opinions as to causation are more informed and persuasive than that of Dr. Crickard.

Petitioner's claim for compensation is denied and no benefits are awarded.

Issue (J) Medical Expenses.

Issue (K) What temporary benefits are in dispute (TTD; TPD)?

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

Given the Arbitrator's Decision on accident and causal connection, these issues are moot.

Petitioner's claim for compensation is denied. No benefits are awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael C. Sanders,

Petitioner,

vs.

NO: 13WC 22725

17IWCC0407

Flanders Precisionaire,

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, prospective medical, causal connection, 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 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 $41,300.00. 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: JUN 28 2017

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LEC/mas
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L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

SANDERS, MICHAEL C
Employee/Petitioner

Case# **13WC022725**

17IWCC0407

FLANDERS PRECISIONARIE
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

1120 BRADY CONNOLLY & MASUDA PC
ANDREW R MAKAUKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0407

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)

Michael C. Sanders
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # 13 WC 22725

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **02/26/2013**, 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, the average weekly wage was $**360.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of $**6,695.87** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**6,695.87**.

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

ORDER

The respondent shall pay the petitioner temporary total disability benefits of $253.00/week for 168 weeks, from 02/28/2013 through 07/12/2016, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act. This period of 168 weeks does not include June 5, 2013, September 23, 2013, nor the period from March 5, 2014 through May 6, 2014.

The respondent shall pay $5,395.88 for medical services, 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.

Robert E. Johnson

Signature of Arbitrator

August 4, 2016
Date

ICArbDec19(b)

AUG 8 - 2016

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

The Arbitrator finds that the disputed medical expenses totaling $5,395.88 were reasonable and necessary and related to the Petitioner's work injuries. In the event that the Respondent has paid any of the bills the Respondent shall receive credit for those bills. All bills are to be paid pursuant to the fee schedule. The unpaid bills are as follows.

Physio Partners (FCE of 01/13/2016):	$ 1,700.16
Provena St. Mary's Hospital (09/09/2013):	286.09
Provena St. Mary's Hospital (11/26/2013):	890.14
Provena St. Mary's Hospital (11/11/2014):	1,011.15
Riverside Medical Center (05/06/2014):	199.34
EMPG of Illinois (03/06/2014):	438.00
EMPG of Illinois (03/11/2014):	438.00
EMPG of Illinois (05/06/2014):	433.00
	TOTAL: $ 5,395.88

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

Petitioner testified as follows. Petitioner was working as a machine operator on the date of the alleged accident. He stated that a fellow employee did not show up for work and the other left early and that his job was highly repetitive and that he had to do the job of both of his fellow employees in addition to his own job duties. The job involved pulling filters off the line behind him, turning around to get the

filters, stacking the filters and wrapping them in plastic, putting the filters into a cardboard box that he had made up, 24 filters to a box, and lifting the full boxes and stacking them on a pallet, lifting the boxes above his head to stack them on the pallet up to ten boxes high. *(R. 22-27)* The Petitioner testified that when he lifted a box and reached up to put it on the top of the pallet, he felt a pinch in his back but he kept working. He stated that after he shrink wrapped the pallet load of boxes, put a sticker on it and went to pull the pallet, the pinch felt like it got worse, so he reported the injury to his supervisor Kay at that time. *(R. 27)* The Petitioner tried to keep working for another two hours but could not do it, so he again informed Kay. She told him to go home and come back the next day to talk to Amy, which he did. *(R. 28)* The next day the Petitioner met with Amy, the human resources manager and told her what had happened and that he felt that he had injured his back on the job, whereupon Amy referred Petitioner to Dr. Panuska at the St. Mary Occupational Health Clinic. *(R. 28-29)*

On February 28, 2013, the Petitioner was seen by Dr. Panuska. The record stated, "He is here for initial evaluation of low back complaints after he was stacking boxes on a skid and she *(sic)* felt a sharp pain to his lower back. He states temporarily his right side went numb, but the numbness has gone away now." *(Pet. Ex. 4)* The initial diagnosis was lumbar strain. Dr. Panuska put the Petitioner on modified work with restrictions of "10 pound lifting, pushing and pulling limit, no repeat lifting, limited bending, stooping and twisting, no reaching while lifting." *(Pet. Ex. 4)*

There was no evidence, medical or otherwise, presented to rebut this testimony and the evidence in the medical records and upon which the Arbitrator could conclude that the Petitioner did not suffer a work-related injury to his low back, as alleged, on February 26, 2013. Accordingly, .the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment with Respondent on February16, 2013.

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

The Petitioner's treatment was mostly with Dr. Panuska of the Provena St. Mary's Hospital Occupational Health Center. *(Pet. Ex. 4)* The Petitioner testified that he was referred there by Amy, Respondent's human resources manager. Amy Hiser testified that she did not "send" Petitioner to Dr. Panuska but told him that he could go there or to Riverside Work Force Health, after Petitioner told her he did not have his own doctor, and that both facilities would accept Respondent's workers' compensation insurance. *(R. 85-86)*

After Petitioner did not improve with conservative care, Dr. Panuska ordered an MRI. On April 16, 2013, the Petitioner underwent an MRI of his lumbar spine at Accelerated Open MRI & Imaging in Frankfort, Illinois, a facility chosen by Respondent. The MRI was read by the treating radiologist to show a herniated disc at L5-S1 as well as straightening of the normal lumbar lordotic curvature, indicating paraspinal muscle spasm. *(Pet. Ex. 5)*

On April 17, 2013, the day after the MRI, Dr. Panuska added to Petitioner's restrictions somewhat, as well as continuing physical therapy, and referred him to Dr. Roland.

On May 8, 2013, the Petitioner saw Dr. Roland, who ordered a right transforaminal steroid injection, pending authorization by the workers' compensation insurance adjuster. A case manager, who was present at this office visit informed Dr. Roland that the Petitioner was being sent for an IME, so approval for the injection would probably not be given at that time. *(Pet. Ex. 9)*

On May 22, 2013, the Petitioner was examined by Dr. Gary S. Shapiro of the Illinois Bone & Joint Institute in Wilmette, Illinois. Dr. Shapiro stated that he disagreed with the radiologist, Dr. Panuska and Dr. Roland. Dr. Shapiro opined that the Petitioner's MRI was "completely normal." *(Shapiro Exhibit 4)* Based on this, Dr. Shapiro stated that Petitioner's complaints and his finding of right EHL and tibialis anterior weakness, which were 4 plus over 5, were "non-verifiable." Dr. Shapiro stated that the Petitioner could return to full duty work without restriction, although he recommended an additional six weeks of physical therapy.

Based on Dr. Shapiro's report the Respondent returned the Petitioner to full duty work on June 5, 2013.

The Petitioner returned to his full duty machine operator job on June 5, 2013, involving lifting, bending and twisting as set forth above. He reported he re-injured his back, as his back pain increased throughout his shift. He saw Dr. Martinez in Dr. Panuska's office on June 6, 2013, with the above history and complaints of low back pain and radiculopathy down the right leg. Dr. Panuska

saw Petitioner on June 10, 2013, and gave Petitioner work restrictions of 20-pound lifting, pushing and pulling, no repeat lifting, limited bending, stooping and twisting, alternate standing and sitting as needed, restart physical therapy and take Tylenol #3, Naprosyn and Flexeril. The Petitioner that Respondent could not accommodate these restrictions and that he was off work again.

The Respondent had Petitioner re-examined on July 10, 2013, by Dr. Shapiro, whose impression was, "Persistent low back pain and right leg numbness and *continued right foot drop." (Emphasis added)* Dr. Shapiro recommended a repeat MRI, "given the persistent foot drop." Dr. Shapiro stated, "If the MRI is unchanged, then he should be returned to work full duty without restrictions and he would be at MMI for this injury. If he is unable to work full duty without restrictions then he should undergo a Functional Capacity Evaluation." *(Shapiro Exhibit 4)* In the meantime Dr. Shapiro recommended restricted duty limited to 20-pound lifting.

On July 29, 2013, the Petitioner underwent a repeat lumbar MRI at Accelerated Open MRI. This MRI showed additional findings. In addition to the L5-S1 disc herniation, it showed, "2 mm retrolisthesis of L5 over S1 vertebra without evidence of obvious lysis. *This is a fresh finding since prior repeat dated 4/16/2013.* Retrolisthesis, 3 mm broad based posterior disc protrusion along with bilateral facet joint hypotrophy at L5-S1 that results in bilateral neural foraminal encroachment and abuts the exiting L5 nerve roots." *(Emphasis added)*

On August 20, 2013, Dr. Shapiro reviewed the actual MRI images of July 29, 2013, and again stated that the MRI was "completely unremarkable." Dr. Shapiro

stated, "Given the negative MRI, he should be returned to work full duty without restrictions. He is at MMI for this injury. If he is unable to work full duty without restrictions, he should undergo a functional capacity evaluation. There is no indication for injections or surgery. His continued complaints of right lower extremity numbness and weakness are non-verifiable."

Based on this report the Respondent cut off Petitioner's TTD benefits and told the Petitioner to return to full duty work. Dr. Panuska continued to restrict the Petitioner's work.

After the July 29, 2013 MRI, Petitioner saw Dr. Roland again on August 12, 2013. Dr. Roland agreed that the MRI showed a fresh finding of retrolisthesis of L5 on S1 of 2 mm and also a 3 mm broad based posterior disc protrusion along with bilateral facet hypertrophy at L5-S1 resulting in bilateral neuroforaminal encroachment and abuts the exiting nerve roots." Dr. Roland found lumbar radiculopathy and ongoing pain in the right lower extremity with decreased reflexes and decreased sensation. Dr. Roland again recommended an epidural steroid injection at the L4-5, L5-S1 levels on the right side. Respondent again denied authorization.

On September 23, 2013, the Petitioner again attempted to return to work on full duty, per Dr. Shapiro but contrary to Dr. Panuska. Petitioner testified that Respondent told Petitioner, "Our IME doctor said you could work full duty." The shift started at 4:30 p.m. By 10:50 p.m. Petitioner could not feel either leg and was in significant pain. The Petitioner told his supervisor, who told Petitioner that if he left work he would be charged a point on the disciplinary program. The

Petitioner was seen at St. Mary's Hospital Occupational Health Clinic by Dr. Moran and given a note to stay off work until seen by Dr. Panuska.

On September 24, 2013, the Petitioner saw Dr. Panuska's nurse practitioner, as Dr. Panuska was out of town. The Petitioner was continued under the same restrictions of Dr. Panuska, no lifting, pushing or pulling over 20 pounds, limited bending, stooping and twisting and alternate standing and sitting positions. Dr. Panuska confirmed these restrictions on October 1, 2013. The Petitioner had a positive straight leg raise at 30 degrees bilaterally. On October 8, 2013, Dr. Panuska requested another MRI, which the Respondent denied, stating that the Petitioner could return to work full duty. Dr. Panuska prescribed Tylenol #3, Naprosyn, ThermaCare patches, and modified work. Petitioner testified that he was told by Respondent that he could not work taking narcotic pain medications and also that the Petitioner could work full duty.

Eventually the Respondent allowed Petitioner to attempt to return to work on March 5, 2014, March 11, 2014 and May 6, 2014, on full duty. On each occasion Petitioner had more back pain and was seen at the emergency room, because the Respondent refused to authorize further treatment by Dr. Panuska. Petitioner kept working until May 6, 2014. On May 6, 2014, after the Petitioner had to leave work and was seen at the Riverside Hospital emergency room, he was given a light duty slip, which he provided to Amy at Respondent. He testified that Amy told him that he could not work until he was 100% and to go home until his light duty was up, which Petitioner did. However, a couple of days later Amy called

Petitioner and told him his employment was terminated, because he was a "no call no show." Petitioner denied ever being a "no call no show." *(R. 45-46)*

Petitioner testified that Respondent had never offered him light duty work. *(R. 93)*

Respondent's witness, Amy Hiser, testified that she had offered Petitioner light duty work but on cross-examination she admitted that if Sedgwick told her that their IME doctor told her that Petitioner could do full duty work, she would make sure that the Petitioner was doing his full duty job. *(R. 89)* This was consistent with Petitioner's testimony that Amy told him she was going by Dr. Shapiro, Respondent's IME doctor, who said he could work full duty, and not Dr. Panuska, who had restricted Petitioner.

On January 13, 2016, Petitioner underwent a Functional Capacity Evaluation at Lakeside Sports Physical Therapy that concluded that Petitioner was limited to sedentary work with restrictions on his ability to stand, work in a bent over position, squat and rotate in a sitting or standing position. The FCE report stated that Petitioner appeared to give a full maximum effort throughout the FCE. The FCE report also recommended further medical treatment because of Petitioner's ongoing symptoms and stated that Petitioner may benefit from vocational rehabilitation to assist him in finding an appropriate job. *(Pet. Ex. 8)*

In addition to the treating records and Petitioner's testimony, the Arbitrator also notes the opinions of Dr. Samuel J. Chmell *(Pet. Ex. 3)*. Dr. Chmell opined that a causal connection existed between Petitioner's initial injury of February 26, 2013 as well as his subsequent alleged injuries or re-injuries and the Petitioner's

conditions of ill-being: L5-S1 disc herniation, right lower extremity radiculopathy, traumatic aggravation of lumbosacral facet joint arthritis, and L5-S1 retrolisthesis.

The Arbitrator does not accept the opinion of Dr. Shapiro that both MRI's were completely normal, in the face of the opinions of the radiologist who read the MRI's, Dr. Panuska, Dr. Roland and Dr. Chmell, who all agreed that the MRI's showed L5-S1 disc herniation, as well as, on the second MRI, L5-S1 retrolisthesis. Similarly, the Arbitrator does not accept Dr. Shapiro's opinion that Petitioner could work full duty in the face of the positive MRI findings and the opinion of Dr. Panuska, that the Petitioner required significant work restrictions, especially since Dr. Shapiro himself found a continued right foot drop.

Based on the record as a whole, the Arbitrator finds that Petitioner's present condition of ill-being is causally related to the injury as alleged in the present case. The Arbitrator notes that the Petitioner suffered several re-injuries to his low back when he attempted to return to work on multiple occasions. Although these subsequent re-injuries may have aggravated the Petitioner's low back condition to some extent, the Arbitrator notes that the Petitioner remained symptomatic after his initial injury of February 26, 2013, and concludes that but for this initial injury the Petitioner would not have sustained the conditions of ill-being from which he continues to suffer.

K. Prospective Medical

The Arbitrator notes the opinion of Dr. Samuel J. Chmell, as well the findings and recommendations of Drs. Panuska and Roland, that the Petitioner is in need of further medical treatment. This treatment recommended included a series of low back injections as recommended by Drs. Panuska and Roland, physical therapy and work hardening, EMG/NCV studies and a CT myelogram, and possibly low back surgery consisting of an L5-S1 decompression and fusion, followed by physical therapy and work hardening and another FCE. At this point the only firm prescriptions were for injections followed by EMG/NCV, CT myelogram if no improvement and possible physical therapy and/or work hardening depending on the outcome of the said treatment, and the Arbitrator awards same and orders the Respondent to authorize and pay for same.

L. Temporary Total Disability

The Arbitrator finds that the Petitioner is entitled to TTD benefits from February 18, 2013 through March 4, 2014, except for June 5, 2013 and September 23, 2013, plus TTD from May 6, 2014 through July 12, 2016, at $253.00 per week for a period of 168 weeks.

This finding is based upon the Petitioner's testimony, including that the Respondent insisted on following Dr. Shapiro's opinion that Petitioner could do full duty work and so refused to offer Petitioner any light duty work once it had Dr. Shapiro's full duty opinion, Petitioner's testimony that his supervisors at Respondent told him he could not work while taking narcotic pain medications, the

treating records of Drs. Panuska and Roland and the records from St. Mary's Hospital and Riverside Medical Center, and Dr. Chmell's opinion.

Also, the Arbitrator notes that the Respondent's termination of Petitioner shortly after he went to the Riverside Hospital emergency room on May 6, 2014 and was given a light duty slip, along with Respondent's denial of medical treatment, does not excuse Respondent from paying TTD when there is a termination before the Petitioner has reached MMI. See *Interstate Scaffolding v. Illinois Workers' Compensation Commission* 923 NE2 266, 236 Ill 2d 132, 337 Ill Dec 707 (2010).

M. Should penalties or fees be imposed on Respondent?

The Arbitrator believes that the Respondent's failure to pay any TTD from August 29, 2013 to March 4, 2014, and again from May 6, 2014 to July 12, 2016, plus its delay in paying TTD for period beginning on February 28, 2013 until March 27, 2013, and its delaying until July 23, 2013 in paying TTD for the period of June 6, 2013 to July 23, 2013, was not unreasonable and vexatious and decdlines the imposition of penalties and attorneys fees under Secs. 19(k), 19(l) and 16.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael C. Sanders,

Petitioner,

vs.

NO: 13 WC 24480

17IWCC0408

Flanders Precisionaire,

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, prospective medical, causal connection, 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 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.

17IWCC0408

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: JUN 28 2017

o:5/17/17
LEC/mas
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

SANDERS, MICHAEL
Employee/Petitioner

Case# **13WC024480**

17IWCC0408

FLANDERS PRECISIONAIRE
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

0393 THOMAS R LICHTEN PC
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

1120 BRADY CONNOLLY & MASUDA PC
ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0408

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

- [ ] 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)

Michael Sanders
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # 13 WC 24480

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 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. [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 [ ] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

17IWCC0408

FINDINGS

On the date of accident, **06/05/2013**, 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, the average weekly wage was **$360.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$6,695.87** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$6,695.87**.

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

ORDER

The Arbitrator finds that the Petitioner sustained a work-related injury to his low back on June 5, 2013. The Petitioner's initial injury occurred on February 26, 2013, and was filed as 13 WC 22725. For reasons explained in the body of that decision all benefits are awarded under 13 WC 22725.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Robert E. Johnson

Signature of Arbitrator

August 4, 2016
Date

ICArbDec19(b)

AUG 8 - 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Kyle Schweppe,

Petitioner,

17IWCC0417

vs.

NO: 13 WC25440

Illinois Environmental Protection Agency,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, wages and rates, and permanent disability, and being advised of the facts and law, modifies the Decision of the Arbitrator on the issue of average weekly wage and otherwise affirms the Decision of the Arbitrator which is attached hereto and made a part hereof.

The parties stipulated at arbitration that Petitioner's salary during the year preceding the injury was $54,252.00 and the average weekly wage was $1,043.31. No wage information was offered into evidence by either party. We hereby modify the Decision of the Arbitrator on this issue to comport with the stipulated wages and rates. All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.54 per week for a period of 19 weeks representing 10% loss of the right hand and a further period of 14.25 weeks representing 7.5% loss of the left hand, as provided in §8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is awarded payment of all medical expenses in Petitioner's Exhibit #1 in accordance with the Fee Schedule, and Respondent is given credit for bills paid by the health insurer.

17IWCC0417

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

DATED: JUN 28 2017
DLS/plv
o-6/8/17
46

David L. Gore

Stephen J. Mathis

DISSENT

I must respectfully dissent from the majority's decision affirming the Arbitrator's finding of repetitive trauma. The Arbitrator found Petitioner's testimony to be credible and found Dr. Schopp's causal opinions to be persuasive. After reviewing all of the evidence and for the reasons set forth below, I disagree. I would reverse the Decision of the Arbitrator and deny this claim.

I do not find that Petitioner testified credibly. During his testimony he denied any prior injuries to his hands and wrists or that he was experiencing any problems prior to the onset of symptoms of his alleged injury. However, the medical records in evidence contradict Petitioner's testimony. In August of 2009 Petitioner sought treatment following a right wrist injury. An x-ray revealed evidence of a fracture - a bone fragment was found on the radial side of the right wrist; Petitioner was treated with splinting. In September of 2009, he complained of chronic right shoulder pain aggravated by stress, sleeping positions, and overhead lifting. The records also show a history of chronic left shoulder pain and arthritis from a prior injury and left shoulder surgery. In April of 2012 Petitioner was examined for bumps on both wrists and was diagnosed with ganglion cysts. What is notably absent from Petitioner's prior medical records is any documentation of the symptoms he allegedly developed over the course of the year leading up to the given manifestation date. The records show that Petitioner saw his primary care physician during this period of time but did not complain of any numbness, tingling, or pain in his hands.

However on May 17, 2013, Petitioner presented to Dr. Schopp with complaints of numbness and tingling in the thumb, index, and long fingers that he related to his work activities. Dr. Schopp diagnosed *"work-related carpal tunnel syndrome, which is by historical only. I have no independent observation of Mr. Schweppe's work duties. Mr. Schweppe denies other activities which exacerbate his symptoms."* In his Notice of Injury to Respondent three days later, Petitioner stated that he went to Dr. Schopp *"to see if injury was work related... reported to supervisor once it was established work related."* Dr. Schopp testified that he relied on Petitioner's history that he previously and unsuccessfully tried splints and anti-inflammatory medications for his symptoms. It is also notable that Petitioner denied smoking or performing any other activities that exacerbated his symptoms when he was examined by Dr. Schopp, although he later admitted to smoking and motorcycle riding.

17IWCC0417

I am not persuaded by the opinion of Petitioner's treating physician. Dr. Schopp opined that "repetitive tasks in general" are known to be causative of carpal tunnel syndrome. (PX3, p. 7) He agreed that the "kinds of things" Petitioner reported doing at work can contribute, cause, aggravate, or exacerbate carpal tunnel syndrome. (*Id. at* 10) On October 9, 2013 after he had already performed a right-sided carpal tunnel release, Dr. Schopp noted *"He does data entry and also stamps forms, sometimes 500 times a day. He states that these activities are the source of his symptoms. Although Joseph is a smoker, he has no other outside activities or risk factors other than mild obesity."* Dr. Schopp testified that it did not matter to him what kind of stamp Petitioner used or how his wrists were positioned; Dr. Schopp relied only on Petitioner's statements, *"[he] told me his symptoms were worsened by the act of stamping so the exact wrist position is less helpful for me.* (PX3, p. 27-28) I am not persuaded that Dr. Schopp's opinions are based on a credible history or accurate description of Petitioner's job duties.

I cannot agree that Petitioner proved his job duties are causally related to the injuries he alleged. During his testimony, Petitioner explained his job duties as follows: *"So basically the entire day no matter if I'm doing FOIA response or if I'm just doing documents for general imaging, all I do is like gross manipulation of large documents or finer such as separating pages, taking out staples, writing things, typing on the computer; and as I said previously, every document has to be stamped whether as releasable to the public or – and then if something is removed, it's stamped exempt. That way it can be referenced in the future. So then those go to imaging, and then they're electronically available for future, so basically my job consists of manipulating paperwork, entering the information on the data base and stamping each piece of paper – each document. I shouldn't say piece of paper, each document. It could be once piece. It could be a hundred, so each document gets stamped."* (T. 13) Petitioner testified that the number of stamps he applied per day was highly variable. Between stamps he read, turned pages, removed staples, made copies, entered data into a database, returned original documents, and gathered and prepared documents for processing. These activities would necessarily give Petitioner the ability to change hand and arm positions frequently and I find no credible evidence of sustained stressful positioning or forceful activities. In conclusion, I am not convinced that Petitioner credibly proved work-related repetitive trauma injuries and based on all of the above I must respectfully dissent from the decision of the majority.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0417

SCHWEPPE, JOSEPH KYLE
Employee/Petitioner

Case# **13WC025440**

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY
Employer/Respondent

On 6/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1189 WOLTER BEEMAN & LYNCH
FRANCIS J LYNCH
1001 S 6TH ST
SPRINGFIELD, IL 62703

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

4993 ASSISTANT ATTORNEY GENERAL
AMY S OXLEY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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

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

JUN 13 2016

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

17IWCC0417

17IWCC0417

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

JOSEPH KYLE SCHWEPPE
Employee/Petitioner

v.

ILLINOIS ENVIRONMENTAL PROTECTION AGENCY
Employer/Respondent

Case # 13 WC 025440

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **4/20/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/17/13**, 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 **$57,967.00**; the average weekly wage was **$1,114.75**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **0** children 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 is entitled to a credit for all medical paid by the group health carrier under Section 8(j) of the Act.

ORDER

Petitioner is awarded 19 weeks of PPD representing 10% loss to the right hand, and 14.25 weeks of PPD representing 7.5% loss to the left hand.

Petitioner is awarded payment of all medical in Petitioner's Exhibit #1 in accordance with the Fee Schedule, and Respondent is given credit for bills paid by the health insurer.

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

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

D. Douglas McCarthy _____ 6/7/2016 _____

Signature of Arbitrator Date

JUN 13 2016

JOSEPH KYLE SCHWEPPE V. ILLINOIS ENVIRONMENTAL PROTECTION AGENCY - 13 WC 025440

This matter came before the Arbitrator for trial on April 20, 2016. The Arbitrator makes the following Findings of Fact.

The Petitioner was working for the Respondent, the State of Illinois Environmental Protection Agency, on 5/17/13. He worked for the IEPA in the same capacity since January of 2013. Prior to that he worked for the Liquor Commission for 3 to 4 months. Prior to that he was at the Illinois Environmental Protection Agency for between 12 to 18 months.

Petitioner's work history included employment at the Illinois Liquor Commission as a Liquor Control Special Agent and a Licensing Assistant, the Department of Human Services as a Rehabilitation Case Coordinator, Federal Express as a delivery agent, Computer Sciences Corporation as a Customer Service Representative, a brief period in the military, and security for Washington University at Saint Louis School of Medicine.

The Petitioner testified that prior to working for the Illinois Environmental Protection Agency he had never experienced symptoms of numbness or tingling in his wrists. He also had not had the experience of waking up during the course of the night with pain, numbness or tingling.

The Petitioner testified his job duties included, but were not limited to: moving bins of documents that weigh up to thirty or forty pounds, constantly using a stamp to mark documents as releasable or exempt from public disclosure between 50 and 300 times a day. He said that he used both hands while stamping, as he had to separate the pages before applying the stamp. He suggested that the stamp was like the one used by the Arbitrator, which was sitting at trial next to the Arbitrator. A photograph of the stamp was admitted into evidence as an exhibit to Dr. Sudukum's deposition, and it verifies that it is very similar to the Arbitrator's stamp. He also types to enter information in to a database which allows for the tracking of documents exempt from public disclosure, composing and responding to emails.

Petitioner testified that he began having finger numbness about five to six months after he began his job. A month or two before seeking treatment, the Petitioner began noticing that he would awaken at night as a result of his symptoms. In May of 2013, he determined that he would return to see his prior treating orthopedic surgeon, Dr. Jeffrey Schopp.

His appointment was on 5/17/13. The Petitioner discussed his symptoms with Dr. Schopp, underwent an examination, and in accordance with his testimony, answered questions from Dr. Schopp about the nature and extent of his employment.

Following that appointment, the Petitioner advised his employer that he had been diagnosed with a work-related carpal tunnel condition. According to the Petitioner's testimony, Tristar, the employer's workers' compensation agent, arranged for him to undergo an EMG/NCV. According to the Petitioner it took some time for that test to be arranged. The records show that the EMG was conducted by Dr. Claude Fortin on June 21, 2013.

The Petitioner testified that initially another doctor was recommended by Dr. Schopp to perform the EMG/NCV, but it would have taken too long to get that appointment. As a result, according to the Petitioner, Tristar, Respondent's workers' compensation administrator, advised him that Dr. Fortin would conduct the EMG on June 21.

Following the EMG, the Petitioner returned to Dr. Schopp and was scheduled for surgery. He underwent right carpal tunnel surgery on 9/23/13. He underwent left carpal tunnel surgery on 10/28/13.

The Petitioner took 3 days off work after each operation. He returned to work under an arrangement of modified duties agreed upon between him and his supervisor.

The Petitioner described an independent medical examination to which he was sent by the Respondent. The IME doctor was Dr. Anthony Sudekum. According to the Petitioner, when he arrived

at Dr. Sudekum's office, grip strength and other tests were performed by office personnel, and a surface EMG (involving a glove-type device and the instrument identified in a photograph marked as P.Ex. 5) was conducted by another technician.

The Petitioner then saw Dr. Sudekum for about 10 minutes or so. According to the Petitioner, Dr. Sudekum spent more time during that examination discussing his hobbies and his motorcycle riding than he did the Petitioner's job. According to the Petitioner, Dr. Sudekum only asked cursory questions about the nature of his employment.

Dr. Sudekum gave the opinion that activities other than the Petitioner's work caused his condition, which he described as subjective hand numbness. (RX 3 at 24) He did not believe that the Petitioner had objective evidence of Carpal Tunnel Syndrome, based primarily on his interpretation of the nerve conduction studies done during the course of his examination. (Id at 21, 24) The activities included riding a motorcycle, smoking, obesity and high cholesterol. Dr. Sudukum was aware of a job description provided by the Respondent which indicated that the Petitioner spent his work day filing, writing and keyboarding, each for 10 % of his work day, and spent the rest of the day looking through documents, which he would stamp. (Id at 18) In his testimony, the doctor said that the work activities did not cause or aggravate his condition. (Id at 25) In his 38 page

narrative report, he said that the Petitioner's job involved light clerical activities, which were nonstrenuous, intermittent and variable. (Id, R. Dep. Ex. 2)

The testimony from Dr. Jeffrey Schopp was introduced into evidence as Petitioner's Exhibit 3. Dr. Schopp testified that he diagnosed the Petitioner with moderate to severe bilateral carpal tunnel. He described an attempt at conservative treatment which was unsuccessful. Ultimately surgery was performed on each wrist. Dr. Schopp confirmed that the Petitioner was returned to work after each operation with post-surgical relief.

Dr. Schopp was offered a hypothetical description of the Petitioner's work which was consistent with Petitioner's testimony (P.Ex. 3, pg. 22). Dr. Schopp also testified that he discussed Petitioner's work with Petitioner during his initial assessment (P.Ex. 3, pg. 8, line 24-pg. 9).

According to Dr. Schopp, the Petitioner's work and work-related tasks included those activities which, according to "A Preponderance of the Literature and Etiology and Hand Surgery", cause, contribute to, or exacerbate carpal tunnel conditions so as to make them symptomatic (P.Ex. 3, pg. 23).

In his evidence deposition, Dr. Schopp specifically addressed the results of the EMG performed by Dr. Fortin as well as the surface EMG performed by Dr. Sudekum's office. Dr.

Schopp testified that the needle of the EMG/NCV such as that performed by Dr. Fortin would have been preferred as a result of "greater accuracy" (P.Ex. 3, pg. 13, line 20). Dr. Schopp noted that the EMG at issue was a needle EMG performed by a neurologist that he had known and trusted for years and which, in addition to the nature of the test, would explain a positive finding of bilateral carpal tunnel by Dr. Fortin and a negative finding by the Respondent's IME physician's surface EMG performed by the IME doctor's office personnel.

The Petitioner also testified that following the carpal tunnel surgery, the symptoms in each hand improved. He said that he notices occasional shooting pains in the wrists and hand fatigue. He says these symptoms are more noticeable at work.

CONCLUSIONS OF LAW

The Arbitrator makes the following conclusions of law. The Arbitrator finds that the Petitioner's description of his work and work-related activity is both uncontradicted and consistent with Dr. Schopp's testimony and opinion. It is clear from both the Petitioner's testimony and the job description that a large portion of his work day is spent using both hands and wrists to review and file stamp documents related to FOIA requests. The rest of the day is also spent doing activities requiring fine manipulations of the fingers. Writing, copying, using White Out

to redact and stapling are things which both the Petitioner and the Respondent, thorough the description referenced by Dr. Sudukum, agree the Petitioner regularly performs. The Arbitrator has reviewed the testimony and narrative of Dr. Sudukum and finds him to be not credible. Instead of simply explaining why his surface nerve studies were more reliable than the standard needle studies relied upon by Dr. Schoop, Dr. Sudukum elected to argue with the Petitioner's attorney over the differences between nerve tests and EMG's. Instead of acknowledging that the majority of his 38 page narrative report was in fact canned or template language, Dr. Sudukum insisted on requiring Petitioner's attorney to define what is meant by "template." In addition, Dr. Sudukum, in his 34 pages of boilerplate language, seems to not understand the well settled law in Illinois as it applies to repetitive trauma. Repetitive trauma is a legal term used to describe accidents which are not identifiable by a single event. It is not a term which must be proven in and of itself in order for a claim to be held compensable. The Petitioner does not have to prove the exact number of repetitions he performs on a given day. He must, however, prove that his work activity is a cause of his injury. Dr. Schoop provided this evidence by his testimony in response to a hypothetical question which essentially matched the facts concerning work duties established by the other trial evidence.

The Arbitrator has also considered the Petitioner's testimony that bilateral carpal tunnel releases substantially improved his symptoms as a factor in support of causation.

Also, regardless of which nerve study was the most reliable, the fact remains that both showed irregularities in the nerve conductions involving the petitioner's median nerves, and both Drs. Schoop and Sudukum noted physical exam findings consistent with carpal tunnel.

Respondent argues that the timeline described by the Petitioner fails to establish causation. Essentially, it argues that the Petitioner's estimate of his symptom onset, 5 to 6 months after he began with the EPA, occurred while he was working for Liquor Control. The argument is not persuasive. First of all, it appears that the 5 to 6 month testimony was an estimate. The facts show that the Petitioner returned to work for the Respondent EPA in January 2013, and he sought his first treatment on May 17, 2013, a period of four and one-half months. Secondly, the Petitioner testified that his symptoms got worse while he was with the EPA such that he finally decided to get care. Also, it should be noted that there was no evidence of any medical treatment for numbness and tingling in the hands prior to May 17, 2013.

The Arbitrator finds the Petitioner's work and work-related activities were a causative factor in the development of his bilateral carpal tunnel.

The Arbitrator finds that the medical care Petitioner received arose out of and in the course of his employment.

The Arbitrator awards the medical bills outlined in Petitioner's Exhibit 1. Those medicals are to be paid by the Respondent in accordance with the Medical Fee Schedule. The Arbitrator notes that the parties have stipulated that the Respondent paid some medical bills and Respondent shall be given all credit in accordance with the Fee Schedule for all medical bills paid under the Workers' Compensation Act. The Arbitrator further notes that following the independent medical examination, the Petitioner's medical care was paid by an 8(j) insurance carrier which was provided by the Respondent as a self-insured benefit to the Petitioner. The parties agree that the Respondent is entitled to an 8(j) credit for those payments.

The Arbitrator notes that although the Respondent is entitled to a credit for medical bills paid, the Petitioner did pay $500.00 in deductible expenses associated with his health insurance carrier and as part of its 8(j) credit, Respondent must hold Petitioner harmless. Pursuant to the findings of causal connection, Respondent must pay the Petitioner $500.00 in

the deductible expenses that he paid out of pocket for his 8(j) medical care.

The Arbitrator noted that the Petitioner is 35 years old. No AMA report was submitted. The Petitioner's job involves the use of his hands, which favors his claim. There is no showing that he has any expected loss of earnings. His symptoms have improved substantially since the operation but he continues to have what he describes as cracking, crepitus, and tightness following the surgery. Although his symptoms are substantially improved from his pre-operative condition, he still has symptoms associated with his work and work-related tasks following the surgery. Dr. Schoop, the treating doctor, testified and wrote in his office notes that the Petitioner had an excellent result from his surgeries. He also indicated that there was a chance of recurrence due to internal scarring of less than 5 %.

The Arbitrator awards the Petitioner 10% loss of the use of the right hand for an amount equal to 19 weeks and 7.5% loss of the use of the left hand for 14.25 weeks in accordance with Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

☒ 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

Steve Maynor,
Petitioner,
vs.

17IWCC0394

NO: 13 WC 27093

Tri-County Coal, LLC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of disease, permanent partial 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 September 29, 2016 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $33,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

JUN 27 2017

DATED:
KWL/vf
O-6/20/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0394

MAYNOR, STEVE
Employee/Petitioner

Case# **13WC027093**

TRI-COUNTY COAL LLC
Employer/Respondent

On 9/29/2016, 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 0.42% 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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF 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

17IWCC0394

Steve Maynor
Employee/Petitioner

v.

Tri-County Coal, LLC.
Employer/Respondent

Case # 13 WC 27093

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **June 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 **Disease/Exposure, Causation and Sections 1(d)-f of the Occupational Disease Act**

17IWCC0394

FINDINGS

On **06/07/13**, 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 **$57,805.80**; the average weekly wage was **$1,111.65**.

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

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

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

ORDER

Permanent Partial Disability: The Arbitrator awards Petitioner 50 weeks of compensation at a rate of $666.99/week because the injury sustained caused 10% loss of 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.

Edward Lee

Signature of Arbitrator

9/24/16

Date

SEP 29 2016

Statement of Facts

Petitioner, Steve Maynor of Virden, Illinois was 65 years of age on the date of arbitration with a date of birth of December 13, 1950. He graduated high school from Murphysboro Township High School, Murphysboro, Illinois. He attended John A. Logan College in Carterville, Illinois and obtained an Associate's degree in applied science. He served in the Marine Corps from 1970 to 1973 attaining the rank of Corporal E-4. He worked a little over 30 years in the coalmining industry, all of which were underground. During the course of his mining career, in addition to coal dust, he was regularly exposed to silica dust, roof bolting glue fumes, and diesel fumes.

He last worked in the coalmine on June 7, 2013. On that day he worked for Tri County Coal Company at their Crown #3 mine. He was 63 years of age at the time and had a job classification of shuttle car operator, and was exposed to and breathed coal dust on that day. This was the last day he worked in the mine because after over 30 years he felt he had reached the age to retire. Petitioner testified that he had no post-mining employment.

Petitioner started his coalmining career in May of 1977 with Freeman Coal Mining Company. He started at the Orient #6 mine in Waltonville, Illinois. He hired in as a laborer and hauled supplies to all areas of the coalmine for the first six months. Petitioner was then assigned to the face of the mine where the coal is being cut. He testified that this is a very filthy area and one of the dustier areas in the mine. Petitioner then began operating the continuous miner machine, which cuts the coal from the face of the mine and did this for approximately three or four years. Petitioner next worked as a roof bolter, which he described as drilling holes into the ceiling of the mine and inserting pins to support that ceiling. Petitioner testified to a large amount of rock dust exposure. Petitioner also testified that in order to secure the pins into the holes, roof-bolting glue was used that had a very distinctive odor that even made some people sick. Petitioner was a roof bolter for approximately five to seven years. Petitioner then took on the job as a scoop operator. A scoop operator operates a scoop that picks up debris and boulders that fall from the walls of the mine after the machines get out of the way. Petitioner testified that at the end of each shift, the scoop operator would take a machine and rock-dust the faces before he left his shift. This was done by putting bags of rock dust in a blowing machine and the rock dust would be blown on the face, ribs and walls of the mine everyday. Petitioner did this job for approximately five or six years. Petitioner also ran a shuttle car that transports the coal from the face of the mine to the belts so it can be removed from the mine. He also worked in the repair department, repairing machines when they broke down in the mine. Petitioner worked at Freeman Orient for approximately 17 years. He then went to Orient #3 mine in Waltonville, Illinois. At that mine he was mainly a rock duster and a prop setter. A prop setter is a person who sets timbers, one end on the floor and one end on the roof to help support the roof. Petitioner then went to Crown II Freeman United mine in Virden, Illinois. There he was a roof bolter, shuttle car operator, scoop operator, laborer, and prop setter.

Petitioner first started noticing breathing problems about two years after he started working in the mines. He started noticing a heavy feeling on his chest, having difficulty breathing, coughing, and spitting up black stuff, which would sometimes be rock dust. He describes his stomach would get full of the dust and would make him sick to the point where he

would throw up. From the time he first started noticing breathing problems to when he left the mine, Petitioner testified that his breathing difficulties worsened. From the time he left the mine until the time of trial, his breathing difficulties have improved. Petitioner testified that he is not currently on any breathing medications. Petitioner testified that his breathing difficulties do affect his activities of daily living. He no longer cuts grass. He used to enjoy hiking in Shawnee Forest but is no longer able to do that. Petitioner testified that his treating physician is Dr. George Burns. He indicated that he did not talk to Dr. Burns an awful lot about his breathing problems because he decided not to take any breathing medications.

Petitioner testified that he is an occasional smoker. Normally in stressful situations and has not smoked since January. In the last 20 years Petitioner describes smoking off and on. Petitioner testified that in addition to his breathing difficulties he was also diagnosed with diabetes a couple years back, his diabetes has been controlled with diet and exercise and he does not currently take any shots or medication.

Dr. Glennon Paul

At Petitioner's attorney's request, Petitioner was examined by Dr. Glennon Paul on August 28, 2013. Dr. Paul is the medical director of St. John's respiratory therapy and clinical assistant professor of medicine at SIU Medical School. (px 1, p 6) Dr. Paul is also the senior physician at the Central Illinois Allergy and Respiratory Clinic. (px 1, p 7) Dr. Paul testified that Petitioner gave a history of working in the coalmines for 31 and a half years. He also talked about his shortness of breath being there since 1988 and given a puff inhaler. (px 1, p 11 & 12) Petitioner gave a history of coughing attacks, which at times were very severe. He gets them so bad that he has to go to the emergency room to get treatment. (px 1, p 12) Dr. Paul testified that Petitioner had one to two plus wheezing and rhonchi. Wheezing is a sound that one who has bronchitis, either of an asthmatic nature or of a bronchitic nature where the windpipes narrow and therefore when the air goes through it it makes a hissing sound, a wheezing sound, much like I guess if you see wind go through a small area, it makes a howling sound. Rhonchi is just the bubbling that you hear when you have somebody with bronchitis or asthma or even heart failure. (px 1, p 15) Dr. Paul testified that he felt Petitioner had chronic bronchitis. (px 1, p 16) Dr. Paul testified that the spirometry showed a mild obstructive disease, which he attributes to chronic bronchitis. (px 1, p 16) Dr. Paul testified that a coalminer that leaves the mine after 31 and a half years will have coal dust that remains trapped in his lungs that cannot be expelled. That coal dust will remain with him for the rest of his life. (px 1, p 16) Dr. Paul testified to a reasonable degree of medical certainty that he felt that Petitioner had coal worker's pneumoconiosis, which was attributed to his coal dust exposure. Dr. Paul also testified to a reasonable degree of medical certainty that Petitioner has chronic bronchitis, which is attributed to his inhalation of coal dust in the coalmine environment. (px 1, p 17 & 18) Dr. Paul also testified to a reasonable degree of medical certainty that Petitioner has obstructive lung disease which is related to his inhalation of coal dust in the coalmine environment. Dr. Paul testified that Petitioner had clinically, radiographically, and physiologically significant pulmonary impairment which was related to his coal dust inhalation in the coalmine environment. (px 1, p 19 & 20) Dr. Paul testified that in light of his diagnosis of pneumoconiosis, chronic bronchitis and obstructive lung disease, the Petitioner is permanently disabled from working in the coalmine environment. (px 1, p 20) In order to have pneumoconiosis, in addition to having coalmine dust deposited in the lungs there

also must be a tissue reaction. That tissue reaction is called scarring or fibrosis. That scarred area of the lung cannot perform the function of normal healthy lung tissue. (px 1, p 21) Dr. Paul testified that it is possible to have injury or disease to your lung despite having normal pulmonary function testing. A person can also have shortness of breath despite having pulmonary function testing within a normal range. (px 1, p 22) Dr. Paul stated that a person can have coal worker's pneumoconiosis that is radiographically significant but not have shortness of breath. That person can also have normal pulmonary function testing, normal blood gases, and normal physical examination. (px 1, p 25) Coal worker's pneumoconiosis is considered a progressive disease that can be life threatening. (px 1, p 25 & 26) Coal worker's pneumoconiosis has no cure and the progression does not end with the coalminer ending his coalmine dust exposure. In fact, Dr. Paul testified that there is no way to stop the progression of coal worker's pneumoconiosis. (px 1, p 26 & 27) In addition to coal dust, Dr. Paul also testified that exposure to silica, diesel fumes, fumes from petroleum products, smoke and fumes from high sulfur coal fires, smoke and fumes from electrical cable fires, fumes from the glues used in the roof bolting process and welding fumes can also cause damage to the lungs. (px 1, p 27 & 28) When asked how many years it would take to develop pneumoconiosis once you begin to work in the mine, Dr. Paul stated that for some it takes 40 years and other people can develop it within two years. (px 1, p 32) Dr. Paul testified that you can have chronic bronchitis and have normal pulmonary function testing, normal blood gases, and normal physical examination of the chest. (px 1, p 35)

Dr. Henry K. Smith

At Petitioner's request, b-reader, Dr. Henry K. Smith reviewed a grade 1 chest x-ray dated August 28, 2013. Dr. Smith found interstitial fibrosis of classification p/p, bilateral upper, mid and lower zones involved, of a profusion 1/1. There are no chest wall plaques or calcifications. There are mild thickened interlobar fissures. There are mild accentuated subpleural fat deposits seen laterally in both mid to lower dorsal dextroscoliosis and spondylosis. Dr. Smith's impression was simple coal-worker's pneumoconiosis with small opacities, primary p, secondary p, upper, mid and lower zones bilaterally, profusion 1/1.

Dr. Michael Alexander

At Petitioner's request, b-reader, Dr. Michael Alexander reviewed a grade 1 chest x-ray dated August 28, 2013. Dr. Alexander found lung volumes normal. Small round opacities present bilaterally, consistent with pneumoconiosis, category p/p, 1/0. No areas of coalescence or large opacities present. No chest wall pleural thickening or pleural calcifications present. The costophrenic angles and diaphragms are clear. Atherosclerotic change is present in the aorta, and mild scarring or plate-atelectasis above the right hilum, otherwise the cardiomediastinal structures and distribution of the pulmonary vasculature are normal. The bones are intact. Dr. Alexander's impression is coal worker's pneumoconiosis, category p/p, 1/0, aa, pa.

Dr. George Burns

On an office note of April 22, 2013 under active problems, chest pain made worse by breathing. (px 4, p 11)

VA Illiana Health Care Systems

On a radiology report dated March 13, 2015, clinical indication: history of black lung disease. Impression: left midlung subsegmental atelectasis or scar. Left perihilar calcified granuloma. No acute cardiopulmonary disease. (px 5, p 14) On a radiology report dated March 13, 2015 under clinical indication: sinus congestion. (px 5, p 15) On a progress note dated February 20, 2015, chief complaint: 64 year old patient came in for his annual check up and to review labs. Complains of stuffy sinuses and runny nose all the year through. Has tried all over the counter medications with no relief. Started about two to three years ago. Denies any chest pain, shortness of breath. Was told in the past he had black lung disease. (px 5, p 58) On a progress note dated February 4, 2015 assessment/plan: chronic rhinitis: advised cetirizine, Fluticasone and will do allergy panel and sinus x-rays. (px 5, p 60) Majority of other records deal with Petitioner's PTSD due to his military service in Vietnam and hearing loss issues.

Dr. Christopher A. Meyer

At Respondent's request, Dr. Christopher Meyer reviewed a chest x-ray dated August 28, 2013. Dr. Meyer testified that they were quality 1. The films were normal. The lungs were clear. There was some mild atherosclerotic calcification of the thoracic aorta, and the remainder of the examination was unremarkable. Under cross-examination Dr. Meyer testified that a negative reading of an x-ray cannot rule out that there is pneumoconiosis. (rx 1, p 43) Dr. Meyer also testified that the macule of coal workers' pneumoconiosis is a permanent abnormality. (rx 1, p 58) He also testified that coal workers' pneumoconiosis is considered to be a chronic progressive disease. (rx 1, p 59) Under cross-examination, Dr. Meyer was asked, "Is it possible that a miner could work thirty or forty years in a coalmine, develop radiographically significant coal worker's pneumoconiosis but not have it manifest itself on the x-ray until the last year, or even the first year, after they leave the coal mine?" Dr. Meyer responded "Yes, that is possible." (rx 1, p 77)

JAMES R. CASTLE, M.D.

At Respondent's request, Dr. James R. Castle did a medical records and films review of Petitioner. This was performed on December 8, 2014 (rx 2, p 21) Dr. Castle gave an opinion within a reasonable degree of medical certainty that Petitioner could perform heavy manual labor based on the data that he reviewed. Dr. Castle testified that it is his opinion to a reasonable degree of medical certainty based on a thorough review of all the data, including the medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gas studies and other data, that Petitioner does not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to the coal mining industry. (rx 2, p 55) Dr. Castle testified it is his opinion that there is no evidence of coal worker's pneumoconiosis radiographically. (rx 2, p 57) On cross examination Dr. Castle testified that you can have lung cancer that you can see on x-ray but have normal pulmonary function testing. You can also have what appears to be a normal x-ray but pathologically have discernable disease; pneumoconiosis, lung cancer, and a number of other diseases. (rx 2, p 67) Dr. Castle agreed that a chest x-ray taken 24 years before he left coalmining, would not tell you whether or not his x-ray was positive at the time he left mining. (rx 2, p 75) Dr. Castle testified that you can have lung disease despite

having a finding of clear lungs on physical exam of the chest. (rx 2, p 77) Dr. Castle testified, to his knowledge, Petitioner had sufficient exposure to the environment of the coalmine to cause coal workers' pneumoconiosis in a susceptible host. (rx 2, p 84) Dr. Castle went on to testify that Petitioner certainly had enough exposure in the coalmine environment to have caused industrial bronchitis. (rx 2, p 79 & 80) Dr. Castle testified that coal workers' pneumoconiosis is a latent and progressive disease. (rx 2, p 85)

NIOSH Records

Respondent produced NIOSH records showing chest x-rays of various readings throughout Petitioner's mining career. All of these readings were negative for coal worker's pneumoconiosis.

Dr. Jeff Selby

There is a b-read for an x-ray of August 28, 2013 where there is no finding of coal workers' pneumoconiosis. (rx 4, p 1) On page two of that report under other comments, reticulonodular scar at cardiac apex scattered calcified and non-calcified granulomas especially peri-hilar. (rx 4, p 2) There is a pulmonary function report dated July 31, 2014. Interpretation: super-normal spirometry with no change post-bronchodilator, normal lung volumes, and normal diffusion capacity. (rx 4, p 7 & 8)

VA Medical Center Records

These medical records are similar to the records proposed in Petitioner's exhibit 5.

CONCLUSIONS OF LAW

Issue (C) and (O): Did Petitioner suffer disease which arose out of and in the course of his employment by Respondent?

The Arbitrator resolves the issue of occupational disease in Petitioner's favor. The Arbitrator concludes that Petitioner suffers from Coal Worker's Pneumoconiosis (CWP), chronic bronchitis, and obstructive lung disease related to his exposures as a coal miner.

Regarding chronic bronchitis: A diagnosis of chronic bronchitis is based on a patient history which reveals sufficient cough. The only expert in this record to personally obtain such patient history was Dr. Paul; therefore, his patient history is the determining factor in determining the preponderance of the evidence on the existence of chronic bronchitis. Respondent could have obtained the medical examination it was entitled to, and thereby have obtained its own patient history on which to base its argument. For its own reasons, Respondent chose to obtain a records review rather than an examination, and is therefore left with no patient history on which to base its argument. The Arbitrator agrees with the opinion of Dr. Paul.

Regarding obstructive lung disease: The PFTs of both Dr. Paul and Dr. Selby reveal a ratio of the FVC to the FEV1 which is below the limits of normal as described in the AMA

Guides. It is unchallenged in the record that a low ratio indicates an obstructive disease. Therefore, as a matter of law, Petitioner's testing revealed an obstructive lung disease. The Arbitrator agrees with the opinion of Dr. Paul.

Regarding CWP: The burden of the Petitioner is to prove his issues by a preponderance of the evidence. In this case, the evidence establishes that CWP first appears pathologically, then can progresses to the point that it can be seen by regular chest x-ray. Literature presented by Respondent's experts establishes that 50% or more of long-term coal miners who did not have radiographically apparent CWP during their life are found to have CWP by pathologic examination at autopsy. The CWP which is seen pathologically has macules and nodules which are of the same constitution as those that may be seen on radiographic studies; they are just at an earlier stage. They still are subject to progression without further active exposure in a living miner, and they still represent an alteration in the function of the lung at the site of the lesion.

The universal or uncontested testimony is that the gold standard for determining the presence of CWP is pathologic examination of the tissue itself. A person can have CWP with a normal chest x-ray, and while a positive x-ray combined with a sufficient history of exposure to coal mine dust provides a sufficient basis for arriving at a diagnosis of CWP, a negative x-ray can never rule out the existence of CWP. In addition, x-rays taken prior to the date of last exposure or even during the first year after exposure ceases may be instructive if indicating abnormalities consistent with CWP. However, they cannot be used to rule out the existence of CWP, because this disease can first manifest itself radiographically within the last months of employment or even after employment and exposure has ceased. One reason for this is that a certain amount of coal dust remains trapped in the miner's lungs for the rest of his life, resulting in continued exposure for the rest of his life. For this reason, CWP is considered a latent and progressive disease.

Under these facts, Petitioner has provided the opinion of two b-reader/radiologists and one examining expert with considerable experience in treating and testing for CWP, having examined as many miners at the request of Respondents as for Petitioners. Respondent has provided the opinion of one b-reader radiologist and one b-reader pulmonologist. While Respondent's pulmonologist reviewed extensive medical records, it is clear from the testimony of Dr. Meyer that a review of treatment records not only will not enhance the ability to make a more accurate b-reading, but may actually bias the reader, making an accurate reading more difficult.

Viewed under these facts, the evidence presents the opinions of two b-readers and Petitioner's examining expert that Petitioner has CWP. In this judgement call, the bases of such opinions are sound. In opposition are Respondent's two b-readers who testified that their x-ray readings cannot rule out the possibility that CWP exists. Overlay these opinions on the literature cited by Respondent's experts. Since CWP will exist in long-term miners 50% of the time or greater when examined at autopsy, it is more likely than not that in this case that CWP exists. There is no testimony in this record that CWP does not or cannot exist in Petitioner. The Arbitrator finds that Petitioner's 30 years of underground coal mine employment qualify him to be considered a long-term coal miner.

Petitioner must prove by a preponderance of the evidence that he has CWP. It is axiomatic that Respondent prevents this by presenting evidence that CWP does not exist. Unquestionably, Petitioner has presented evidence that he has CWP, but Respondent has presented no credible evidence that he does not. The preponderance of the evidence, therefore, is in Petitioner's favor regarding CWP.

The Arbitrator arrives at these conclusions of law for the reasons outlined below:

Dr. Paul, Petitioner's examining expert, diagnosed CWP, chronic bronchitis, and obstructive lung disease, all caused by his coal mining exposures. (PX 1, pp. 17-18) Petitioner's baseline pulmonary function testing (PFT) showed an FVC of 82% of predicted, an FEV1 of 79%, and an FEV1% (ratio) of 72%. His diffusing capacity (DLCO) was measured as 67%. (Paul report) CWP was also diagnosed by b-reader/radiologist Dr. Michael Alexander (PX 3) and b-reader/radiologist Dr. Henry Smith. (PX 2) There was no testimony that CWP can be caused by anything other than coal mining.

Dr. Paul's pulmonary function testing showed obstructive lung disease. (PX 1, p. 18) This means that the elasticity of his lung tissue has been reduced and there has been destruction of the small airways. (PX 1, pp. 29-30) The ratio on PFT suggests the amount of obstruction. (PX 1, p. 43)

Dr. Paul described Petitioner's cough and its severity. "...he gets coughing attacks which are very severe at times, which...by my definition means constant, day in and day out. He gets it so bad that he has to go to the E.R. to get treatment...This bronchitis can become so severe that it causes a lot of spasm of his windpipes which then causes him to have severe shortness of breath and problems with a lot of mucous production." (PX 1, p. 12) He testified that Petitioner's chronic bronchitis is a permanent condition. "The bronchitis is there all the time even though he has exacerbations...When he gets a virus infection or he inhales another irritating chemical, the inflammation worsens and his symptoms then worsen." (PX 1, pp. 12-13) He described chronic bronchitis as resulting in changes in the tissues of the airways. "You can cut into the tissue, put it on a scope, and you'll see a lot of inflammation." (PX 1, p. 14) He added that when a miner has chronic bronchitis, by definition, he will have an alteration in the function and architecture of the bronchial tubes. (PX 1, p. 15) Dr. Castle did not disagree, testifiying that chronic cough indicates something other than a normal state. (RX 2, p. 128) He testified that when a miner leaves the mine, all the coal mine dust in his lungs cannot be expelled, and it remains there for the rest of his life. It is always there, which is why chronic bronchitis can sometimes progress after the active exposure of coal mining ends. (PX 1, p. 17) On physical examination of the chest, Dr. Paul found 1 to 2+ wheezing and rhonchi. (PX 1, p. 15) He concluded that Petitioner's chronic bronchitis is manifesting itself in terms of physical symptoms, the wheezing and rhonchi, the secretion of mucous, and also measurable pulmonary function findings. (PX 1, p. 16)

<u>Regarding obstructive disease</u>, Dr. Castle did not examine Petitioner, but performed only a records review. That review included PFTs from Dr. Jeff Selby which showed an FVC of 138% of predicted, an FEV1 of 120%, and a ratio of 70%. Dr. Castle described this testing as entirely normal. (RX 2, p. 47) However, the Arbitrator notes that Dr. Castle was in error as a

matter law inasmuch as the AMA Guides to Impairment, Pulmonary Dysfunction Table (AMA Guides) require a ratio of 75% for the testing to be normal. Dr. Castle stated that a ratio below the lower limit of normal could be consistent with obstructive lung disease. (RX 1, p. 81) In any event, Dr. Castle testified that having PFTs within the range of normal does not mean your lungs are free of any lung damage, injury or disease, noting that one can even have lung cancer with normal PFTs. (RX 2, p. 113)

Dr. Castle also described Dr. Selby's blood gas testing, which showed a resting pO2 of 72 and an exercise pO2 of 82 as normal; however, according to Dr. Selby's PFT lab, the lower limit of normal for a pO2 measurement is 80. He explained, "I don't adhere to that because the company or wherever the hospitals get those printouts and what they use is basically a one-size-fits-all." (RX 2, p. 73) Dr. Castle described Dr. Selby's diffusing capacity as being normal "...after correction for alveolar volume." (RX 2, pp. 57-58) However, under the AMA Guides, it is the DLCO that determines impairment, not the corrected DLCO.

Regarding chronic bronchitis: While Dr. Castle admitted that Petitioner had sufficient coal mine exposure to cause chronic bronchitis, (RX 2, pp. 79-80) he opined that Petitioner did not have "definitive" findings of chronic bronchitis in the treatment records. (RX 2, p. 48) However, chronic bronchitis is determined by the patient history of coughing, and Dr. Paul was the only specialist he knows of that examined and took a specific history to include concerns about chronic bronchitis. (RX 2, pp. 60-61, 67-68) "We have none from Dr. Selby. We just have his testing." (RX 2, p. 79) He admitted that Dr. Paul found chronic bronchitis and talked to Petitioner about its severity; however, he added "This man did have several attacks that were described as bronchitis but there was no chronicity to that that I could determine." (RX 2, pp. 67-68) But he admitted that he doesn't know what questions any of the treaters would have asked concerning the frequency of Petitioner's cough. "What I have to go by is what they put in their report and if that report is incomplete, then I have to go by that." (RX 2, p. 69)

Dr. Castle described the potential insufficiency of the treatment records for diagnosing chronic bronchitis, and testified that "As a pulmonologist, if somebody comes to see me or I'm following them for their lung disease, then I ask them specifically what kinds of problems they're having and go through that." (RX 2, pp. 69-70) He admitted that his records review did not provide him with the thorough patient history that he would have taken had he been allowed the chance to perform an examination. He said that if Petitioner would get to him, he would ask the proper questions to determine if the frequency of cough was sufficient to diagnose chronic bronchitis. He'd specifically ask the right questions. (RX 2, pp. 71, 72) He also admitted that there are individuals who just don't complain to their doctor about things like cough. (RX 2, pp. 70-71) He documented that there's nothing in this data set that said that Petitioner did not have chronic bronchitis. (RX 2, pp. 71-72)

Dr. Castle admitted that he quit seeing patients in the hospital in 2003 and quit seeing them altogether in 2007. His practice now "...pretty much consists of the kind of thing we're doing today. (RX 2, p. 86)

Regarding the relative value of his records review versus an actual examination, Dr. Castle testified that if in addition to the records, "...you can perform a complete independent

medical exam ...he'd be in a better position to make the most accurate assessment that Dr. Castle was capable of." (RX 2, pp. 92-93) He testified, "I would always want to go by my own exam if possible. (RX 2, p. 93) He said that there is a skill to taking a patient history, that as a pulmonologist, he has special training in that, and that all physicians are not as good as all other physicians in taking patient histories. (RX 2, pp. 93-94)

Regarding CWP, Dr. Meyer, b-reader/radiologist for Respondent, testified that a lack of complaints or visits to the primary care physician would not mean that Petitioner could not have CWP. He said that a miner who has 1/0 CWP probably won't even know he has it; he probably won't complain to his doctor; and "until he gets a b-reading that tells him he has it, he probably just won't know." He drew an analogy between CWP and prostate cancer or colon cancer. Until they get the diagnosis after testing, most people would have no idea they had the disease. (RX 1, p. 67) He testified that CWP is a chronic, slowly progressive disease, not an acute disease which would come on suddenly. (RX 1, p. 75) Dr. Castle explained that a miner can have CWP despite having normal blood gas testing, normal physical examination of the chest, and no symptoms. (RX 2, pp. 98) He agreed with Dr. Meyer, testifying that when a coal miner has simple CWP, until he goes in and gets a b-reading, he probably won't know he has it. (RX 2, pp. 97-98)

Both Dr. Meyer and Dr. Castle testified that they did not see CWP on the x-rays they read. However, both Dr. Meyer and Dr. Castle admitted that they could not state that Petitioner does not have CWP. Dr. Meyer testified that notwithstanding his findings of no pneumoconiosis, such would not rule out the possibility that at autopsy or pathology there may be pathologically significant CWP. "It is possible to find coal macules with a negative chest x-ray." (RX 1, pp. 88, 90) Dr. Castle also admitted that a miner could have CWP despite having a normal chest x-ray. (RX 2, p. 109) Dr. Meyer testified that the gold standard for determining the existence of lung disease is pathologic review of the tissue itself, not radiology. (RX 1, p. 48)

Dr. Meyer admitted that the abnormalities of CWP that may be found pathologically in the absence of radiographic findings would have the same constitution as the macules or nodules that would show on an x-ray, just perhaps smaller. They would still be subject to potential progression as any other pneumoconiosis abnormality might be. (RX 1, pp. 90-91)

Dr. Castle described the progression of CWP. In the miner with CWP, the first thing is that his body recognizes that there is something there that shouldn't be there. Then, macrophages, literally "big eaters," are sent to that area, to try to kill the coal dust. The coal dust cannot be killed, and the macrophages eventually die, releasing their contents on the surrounding tissue. Their contents, in the most crude sense, would be the body's Adolph's Meat Tenderizer which cannot do anything to the coal, but irritates the adjacent tissue. After years and years of continuing irritation, collagen forms causing scar tissue. That scarring tugs at the adjacent tissue, causing it to lose its elasticity and resulting in the emphysema that is associated with the macule or nodule. In the very unlucky miner who develops progressive massive fibrosis, after the body first wraps the coal dust in scar, it then sees the scar and repeats the same self-defeating process, wrapping that scar in more scar. (RX 2, pp. 106-109)

Dr. Meyer also testified regarding the progression of CWP. He stated that with simple CWP, the body may recognize the presence of the coal dust, try to get rid of it and, in doing so, end up with the tissue damage that is called a macule. In the very unlucky miner who develops progressive massive fibrosis, the body can recognize the presence of the large macule and the fibrosis that has been laid out and try to get rid of it by the same process, thereby making a large lesion. (RX 1, pp. 65-66)

Dr. Meyer testified that all long-term coal miners will come out of the mines with some dust trapped in their lungs. "...so what happens is there's a buildup of dust over time to the point where depending on the level of exposure, the amount of dust in the lung can be as much as one-half the total weight of the lung itself." (RX 1, p. 54) Dr. Castle added that with CWP, the trapped dust will never be removed from the lungs. Essentially, the exposure to that insult never ends. It is always there. The lung tissue would be exposed to that trapped dust which would be there for the rest of their life. (RX 2, pp. 102-103) He also testified that when CWP progresses, there can be two reasons: first, more coal mine dust can be deposited resulting in more tissue reaction; and second, there's a further scarring process on what's already in the lungs. (RX 2, p. 99-100)

Both Dr. Castle (RX 2, pp. 109-110) and Dr. Meyer, (RX 1, p. 88) testified that studies have shown that at autopsy, 50% or more of long-term coal miners have CWP that can be diagnosed by pathology that was not diagnosed radiographically during their life. Dr. Meyer added that "There is an old study that shows a much higher incidence of finding coal macules in coal workers that haven't reached the degree of severity to be seen at x-ray." (RX 1, p. 88) Dr. Meyer explained that it is possible to have CWP determined by pathology that wasn't diagnosed radiographically, (RX 1, p. 88) and that if he has read an x-ray to be positive and there is a sufficient history of exposure to cause CWP, such would warrant a finding of CWP, but if you find it negative that doesn't necessarily rule out that the miner could have CWP pathologically. (RX 1, p. 90)

Respondent offered b-readings of NIOSH screening x-rays taken of Petitioner. Initially, the Arbitrator notes that Dr. Meyer testified that a long-term coal miner can develop category 1 CWP that doesn't manifest itself on x-ray until the last few months of coal mine employment or even until the year after the end of coal mine employment. (RX 1, pp. 71, 77) By Dr. Meyer, x-rays taken prior to the end of Petitioner's coal mine employment could not prove that Petitioner did not have CWP when he quit coal mining. He testified that a negative x-ray could never rule out CWP, but a positive x-ray is sufficient to make a CWP diagnosis. (RX 1, p. 90) Dr. Castle testified that "You could have what appears to be a normal x-ray but have pathologically discernible disease, pneumoconiosis, lung cancer, a number of other diseases." (RX 2, p. 67) Dr. Castle testified that it is possible to have CWP notwithstanding the data set which was presented. (RX 2, p. 85)

The Arbitrator notes that both of Respondent's witnesses testified that studies have shown that at autopsy, 50% or more of long-term coal miners whose x-rays were negative during life have been found to have CWP by pathologic examination. (RX 1, p. 88) (RX 2, pp. 109-110) By this admission, according to the literature introduced by Respondent, it is more likely

than not that Petitioner, with over 30 years of underground coal mine employment, has CWP at the pathologic level.

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

There is no question that if a miner has CWP, he suffers disablement under the Act, both in terms of an impairment in the function of the lungs and in an inability to safely return to the coal mine environment. Such was the testimony of all witnesses. (RX 1, pp. 57, 58) (RX 2, pp. 95, 103-104) (PX 1, pp. 22, 18)

As described above, the PFTs of both Dr. Paul and Dr. Selby reflected a ratio which indicated an obstructive lung disease under the AMA Guides.

Dr. Paul testified that Petitioner has clinically significant pulmonary impairment, radiographically apparent pulmonary impairment, and physiologically significant pulmonary impairment. (PX 1, pp. 19-20) He further testified that Petitioner is totally disabled from working as a coal miner; that such disability is permanent; and that Petitioner could not go beyond moderate manual labor. (PX 1, p. 20)

The Arbitrator finds that Petitioner has proven that he has both pulmonary and environmental disablement related to his coal mine employment.

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

Based on the above, Petitioner has carried his burden of proof that he has both work-related disease and associated disablement. He has proven that he has multiple work-related pulmonary diseases and, measurable pulmonary function deficits related to them. His disease goes beyond the level of simply radiographically significant CWP. The Arbitrator therefore awards Petitioner 10% MAW. The Arbitrator notes that Sec. 8.1 b of the WC Act refers to "accidental injuries" and not exposures to occupational risks.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BYRON HUDSON,

Petitioner,

vs.

NO: 13 WC 29411

AMERICAN STEEL FOUNDRIES,

17IWCC0415

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 causation, medical expenses, and prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Commission finds that, although claimed by Petitioner, the medical bill for $2,661.20 from Gateway Regional Medical Center is not in evidence. We therefore modify the Arbitrator's decision to deny that bill and hereby award medical expenses of $16,386.00 under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $16,386.00 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent 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.

17IWCC0415

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 $16,400.00. 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: JUN 28 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 6/6/17
49

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

HUDSON, BTRON
Employee/Petitioner

Case# **13WC029411**

AMERICAN STEEL FOUNDRIES
Employer/Respondent

17IWCC0415

On 4/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.40% 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:

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EAST ALTON, IL 62024

0385 BONALDI CLINTON AND DAVIS LTD
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17IWCC0415

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)

Byron Hudson
Employee/Petitioner

v.

American Steel Foundries
Employer/Respondent

Case # 13 WC 29411

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 **May 28, 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

17IWCC0415

FINDINGS

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

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,296.79**; the average weekly wage was **$742.39**.

On the date of accident, Petitioner was **48** 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.

ORDER

Respondent shall pay reasonable and necessary medical services of $19,047.20, 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.

Because Petitioner failed to establish that his current condition of ill-being is causally related to the accident Petitioner's request for prospective medical care is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Michael K. Nowak, Arbitrator

3/28/16
Date

APR 27 2016

FINDINGS OF FACT

Petitioner sustained an undisputed accident on 8/5/13 as he was cleaning dust off the top of some lockers while standing on a bench. He slipped and fell directly onto the bench landing on his buttocks before falling to the ground. Shortly thereafter, he was taken to the emergency room at Gateway Regional Medical Center where he underwent several CT scans. The lumbar CT showed stenosis at L3-4 and degenerative changes at L4-5. (PX1, p. 11-14) He was diagnosed with contusions to the scalp, middle back and low back. (PX1, p. 4)

Petitioner followed up with Midwest Occupational Medicine on 8/5/13, 8/7/13, 8/12/13, and 8/19/13. (RX8) He denied any previous injuries to his back. (RX8, p. 4) On each office visit, his pain diagram showed low back pain only. (RX8, p. 3-15) He was diagnosed with low back pain and provided with conservative treatment, including medications and a referral for physical therapy. A lumbar MRI was also ordered. (RX8) Petitioner attended physical therapy from 8/7/13 through 8/28/13. (RX9) On 8/20/13, the MRI showed multi-level degenerative change. There were no annular tears or herniations described. (RX8, p. 17)

Petitioner was then referred by his attorney to Multi-Care Specialists where he began treating with Dr. Mark Eavenson, DC on 8/29/13. (RX14, p. 1) Petitioner reported he had never had a prior problem with his low back, but that since the fall he continued to have low back pain and tingling in both lower extremities. (PX2, p. 113) Dr. Eavenson diagnosed a lumbar disc protrusion, prescribed chiropractic care and physical therapy, and made a referral to an orthopedic surgeon, Dr. Matthew Gornet. (PX2, p. 113-114) Dr. Eavenson and his physical therapist provided treatment through 11/5/13 and, on each office visit, both would treat Petitioner. (PX2, p. 55-115)

Dr. Gornet testified by deposition. (PX6) Petitioner first saw Dr. Gornet on 9/20/13 complaining of low back pain, as well as some buttock and leg complaints. (PX6, p. 5) He denied any problems with his low back or legs prior to the 8/5/13 accident. (PX6, p. 6, 22) Dr. Gornet noted that Petitioner weighed 295 pounds. (PX6, p. 6) He diagnosed acute low back pain, recommended continued conservative treatment and allowed Petitioner to continue working without restrictions. (PX6, p. 7, 26) Petitioner next followed up with Dr. Gornet on 11/7/13. Dr. Gornet reviewed the MRI and thought it showed an annular tear at L4-5, although he was critical of the quality of the study. (PX6, p. 7) Dr. Gornet thought Petitioner was getting better and would not require any further treatment. (PX6, p. 32-33) Dr. Gornet did not have "any real assessment" then, noting that Petitioner had a low level of pain. (PX6, p. 31) Dr. Gornet stopped the chiropractic treatment and physical therapy. (PX2, p. 55) He thought Petitioner could continue working without restrictions, but did not believe Petitioner was at MMI. (PX6, p. 7, 31)

Petitioner testified that on 12/25/13 he fell off the third or fourth rung of a ladder while trying to take down outdoor Christmas lights, landing on his back and buttocks. He immediately went to the St. Elizabeth's Hospital emergency room where he complained of low back pain which was 10 out of 10. (RX10, p. 2) He gave a history of feeling a pop when he hit the ground and of getting tingling in his left leg. (RX10, p. 10) He underwent an x-ray and CT scan of the lumbar spine which showed extensive degenerative changes with bilateral foraminal stenosis and lateral recess narrowing from L2-L5 and received two pain shots. (RX10, p. 14-16) He was diagnosed with low back pain and a possible herniated disc. He was instructed to follow up with his primary care physician, Dr. Phillip Chu, and was taken off work until cleared by Dr. Chu. (RX5, p. 12) Petitioner did not follow up with Dr. Chu. (RX12, p. 6-8) Petitioner testified that this fall "significantly" increased his low back pain.

On 1/16/14 Petitioner returned to Dr. Gornet indicating that his low back and leg symptoms were worse. Dr. Gornet noted that Petitioner presented with a new onset of numbness in the left leg in the L5 distribution.

(PX6, p. 35) Petitioner did not recall whether he told Dr. Gornet about the Christmas day fall or the new radiographic studies taken in the ER. Dr. Gornet testified that he did not receive any history for the new symptoms, stating that there had been no new slips, falls or other trauma to his knowledge, and that Petitioner's condition had been resolving but "now it came back again." (PX6, p. 35) Dr. Gornet ordered a lumbar MRI which was performed on 3/6/14. (PX3, p. 12) He read it as showing a central herniation at L3-4 and a central and lateral herniation at L4-5 particularly on the left with some lateral recess stenosis and foraminal stenosis at that level. (PX1, p. 9, 37) He then prescribed lumbar injections which were performed on 3/17/14 and 3/31/14. (PX6, p. 38, PX4) Those did not provide lasting relief, so on 5/18/14 Dr. Gornet prescribed a CT discogram and MRI spectroscopy. (PX5, p. 8)

On 6/5/14, Petitioner followed up with his primary care physician, Dr. Chu, because he was having trouble sleeping due to the pain in his legs and feet. (RX12, p. 13) Dr. Chu diagnosed Restless Leg Syndrome and prescribed medication. Petitioner acknowledged that Dr. Chu has been refilling that medication. (RX12, p. 17) Petitioner also testified that Dr. Chu told him this condition affected the nerves in his legs and caused pain, tingling and throbbing in the legs, symptoms Petitioner testified he was experiencing.

On 7/16/14, Dr. Gornet performed a discogram but Petitioner's obesity prevented him from testing more than one level so there was no control level. (PX6, p. 13, 39; PX3, p. 10-11) Dr. Gornet then did MRI spectroscopy which he described as a chemical biopsy of the discs for purposes of determining which are painful. (PX6, p. 12) This study showed the L3-4 level was painful but the other levels were not. (PX6, p. 12, 40) On 7/28/14, Dr. Gornet prescribed physical therapy and weight loss. (PX6, p. 43-44) On 9/29/14, Dr. Gornet continued to believe that Petitioner had structural back pain with tingling in the left leg and thought he might be a surgical candidate if he were able to lose additional weight without an improvement in his overall quality of life. (PX6, p. 43-44) Dr. Gornet emphasized that he was in no hurry to perform surgery given that Petitioner had been able to work full duty all along. (PX6, p. 47-48) Dr. Gornet next saw Petitioner six months later on 2/2/15 when Petitioner described worsening numbness and tingling in his left leg. (PX5, p. 2) Dr. Gornet allowed Petitioner to continue working without restrictions. On 5/4/15, Dr. Gornet recommended a disc replacement surgery at L3-4 and a fusion at L4-5 now that Petitioner's weight was down to 250 pounds. He allowed him to continue working without restrictions. (PX5, p. 1)

Petitioner testified that he continues to have low back pain with occasional leg pain. He wishes to undergo the surgery proposed by Dr. Gornet. He testified that he has not lost any time from work as a result of his back or leg pain after the 8/5/13 accident.

Petitioner testified on direct examination that he had not experienced any back pain or leg pain prior to the 8/5/13 accident. Petitioner also testified that he completed a "Statement of Injured Party" form on 8/5/13 wherein he denied having previously experienced any pain, discomfort, numbness or other symptoms to his lower back. (RX3) He completed a different form for the workers' compensation insurance company again indicating that he had never injured his low back before. (RX4, p. 2) On cross-examination, Petitioner was asked about a number of entries in the medical records from Dr. Chu, who has been treating him since approximately 1997. (RX6) Dr. Chu's 5/24/00 office note indicated Petitioner had injured his low back lifting a washer and dryer in his basement and had a lumbar x-ray. (RX6, p. 1-5) On 2/11/05, Dr. Chu noted that Petitioner had fallen on ice four days earlier and was complaining of low back pain, prompting x-rays of the pelvis and sacroiliac joints, an MRI of the pelvis, and a whole body scan. (RX6, p. 11-16) On 3/3/08, Dr. Chu noted that Petitioner had low back pain off and on for one week without trauma. (RX6, p. 17-18) He was sent for a lumbar x-ray which showed moderate degenerative changes. (RX6, p. 19) On 10/6/11, Dr. Chu noted that Petitioner was complaining of left leg numbness, and his exam findings were positive for left sciatica which

became the diagnosis. (RX6, p. 23-24) He ordered a lumbar x-ray, and the radiology report included a history of "left leg/thigh numbness for one year, left sciatica" and a finding of L4-5 and L5-S1 degenerative disc height loss with multi-level endplate spurring and lower lumbar facet arthropathy. A 10/6/11 venous duplex doppler was performed for left leg pain and swelling for one year, and it was negative for DVT. (RX6, p. 26) Petitioner admitted remembering all of the events mentioned in Dr. Chu's pre-8/5/13 records.

Dr. Gornet testified that Petitioner's current condition of ill-being was causally related to the 8/5/13 work accident, noting that he had no information indicating that Petitioner had any active or significant problems in his back before that accident, and that therefore Petitioner's symptoms would be work related because a medical record had not previously documented any back symptoms. (RX1, p. 17) In reaching this opinion, Dr. Gornet had not reviewed any outside medical records other than those that were generated as a direct result of his case and treatment. (PX6, p. 28)

Dr. Richard Katz performed §12 examinations on 10/7/13 and 5/12/14. He testified by deposition. (RX1) Dr. Katz reviewed all the pertinent medical records before and after the 8/5/13 accident. (RX1, p. 12, 25-26, 38-40, 42) For the 10/7/13 exam, Petitioner completed a "Personal Health History" form and, in the history section, he wrote that he had sustained a work-related injury, that this episode of pain began on 8/5/13, and that in the past two years he had episodes of pain "every day". (RX1, p. 15; Dep. Exh. 3) Petitioner reported that his current pain was very mild. (RX1, p. 16) Dr. Katz noted that Petitioner was 5' 10" and weighed 270 pounds. (RX1, p. 17) The physical examination was normal with no objective findings. (RX1, p. 17) He diagnosed work-related mechanical low back pain or a strain/sprain, did not believe any additional testing or treatment would be required other than a home exercise program, believed Petitioner would reach MMI within six weeks, and did not believe any work restrictions were necessary. (RX1, p. 17-19, 22-24) Dr. Katz believed all treatment through his exam had been appropriate except he felt the chiropractic care and physical therapy Petitioner received at Multi-Care Specialists were redundant. Dr. Katz believed one of those treatment modalities would have been appropriate, but not both. (RX1, p. 20-21)

During the second §12 exam on 5/12/14, Dr. Katz noted some give way weakness and a positive Waddell's test, suggesting non-neurologic causes of the low back pain. (RX1, p. 29-30) There were again no objective findings on exam, and his diagnosis was unchanged. (RX1, p. 30-31) Dr. Katz believed Petitioner had reached MMI six weeks after his first exam, did not believe the epidural injections or discogram had been necessary, and did not believe Petitioner was a surgical candidate. (RX1, p. 31-32, 34) He continued to believe Petitioner was capable of working without restrictions. (RX1, p. 35) Dr. Katz did not believe Petitioner's complaints as of the second exam were related to the 8/5/13 accident. (RX1, p. 38) He believed Petitioner's obesity was playing a role in the ongoing complaints. (RX1, p. 37) Dr. Katz also relied on Dr. Chu's medical records before the work accident documenting prior back and leg complaints, as well as the ER records documenting the 12/25/13 fall off a ladder. (RX1, p. 38-40, 42) In addition, Dr. Katz pointed out that he had examined Petitioner in connection with a different workers' compensation claim on 5/27/11. At that time he performed electrodiagnostic testing which revealed a generalized peripheral neuropathy in the lower extremities. Dr. Katz testified that this condition can be associated with pain, numbness and tingling in the legs. (RX1, p. 42-43) Dr. Katz noted Petitioner was diabetic and opined that the neuropathy was consistent with his diabetes. (RX1, p. 42-43, 47-48)

Dr. Frank Petkovich also performed a §12 examination on 2/17/15. Dr. Petkovich testified by deposition. (RX2) After reviewing all the relevant medical records and imaging studies before and after the 8/5/13 work accident and after taking a history and performing a physical examination, Dr. Petkovich testified that Petitioner sustained an acute muscular contusion and strain as a result of the 8/5/13 accident which reached

MMI by 10/7/13 when Petitioner saw Dr. Katz for the first time. (RX2, p. 8-12, 17-20, 32-39) Dr. Petkovich believed that all treatment provided through 10/7/13 had been appropriate except for the combined chiropractic and physical therapy treatment provided at Multi-Care Specialists. (RX2, p. 39-41) He explained that there was no medical rationale or medical literature to support providing both forms of treatment at the same time, noting that either form of treatment would have been appropriate by itself. Dr. Petkovich did not believe Petitioner required any additional testing or treatment after 10/7/13 relative to the 8/5/13 accident. (RX2, p. 41) He believed the work-related injury should have resolved within six weeks of its occurrence and had resolved by the time he examined Petitioner. (RX2, p. 41) Dr. Petkovich testified that Petitioner sustained another lumbar strain on 12/25/13 when he fell off a ladder and sought treatment thereafter. He said the radiographic studies taken that day did not show any acute findings. (RX2, p. 12-13, 17-18, 20, 42) Petitioner presented to Dr. Petkovich with only low back pain. There were no radicular symptoms. (RX2, p. 45) Dr. Petkovich related those complaints to the chronic degenerative conditions in the lumbar spine which had been present long before the work accident. (RX2, p. 45) Based on his review of the imaging studies from 3/3/08 through 7/16/14, Dr. Petkovich felt that none showed any acute findings, and that there had been a natural progression of those degenerative changes. (RX2, p. 10-11, 43-44) Thus, he did not believe there had been any aggravation or acceleration of those changes as a result of the 8/5/13 accident. (RX2, p. 43) Dr. Petkovich did not believe there was any indication for surgery, and opined that any such surgery would not be related to the work accident. (RX2, p. 45-46) Dr. Petkovich noted that Petitioner denied having any low back pain prior to 8/5/13 but that the medical records contradicted that history. (RX2, p. 29) Dr. Petkovich also thought Petitioner's obesity was playing a role in his lumbar pain. (RX2, p. 47) He recommended weight loss and a home exercise program. (RX2, p. 47-48) He did not believe Petitioner required any work restrictions. (RX2, p. 48)

CONSLUSIONS

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

In this case the Arbitrator found the testimony and opinions of Dr. Katz and Dr. Petkovich more persuasive than those of Dr. Gornet. Unlike Dr. Gornet, they reviewed all the relevant medical records and were aware of Petitioner's history of low back and leg pain prior to 8/5/13 as well as the 12/25/13 fall from the ladder. Dr. Petkovich also reviewed the pre-8/5/13 diagnostic studies. Dr. Gornet's causation opinion was largely premised on his belief that Petitioner had not experienced any back or leg symptoms before 8/5/13. This assumption is contrary to the medical evidence in the record.

The Arbitrator finds that the 8/5/13 accident caused a lumbar strain and contusion which had reached MMI on 11/7/13 when Dr. Gornet terminated the physical therapy and chiropractic care and indicated he did not expect Petitioner to require any additional treatment. The Arbitrator further finds that the 12/25/13 fall from the ladder constitutes an intervening accident. Dr. Gornet admitted that on 11/7/13 Petitioner had a low level of pain, was improving, and was not likely to require any additional treatment. This is consistent with the opinions of Dr. Katz and Dr. Petkovich, who believed Petitioner had recovered from the 8/5/13 accident prior to the 12/25/13 fall. The Arbitrator finds it significant that Petitioner admitted that his pain significantly increased following the 12/25/13 fall.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has failed to meet his burden of proof in establishing that his current condition of ill-being is causally related to the 8/5/13 accident.

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

Petitioner submitted medical bills as set forth in Petitioner's exhibit 7.

The Arbitrator notes that Petitioner was concurrently receiving Chiropractic care and physical therapy at Milti-Care Specialists. Dr. Katz and Dr. Petkovich opined that the treatment was duplicative and that Petitioner needed one or the other, but not both. Dr. Gornet recommended Petitioner obtain both. Having reviewed the billing statements and records it appears to the Arbitrator that Petitioner was receiving distinct modalities of treatment from Dr. Eavenson and the physical therapist, Corey Voss. The Arbitrator therefore finds that this treatment was not duplicative. Having previously found that Petitioner reached maximum medical improvement from the injuries sustained in the accident of 8/5/13 on 11/7/13, the Arbitrator finds that all treatment provided to Petitioner through 11/7/13 was reasonable, necessary and related to the 8/5/13 accident.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent shall pay the following reasonable and necessary medical services of $19,047.20, as provided in Sections 8(a) and 8.2 of the Act:

MFG Spine LLC/Dr. Matthew Gornet 9/20/13 - 11/7/13	$ 726.00
Imaging Center at Wolf Creek, LLC 8/20/13	1,395.00
Gateway Regional Medical Center 8/5/13	2,661.20
Multi-Care Specialists 8/29/13 – 11/7/13	14,265.00
	$19,047.20

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.

The bills for the medical services of Pain and Rehabilitation Specialists of St. Louis, the facility bill of the St. Louis Spine and Orthopedic Surgery Center, the bill of MRI Partners of Chesterfield, and the bill of CT Partners of Chesterfield were provided after 11/7/13 and are therefore denied. Likewise the charges of Multi-Care Specialists and MFG Spine LLC/Dr. Matthew Gornet following 11/7/13 are denied.

Issue (K): **Is Petitioner entitled to any prospective medical care?**

Based upon the above findings regarding causation, MMI and the reasonableness and necessity of treatment, the Arbitrator finds that Petitioner failed to prove that he is entitled to any prospective medical treatment, and his claim for same is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

☐ 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

CORY MULLINS,

Petitioner,

17IWCC0420

vs.

NO: 13 WC 040618

BIG 3 PRECISION PRODUCTS,

Respondent.

DECISION AND OPINION ON REVIEW UNDER §19(b)

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 and temporary total disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission modifies the Decision of the Arbitrator to vacate the award of medical expenses and temporary total disability benefits related to Petitioner's right shoulder as it finds Petitioner suffered a compensable injury only to his thoracic spine on August 20, 2013.

Petitioner suffered an injury to his thoracic spine on August 20, 2013, the result of attempting to secure a steel frame to a hook by hand. That day, he completed a Supervisor's Accident Report in which he indicated that "something on the right side of his back popped."

The same was recorded by emergency room personnel of St. Mary's Hospital, Petitioner complaining of back pain.

The emergency room chart from Petitioner's August 20, 2013, visit to St. Mary's Hospital makes multiple references to Petitioner's spine and not to his right shoulder. The History of the Present Illness recalls Petitioner was pulling a part at work and injured his back. The physical examination resulted in a finding of tenderness, pain, and spasm about Petitioner's thoracic spine. The pain diagram indicates Petitioner felt pain in the area of the right scapula as close, if not closer, to his thoracic spine than to his right shoulder. The clinical impression of Petitioner's condition was back pain. The musculoskeletal assessment noted complaints of low back pain and all other assessed parts of the musculoskeletal system to be within defined limits. The Commission finds nothing in Petitioner's medical charts from his August 20, 2013, visit to St. Mary's Hospital that indicates either that Petitioner expressed any complaint involving his right shoulder or hospital personnel found anything noteworthy about Petitioner's right shoulder.

Nine days after his August 20, 2013, accident, August 29, 2013, Petitioner presented to his primary care medical provider, Nurse Practitioner Denise Orrill for a previously scheduled appointment. During the appointment, Petitioner, as recorded in the Review of Systems, indicated he had no muscle aches or pain. The physical examination of Petitioner's extremities elicited no findings of aches, pains, or tenderness. A presumption is made that Petitioner's right upper extremity was part of the physical examination of his extremities, and an inference is made that Petitioner's thoracic spine symptoms had resolved by this visit as both his Review of Systems and physical examination were negative for aches, pains, and tenderness.

Petitioner missed work on September 10, 2013, and, on redirect examination, testified that he missed work that day on account of his right shoulder. The Commission notes Petitioner completed an Employee Absence Form the same day that only indicated his absence was due to illness.

Petitioner missed work again on September 18, 2013, and again completed an Employee Absence Form. On this form, Petitioner indicated he missed work because of his shoulder and, in parenthesis, his back. He provided no attribution as to what caused or might have caused his shoulder and back to hurt. At his arbitration hearing, Petitioner recalled taking a personal day on September 18, 2013. No testimony was elicited from Petitioner at that time as to what, if any activities, he engaged in on September 18, 2013.

Petitioner presented to Orthopedic Center of Southern Illinois on the morning of September 25, 2013, and was seen by Certified Physician's Assistant Devin Haertling to address complained-of pain in his right foot. The Review of Symptoms, as recorded in the medical chart for this visit, indicated the only positive complaints were of low back pain and right foot pain. All other systems were deemed negative. Later that same day, Petitioner returned to Nurse Practitioner Orrill with his chief complaint being pain that involved his right shoulder.

The History of Present Illness included in the medical chart authored by Nurse Practitioner Orrill on September 25, 2013, gave no indication as to what caused Petitioner's right shoulder to become painful and did not note Petitioner having previously experienced right shoulder pain on either September 11, 2013, or on September 18, 2013. Petitioner was diagnosed as having right shoulder pain without attribution as to its origin.

Petitioner returned to Orthopedic Center of Southern Illinois on November 8, 2013, with a complaint of right shoulder pain. He completed an intake form and, on it, indicated that he injured his back on March 20, 2013, and that his right shoulder became symptomatic the following day. No indication is given on the form as to how his back came to be injured on March 20, 2013. This history is contradicted by the history as was written by Certified Physician's Assistant Haertling and memorialized in the History of Present Illness section of Petitioner's November 8, 2013, medical chart. Given as the History of Present Illness was Petitioner pulling something in his back at work and treating it and then, after the back pain resolved, experiencing pain in his right shoulder. No reconciliation is made of these histories.

It is not until Petitioner seen by Dr. Nathan Mall on November 20, 2013, three months after the accident, that he presented a history of experiencing a pop in the right inferior scapula on August 20, 2013, and of experiencing immediate pain that later came to involve his right shoulder. Nothing in Dr. Mall's chart from that day indicate Petitioner sustained an injury to his spine on August 20, 2013.

Petitioner returned to Nurse Practitioner Orrill on April 30, 2014, for an unrelated matter but, that same day, she amended the chart note she authored on August 29, 2013, to reflect that she reviewed the pain diagram from Petitioner's emergency room chart that indicated pain at Petitioner's right scapula also to note that Petitioner had reported an incident involving his right shoulder during his August 29, 2013, examination. She indicated that she hadn't made a contemporaneous record of Petitioner's incident because Petitioner hadn't presented to her at that time to treat his shoulder. It is uncertain why she felt compelled to amend the August 29, 2013, chart when Petitioner presented to her on April 30, 2014, for a follow-appointment for an ankle injury and to monitor a recently-made change to his medication. The Commission finds it inconsistent for Nurse Practitioner Orrill to note Petitioner's purported right shoulder complaints on April 30, 2014, when she saw him for matters unrelated to his shoulder but not note the same on August 29, 2013, because, as she had testified to, she was seeing him for matters unrelated to his shoulder.

The Commission recognizes the pain diagram created when Petitioner presented to the emergency room of St. Mary's Hospital on August 20, 2013, after his work accident earlier that day. It indicates he experienced pain to his right scapula and not his right shoulder. This conclusion is supported by the lack of any verifiable subjective complaints of pain or objective findings involving his shoulder until September 18, 2013. Even then, Petitioner's medical charts make no mention of his right shoulder pain begin causally related to any work activity until

November 20, 2013, by then Petitioner had multiple opportunities to allege such a relationship to both Respondent and the medical professionals who treated him.

The Commission finds neither Petitioner, the Nurse Practitioner nor Dr. Mall to be credible historians. Dr. Mall, possibly through no fault of his own, relied on the history Petitioner provided him, a history that is inconsistent with the documentary record. Accordingly, the Commission finds Petitioner failed to prove in any way that his complaints involving his right shoulder are causally related to his employment.

In finding that the condition of Petitioner's right shoulder is unrelated to his employment, the Commission finds the temporary total disability benefits awarded to Petitioner under §8(b) of the Act to have been erroneously awarded as Petitioner was deemed to be temporarily totally disabled from working on account of the condition of his right arm. The Commission, therefore, finds Petitioner failed to prove his alleged temporary total disability from December 7, 2013, through November 5, 2015, was the causally related to his employment.

The Commission, in reviewing the medical services provided to Petitioner, finds only Petitioner's August 20, 2013, visit to St. Mary's Hospital to be causally related to Petitioner's work-related injury. All other medical treatment Petitioner received was not proven to be related to this accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that all benefits related to Petitioner's right shoulder are vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision of the Arbitrator is modified to reflect that the condition of Petitioner's right shoulder on and subsequent to August 20, 2013, is not causally related to his August 20, 2013, accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the cost for reasonable and necessary medical care Petitioner incurred on August 20, 2013, as provided in Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award prescribing the prospective medical care recommended by Dr. Mall is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary total disability benefits is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given credit for medical benefits that have been paid, if any, 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.

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.

JUN 29 2017

DATED:
KWL/mav
O: 05/22/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0420

MULLENS, CORY
Employee/Petitioner

Case# **13WC040618**

BIG THREE PRECISION HOLDINGS
Employer/Respondent

On 6/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5341 BROWN & BROWN
RICHARD E SALMI
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HEIGHT, IL 62208

1893 LAW OFFICES OFDONALD B BALFOUR
RANDEE SCHMITTDIEL
530 MARYVILLE CTR DR SUITE 31
CHESTERFIELD, MO 63107

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)

17IWCC0420

Cory Mullens
Employee/Petitioner

v.

Big Three Precision Holdings
Employer/Respondent

Case # 13 WC 40618

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 **Mt. Vernon**, on **11/5/15**. 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. ☒ 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, **8/20/13**, 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 **$5,770.46**; the average weekly wage was **$457.87**.

On the date of accident, Petitioner was **38** 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 $15,108.48, 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 and pay for prospective medical care as recommended by Dr. Mall, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $305.25/week for 99 6/7 weeks, commencing 12/7/13 through 11/5/15, 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.

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

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

Signature of Arbitrator

6/6/16
Date

ICArbDec19(b)

JUN 13 2016

FINDINGS OF FACT

Cory Mullens, ["Petitioner"], a forty year old Welder for Big Three Precision Holdings ["Respondent"], sustained a work accident on August 20, 2013. The disputed issues are whether his shoulder injury is causally related to the work accident, past and future medical treatment for the shoulder, and ttd related to the shoulder.

On August 20, 2013 Petitioner was on the end of Line 6, building end frames weighing from 100 to 200 pounds. He was attaching an end frame to a crane when the crane became stuck. Petitioner went to put the strap from the end frame to the hook on the crane, but it was a little bit short, so he tried to lift the end frame by the strap to reach the hook on the crane. (T.12-13). He was using an upward motion, his arms in front, trying to pull up the frame when he heard a pop around his upper back shoulder area and he could hardly move. (T.13-14).

Petitioner immediately reported the accident to his supervisor, Chad Minor, and an incident report was completed. (T.15). The Supervisor's Accident Report of August 20, 2013 lists a strain/sprain to the back. (Rx10). Petitioner provided a written description: "Was pulling end frame forward to put hoist on it and something on the right side of my back popped. Can barely bend over takes my breath every time I bend over or turn too far." (Rx10). Petitioner described the shortness of breath when he turned, a spasm all the way down through his back, but mostly in the shoulder. (T.16).

Petitioner reported to the St. Mary's Hospital emergency room on August 20, 2013. (Px1:2). The chief complaint is pain in back. (Px1:3). The primary symptoms include back injury, back pain. The current episode started three to five hours ago and is associated with lifting (pulling items at work). Patient notes prior minor injuries to the back. The pain is present in the lower back and thoracic on the right side. (Px1:3-4). The pain was rated as an 8/10 (with turning to the right and bending over the patient states it takes his breath away and pain increases 10/10). The incident occurred at work. (Px1:4). The emergency room note shows a picture of the location of the pain along the right shoulder blade. (Px1:6). The nursing notes indicate while lifting a part at work something popped in his back today. (Px1:7).

Petitioner explained the emergency room diagram along the border of the scapula is exactly where he felt a pop. (T.17). He explained by the next morning he was having more pain throughout his shoulder. (T.17). He reported to his supervisor Chad Minor and Terry Mount that his arm was hurting. (T.17). He was allowed to return to work full duty until September 25, 2013, the first time a doctor provided restrictions. (T.40). Petitioner testified he had been trying to have further treatment approved by the workers' compensation carrier without success. (T.18).

On August 29, 2013, Petitioner presented to Irvington Friendly Care for a follow up appointment for medication changes for an unrelated condition. The office note of that date is absent any reference to right shoulder problems. (Px5:19).

Petitioner told his Family Nurse Practitioner, Denise Orrill about the problems with his shoulder at the August 29, 2013 appointment, but did not ask her for treatment since he was trying to have treatment for the shoulder approved by the workers' compensation carrier. (T.21).

An addendum to the August 29, 2013 office note was written by Denise Orrill on April 30, 2014: "right shoulder pain: upon reviewing ER visit from August 20, 2013, ER doctor indicated pain to right scapula on

body image. patient was seen on August 29, 2013 in office. Patient reported incident with right shoulder at that time, but was under the impression that workers' compensation was determining treatment plan." (Px5:20).

An Absence History Report indicates Petitioner missed work for shoulder and back pain on September 18, 2013. (Rx11). He was off work on September 19, 2013 since he had to move. (Rx11). Petitioner confirmed he did not injure himself moving. He missed work on September 24, 2013 because his back hurt. (Rx11).

On September 25, 2013, Petitioner reported to Orthopedic Center of Southern Illinois for continuing treatment of a prior right foot injury. (Px6:7). The office note by Devin Haertling, PAC includes a review of symptoms of low back and right ankle pain. All others are negative. (Px6:9). Petitioner testified he did not report his ongoing right shoulder problems since he was there for treatment of the ankle, not the shoulder. (T.22, 53). He confirmed he did not sustain further injury to his shoulder between the time of his appointment with Devin Haertling and Denise Orrill, but just the continued problems from his work injury of August 20, 2013. (T.24-25).

Petitioner returned to Irvington Friendly Care on that same date, September 25, 2013 complaining of right arm pain. (Px5:21). He presented for right shoulder pain, unable to lift anything over five pounds from the ground up, unable to lift the arm above the shoulder, hurts to cross the right arm over chest, and right arm feels numb. (Px5:21). A CT scan of the right shoulder was ordered and he was referred to an orthopedist. (Px5:21-22). He returned to see FNP Orrill on October 23, 2013 for the right shoulder with complaints of the back of the shoulder hurting and shooting pain down the right shoulder. (Px5:23).

Petitioner returned to Orthopedic Center of Southern Illinois on November 8, 2013 with complaints of right shoulder injury. (Px6:2). He reports he pulled something in his back at work, was sent to the ER at the time for back pain which had resolved but he is now having pain in the right shoulder as well. He turned this into his workers' compensation carrier and they were contesting it. (Px6:2). The assessment was right shoulder rotator cuff tendinopathy with possible labral injury. (Px6:2). An MRI was recommended. (Px6:2).

On November 20, 2013, Petitioner was seen by Dr. Nathan Mall at the recommendation of his attorney. His chief complaint was right shoulder pain. The history of injury states that in August 2013 he was building frames, he lowered down a hoist on August 20, 2013 and did not quite get it all the way down to the hook where it needed to be and tried to lift up to place this on the appropriate hook and felt a large pop in his right inferior scapula which took his breath away. (Px7:111). That evening and the next day his right shoulder started hurting mostly in the front of the shoulder but also slightly in the posterior aspect of the shoulder as well, his arm will go numb on occasion and he continues to get popping in the front of the shoulder and in the inferior border of the scapula posteriorly. (Px7:111). Dr. Mall stated the right shoulder pain and scapular pain are related to his work accident of August 20, 2013. (Px7:112).

On November 22, 2013, Dr. Mall reviewed the MRI which demonstrates a clear superior labral tear. (Px7:107). The assessment was right shoulder superior labral tear and right shoulder scapulothoracic bursitis. (Px7:107). Petitioner worked light duty until December 6, 2013 when he was laid off and has not been called back to work since. (T.26).

On December 27, 2013, Dr. Mall recommended a cortisone injection and physical therapy. (Px7:104). On January 24, 2014, Dr. Mall suggested the need for a biceps tenodesis. (Px7:101). Petitioner was continued

on light duty restrictions. (Px7:103). On March 5, 2014, Dr. Mall continued to recommend the right shoulder arthroscopy and biceps tenodesis. (Px7:98). Light duty restrictions were continued. (Px7:99).

Petitioner was evaluated by Dr. Michael Nogalski pursuant to §12 on February 10, 2014. (Rx1:80). Petitioner reported he felt a sudden pop in his shoulder blade area and was sent to the emergency room by his supervisor. (Rx1:80). Petitioner states the next day he had increasing pain and ultimately, his regular doctor placed him on light duty and referred him to an orthopedic surgeon. (Rx1:80). Petitioner denies any previous problems or injuries with the right shoulder. (Rx1:80). He had difficulty getting anything approved through his work because they state he did not follow proper protocol after the injury. (Rx1:80).

MRI of the right shoulder is consistent with a tear or delamination of a portion of the superior labrum off the glenoid margin. (Rx1:81). Dr. Nogalski reviewed treatment records from Irvington Friendly Care, St. Mary's from August 20, 2013 and Orthopedic Center of Southern Illinois. (Rx1:81-83).

Dr. Nogalski's diagnosis is right shoulder pain which appears to localize predominantly to be biceps/superior labral complex. (Rx1:83). He agreed that if Petitioner had a torn labrum on August 20, 2013 it would be reasonable he would have felt immediate pain and would have reported a pop and symptoms at that time. (Rx1:83). He does not believe there were any shoulder complaints or problems noted at the emergency room on August 20, 2013. He also noted there did not appear to be any shoulder complaints or problems on August 29, 2013. (Rx1:83). Dr. Nogalski concluded that from the lack of reports on August 20, 2013 and August 29, 2013 it appears there was a new onset of right shoulder problems that post-dated those dates of treatment. He was not aware of any specific right shoulder problem prior to September 25, 2013. (Rx1:84).

Dr. Nogalski concluded Petitioner is a surgical candidate given his shoulder findings. Arthroscopy and evaluation of the superior labral attachment, debridement, repair of the labrum or possible biceps tenodesis would be reasonable. Work restrictions of no lifting more than 10 pounds and no use of the left arm up over shoulder level are indicated. (Rx1:84).

On April 30, 2014 Petitioner saw Denise Orill and pointed out to her that she had not documented their prior discussion about his shoulder problems from the August 29, 2013 office visit. (T.61-63). Accordingly, FNP Orill entered an addendum to the August 29, 2013 note detailing her recollection of the conversation of that date. (Px5:20).

Petitioner continued to follow up periodically at Irvington Friendly Care for medications for his right shoulder. (Px5:33). He also continued to follow up with Dr. Mall while awaiting authorization for surgery. (Px7:87 et seq.). He has continued on light duty restrictions to present. (Px10:1 et seq.).

Dr. Nathan Mall, a board certified orthopedic surgeon, testified by deposition on behalf of Petitioner on November 19, 2014. (Px7). He testified consistent with his medical treatment records. (Px7:8 et seq.). Dr. Mall explained that on physical exam, Petitioner had pain to palpation over the parascapular region of the shoulder and posteriorly. The shoulder pain is related to the biceps tendon tear. The mechanism of his injury was very consistent with an injury to the superior labral complex. (Px7:11). He continued to see Petitioner through October 1, 2014. (Px7:15).

Dr. Mall reviewed a large amount of medical treatment records from 2004 up until present including the emergency room visit for the initial injury. (Px7:17). Dr. Mall found it significant the pain diagram indicates parascapular pain which is shoulder related and can very clearly be related to a SLAP tear. (Px7:17-18). A typical presentation is seeing a more global pain which can start to localize more closely following an injury. (Px7:18).

Dr. Mall notes he and Dr. Nogalski agree on the nature of the condition and need for surgery (Px7:20). Dr. Mall sees many patients with parascapular pain related to a shoulder injury. (Px7:24). The injury mechanism is consistent with a superior labral tear. The MRI shows a superior labral tear and his exam is consistent with a superior labral tear, so it all adds up. (Px7:25).

Dr. Mall's opinion regarding causation is based on the history from the patient and his review of the medical treatment records. (Px7:29). The emergency room pain diagram reveals right-sided parascapular pain indicating a right shoulder problem. (Px7:32). Where Petitioner was being seen for one acute problem by his primary care physician, Denise Orrill on August 29, 2013, many practices will only see one acute injury at a time. (Px7:40-42). Dr. Mall stated Petitioner probably would have had "some deep shoulder pain," and "could have had "periscapular pain," nine days after the accident. (Px7:43).

Dr. Nogalski testified on behalf of Respondent by deposition on February 2, 2015. (Rx1). He testified consistent with his report of February 10, 2014. He testified Petitioner reported a pop in the area just below the shoulder blade. (Rx1:10). He testified symptoms or complaints of a superior labrum tear would be pain in the front top of the shoulder, pain with reaching up in front or holding objects out away from the body and some pain with resistant biceps maneuvers, but typically in the front of the shoulder. (Rx1:14).

Dr. Nogalski testified that he would see a patient and treat them for all of their problems and conditions if he were seeing an established patient in his practice. (Rx1:16). He testified pain along the thoracic region or the junction between the shoulder blade and the back does not support an injury to the area around the ball and socket joint. There is typically pain that occurs in the front of the shoulder. (Rx1:22).

Dr. Nogalski finds it significant that there was no complaint of a shoulder problem in the August 29, 2013 Irvington Friendly Care office note that he reviewed. (Rx1:27). Dr. Nogalski's causation opinion is based on a lack of any complaint of right shoulder pain until September 25, 2013; no shoulder pain documented by the orthopedist on September 25, 2013 in the morning, but complaints of shoulder pain to the primary care physician that afternoon. (Rx1:37-38).

Dr. Nogalski disagrees with Dr. Mall's conclusion relating the shoulder blade symptoms to the present work injury because none of that pain existed until a month after the claimed event. (Rx1:40).

Dr. Nogalski agrees Petitioner has a shoulder injury in need of surgical intervention and that his treatment to that point had been reasonable and necessary. (Rx1:43-44). He agrees that work restrictions are indicated for the shoulder condition. (Rx1:44). He does not see any documentation of any alternate mechanism of injury other than the August 20, 2013 work accident. (Rx1:46).

Denise Orrill, FNP testified on behalf of Petitioner on August 7, 2015. She sees patients from pediatrics through elderly for general health problems, chronic disease processes. (Px8:5-6). She has a Doctorate Degree in Nursing Practice and is Board Certified. (Px8:6).

She began treating Petitioner on June 5, 2013 for a right ankle injury. (Px8:7). She saw Petitioner for a follow up of his right ankle injury on August 29, 2013. (Px8:8-9). The original office note of August 29, 2013, did not reference any complaints by Petitioner of a right shoulder injury. (Px8:9). However, Nurse Practitioner Orrill does recall the conversation with Petitioner at that appointment that he was having problems with his right shoulder. (Px8:9). She recalled that he stated that he had hurt his shoulder, that he had reported it at work, and was taking care of it through the work comp carrier through his job. (Px8:9-10). She did not document the right shoulder complaints in the original office note because she was not seeing him for the shoulder injury and he mentioned that somebody else was taking care of it, through the workers' compensation carrier. (Px8:10).

She provided an addendum to her August 29, 2013 office note on April 30, 2014 in which she charted that Petitioner had an ER visit on August 20, 2013, indicating pain to the right scapula, and that he had reported the incident but was under the impression that workers' comp was determining the treatment plan at that time. (Px8:10). She testified she has an independent recollection of the discussion with Petitioner about his right shoulder that had happened back on August 29, 2013. (Px8:11).

She also saw Petitioner for a scheduled follow up appointment for September 25, 2013. (Px8:11). It had not previously been scheduled as an appointment for the shoulder, because her office had not been taking care of that injury. (Px8:12).

The September 25, 2013 appointment became the first time that she initiated treatment for the shoulder complaint. (Px8:13). She began treatment for him for the shoulder on that day because nobody else was treating him for the shoulder. (Px8:14). Per the history from Petitioner, his shoulder complaints had continued from his previous appointment of August 29, 2013. (Px8:14). It was her understanding that his right shoulder symptoms had come from a work injury. (Px8:14). It is her opinion that she had continued to see him for the same shoulder problems he had reported to her on August 29, 2013. (Px8:14-15).

On cross exam, FNP Orrill testified that she tries to keep an appointment focused on the chief complaint. (Px8:18). If there were other issues, those would have to be addressed at a follow up appointment. (Px8:18). She does not recall why she did not make an addendum to the August 29, 2013 office note until the April 30, 2014 office visit when Petitioner brought it to her attention that she had not previously made any notation in the August 29th visit about the shoulder. (PX8:45-47). Petitioner did not ask her to go back to make an amendment, he just informed her that it was not in there. (Px8:47). So when it was brought to her attention that she had not previously made an entry about the shoulder at that office visit, she entered the amendment. (Px8:47-48). When FNP Orrill interprets the Emergency Room records, she feels the pain diagram references symptoms in the area of the scapula. (Px8:57).

She confirmed that fortunately, she has a really good memory and remembers most things about her patients such that she has a specific recollection of the August 29, 2013 report from Petitioner that his shoulder was bothering him. (Px8:65-66). She was under the impression on August 29, 2013 that the shoulder injury was

being taken care of through Petitioner's workplace. (Px8:69). Her understanding was that basically he had injured his shoulder and his workplace was taking care of it. (Px8:70).

Terry Mount testified on behalf of Respondent. At the time of Petitioner's work accident, he was Plant Manager, but he is now a project manager. (T.70). He was aware of Petitioner's accident of August 20, 2013 and that it was reported to Petitioner's supervisor, Chad Minor. (T.73-74). He does not recall being told about Petitioner's shoulder problems from the work accident. (T.76). He does not know whether Petitioner had a drug test performed after the work accident. (T.77). He agrees Petitioner requested time off for his shoulder problems on September 18, 2013. (T.79). Mr. Mount did not directly supervise Petitioner and was not present at the time of the accident. (T.84).

Petitioner testified he continued to keep his immediate supervisor, Chad Minor, informed of the problems he was having with his shoulder after the accident. (T.88 – 89). Mr. Minor did not appear at trial on behalf of Respondent.

Petitioner continues to have problems lifting above his head. T.27. He has trouble with daily activities involving pulling and lifting, problems which have been present since his work accident. T.27-28

CONCLUSIONS

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

The Arbitrator finds the testimony of Petitioner to be credible evidence of his injury and continued right shoulder complaints following his work injury. His report of continuing shoulder problems following the work accident is corroborated by his treating health care provider, Denise Orrill. It is supported by his unrebutted testimony of continuing reports of shoulder problems to his immediate supervisor, Chad Minor. It is further documented in Respondent's attendance sheet indicating complaints of right shoulder pain on September 18, 2013, as well as the pain chart from the initial emergency room visit.

Dr. Mall's causation opinion is more persuasive than the opinion of Dr. Nogalski. Dr. Mall and Dr. Nogalski agree Petitioner has an injury to his right shoulder consisting of a labral tear for which light duty restrictions are appropriate and surgery is indicated. There is no evidence of record to indicate any right shoulder problems predating the work accident and Petitioner's unrebutted testimony is that he did not have any prior right shoulder problems. Dr. Mall finds the emergency room records with a diagram of Petitioner's complaints of pain in the right shoulder blade area and his reports of developing right shoulder complaints shortly after the accident to be consistent with his mechanism of injury on August 20, 2013 and his current shoulder condition and need for treatment. Dr. Nogalski relies on the absence of any specific history of shoulder complaints in the emergency room notes; the lack of shoulder complaints to his Nurse Practitioner on August 29, 2013, and the lack of documented shoulder complaints prior to September 25, 2013, to reach his conclusion Petitioner's shoulder condition is unrelated to his work accident.

The opinion of Dr. Nogalski is not properly informed and is therefore not persuasive. Petitioner's testimony indicates he developed increasing shoulder pain the evening of the work accident and he continued to report his shoulder problems to his immediate supervisor, Chad Minor. His report of shoulder problems has been confirmed by Denise Orrill, who testified to a specific conversation she had with Petitioner on August 29,

2013. She recalls that Petitioner was under the impression his injury would be taken care of by the workers' compensation carrier. Additionally, Respondent's attendance records document shoulder complaints by Petitioner on September 18, 2013. Dr. Nogalski was never provided any of the additional information regarding later discovered documentation of complaints prior to September 25.

Dr. Mall accepted Petitioner's history of shoulder complaints following the work accident in reaching his causation opinion. That history is supported by Respondent's attendance sheets and the credible testimony of Denise Orrill. Accordingly, his opinion causally relating Petitioner's current condition to his work accident is given controlling weight.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that his current condition of ill-being is causally related to the undisputed accident of August 20, 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): **Is Petitioner entitled to any prospective medical care?**

The Arbitrator has reviewed the medical bills in Petitioner's Exhibit #9 and finds the following medical bills causally connected to Petitioner's shoulder injury.

Provider	Date of Service	Amount of Bill	Amount Paid/Payor
Irvington Township Rural Health	1/31/14	$79.21	$79.21 HFS
Timothy Carmody	3/6/14	$50.86	$10.47 HFS
Timothy Carmody	3/6/14	$67.81	$18.95 HFS
Irvington Township Rural Health	4/1/14	$79.21	$79.21 HFS
Timothy Carmody	4/9/14	$298.38	$31.35 HFS
Irvington Township Rural Health	4/30/14	$79.21	$79.21 HFS
Irvington Township Rural Health	12/31/14	$79.21	$79.21 HFS
Irvington Township Rural Health	1/28/15	$79.87	$79.87 HFS
Irvington Township Rural Health	2/26/15	$79.87	$79.87 HFS
Irvington Township Rural Health	3/27/15	$79.87	$79.87 HFS
Irvington Township Rural Health	4/23/15	$79.87	$79.87 HFS
Irvington Township Rural Health	5/20/15	$85.00	$79.87 HFS
Irvington Township Rural Health	6/17/15	$85.00	$79.87 HFS
Irvington Township Rural Health	7/15/15	$85.00	$79.87 HFS
Byrd Watson Drug Co.	10/5/14	$75.80	$27.14 HFS
Byrd Watson Drug Co.	11/4/14	$92.05	$27.14 HFS
Byrd Watson Drug Co.	12/3/14	$85.00	$27.14 HFS
Byrd Watson Drug Co.	2/27/15	$97.10	$50.30 HFS
Byrd Watson Drug Co.	3/27/15	$101.70	$47.98 HFS
Byrd Watson Drug Co.	7/24/15	$101.70	$42.84 HFS
Irvington Township Rural Health	9/25/13	$85.00	$36.30 BCBS
Mid-America Radiology	10/17/13	$281.43	$0.00 BCBS
St. Mary's Hospital	10/17/13	$2,151.00	$0.00 BCBS
Irvington Township Rural Health	10/23/13	$85.00	$36.30 BCBS

Dr. James Chow	11/8/13	$240.00	$119.60 BCBS
Diagnostic Imaging	11/20/13	$29.00	$0.00 BCBS
St. Luke's Hospital	11/20/13	$245.90	$0.00 BCBS
Orthopedic Center of S.I.	11/22/14	$30.00 N/S fee	$30.00
Orthopedic Center of S.I.	11/8/13	240.00	240.00 BCBS
Irvington Township Rural Health	12/17/13	$85.00	$36.30 BCBS
Regeneration Orthopedics (Px#10)		$5,061.00	$5,061.00 ($537.15 Interest)
St. Mary's Hospital	8/20/13	$281.00	$281.00
St. Mary's Hospital	10/17/13	$2151.00	$443.11 BCBS
Midwest Radiology	10/17/13	$281.43	$281.43
MRI Partners	10/17/13	$2,000.00	$2,000.00 ($400 Interest)

There is no dispute between Dr. Mall and Dr. Nogaski regarding the need for surgery.

Based upon the foregoing and the record taken as a whole, including the Arbitrator's finding with regard to issue F, the Arbitrator finds Respondent shall pay reasonable and necessary medical services of $15,108.48, 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 further authorize and pay for prospective medical care as recommended by Dr. Mall, as provided in Sections 8(a) and 8.2 of the Act.

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

Petitioner remains under light duty work restrictions which Respondent is no longer accommodating as of his lay off on December 7, 2013. Dr. Mall and Dr. Nogalski both indicate the need for light duty restrictions as a consequence of the shoulder condition.

Based upon the foregoing and the record taken as a whole, including the Arbitrator's finding with regard to issue F, the Arbitrator finds Respondent shall pay Petitioner temporary total disability benefits of $305.25/week for 99 6/7 weeks, commencing 12/7/13 through 11/5/15, as provided in Section 8(b) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tamara Davidson,
Petitioner,

vs.

NO: 14 WC 00012

University of Illinois,
Respondent,

17IWCC0401

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, 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 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.

The party commencing 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: JUN 27 2017
o060817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

DAVIDSON, TAMARA
Employee/Petitioner

Case# **14WC000012**

13WC009757

UNIVERSITY OF ILLINOIS
Employer/Respondent

17IWCC0401

On 8/12/2016, 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 0.44% 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:

2333 WOODRUFF JOHNSON & PALERMO
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
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0904 STATE UNIVERSITY RETIREMT SYS
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CHAMPAIGN, IL 61825

1073 UNIVERSITY OF ILLINOIS
OFFICE OF CLAIMS MANAGEMENT
103 TRADE CENTER DR SUITE 103
CHAMPAIGN, IL 61820

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

AUG 12 2016

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

17IWCC0401

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Tamara Davidson
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # 14 WC 00012

Consolidated cases: 13 WC 09757

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

DISPUTED ISSUES

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

FINDINGS

On **December 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 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 **$40,533.26**; the average weekly wage was **$669.30**.

On the date of accident, Petitioner was **46** years of age, *single* with **1** dependent child.

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

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

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

Respondent is entitled to a credit for all medical benefits paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on December 7, 2013 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being in her right hand/wrist and elbow is causally related to her employment or her accident of December 7, 2013. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

August 12, 2016
Date

AUG 12 2016

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner has been employed by Respondent since 2001 as a cook preparing food for students attending the University of Illinois.

Petitioner submitted her medical records from Carle Foundation Hospital/Carle Clinic into evidence as PX 2. No records prior to January 1, 2013 were submitted.[1] However, based upon a review of PX 2 it appears that Petitioner was diagnosed with chronic migraines in 2012 and had some bilateral hip and back pain symptoms in August and September of 2012. (PX 2)

According to time records (RX 2, dep. ex. 4), Petitioner had accumulated 40 hours of work between January 9, 2012 and Friday, January 13, 2012. She then didn't earn any further hours until December 12, 2012. Petitioner worked December 12, 13, 14, 16,17,18,19, and 20, 2012. She didn't work again until January 13, 2013. She then worked that day and the 14th followed by the following: January 16, 17, 18, 19, 20, and 21, 2013. Petitioner then worked from 8:00 a.m. through 10:38 a.m. and 11:06 a.m. through 2:30 p.m. on January 23rd. Petitioner took a sick day on January 24, 2013. (RX 2, dep. ex. 4)

On January 24, 2013, Petitioner was evaluated by Dr. Bruce Kaplan at Carle Family Medicine. Petitioner provided a history that her body had been aching for the past three days, primarily in her shoulders. She further reported that moving her arms aggravated her pain and that she had been doing a lot of stirring and lifting at work as a cook for Respondent. She also complained of left neck pain and a headache. Dr. Kaplan's assessment was chest wall pain, migraine headache, elevated blood pressure, and left-sided neck pain. Petitioner was taken off of work and told to follow-up with her primary care physician. (PX 2)

Petitioner worked eight hours on January 25, 2013. (RX 2, dep. ex. 4)

Petitioner worked eight hours per day on the following dates: January 30, 2013; January 31, 2013; February 1, 2013; February 2, 2013; and February 3, 2013. She did not work on February 4, 5, or 6th, 2013. (RX 2, dep. ex. 4)

On February 6, 2013, Petitioner was seen by Dr. Natalie Renee Sessions at Carle. At that time, Petitioner reported ongoing bilateral hip and pelvic pain. She also reported shoulder and neck pain which was made worse when she was working as a cook for Respondent. She indicated that she did a lot of stirring as well as lifting of heavy baskets and she felt this exacerbated her symptoms. Petitioner advised that her pelvic pain continued to bother her most when she went to change positions such as lying down at night and then going to sit up or getting out of car. When standing Petitioner felt a throbbing in her left leg and pelvis. It was

[1] See authorization signed by Petitioner (PX 2, pp. 3-4)

also noted that "Since her last visit[2], she also now reports pain involving the area from her elbows to her hands bilaterally with numbness in her hands. This occurs mostly at night and will wake her up." Petitioner was assessed with myalgia and myositis, unspecified, along with pelvic and thigh pain, back pain, an unspecified vitamin D deficiency, and obstructive sleep apnea. (PX 2)

Petitioner worked on February 7, 8, 9, 10, 12, 13, 14, 16, and 17, 2013. (RX 2, dep. ex. 4)

On February 20, 2013, Petitioner was evaluated by Dr. Charles Liang at Carle Convenient Care. Petitioner complained of right shoulder pain after lifting pasta at work. She had been seen by Dr. Kaplan on January 24, 2013. She was previously given Demerol for her migraines and her shoulder pain got better until the 24th when she noticed, while pushing off a chair, that she experienced a sharp pain in her right shoulder. The shoulder pain was made worse when letting her arm hang at her side. Dr. Liang's assessment was pain in joint, shoulder region and migraine. Petitioner was instructed to follow-up with her primary care physician for her shoulder pain and to work on range of motion shoulder exercises. (PX 2) Petitioner did not work that day. (RX 2, dep. ex. 4)

Petitioner worked on February 21, 22, 23, and 24th. (RX 2, dep. ex. 4)

Petitioner completed a First Report of Injury on February 24, 2013. Petitioner indicated that she sustained an injury while working at "Penne Lane" on January 24, 2013. Petitioner indicated "shoulder pain and something popped." She stated "everytime I lift that pasta basket and the pain get worse and mixing food in the pot make it hurt more and picking up basket or pushing heavy carts." Petitioner identified "Keith and Carrie" as witnesses. She also advised that she had been taken off work at Carle for three days. (RX 2, Depo exhibit 1).

Petitioner returned to Dr. Kaplan on February 26, 2013 with continued complaints of right shoulder pain. Petitioner reported that the right shoulder pain began four days after she was last seen by Dr. Kaplan. She "believe[d] hurt it at work." Petitioner explained that she worked for Respondent and cooks with increased lifting at work and stirring. Petitioner reported repetitively lifting and pouring contents into a pan. She estimated that baskets of pasta weighed about 15 lbs. On examination, Petitioner's right shoulder was tender and abduction of her right upper extremity to 130 degrees caused pain. Petitioner could abduct her left shoulder to 160 degrees. Dr. Kaplan's assessment was right shoulder pain with a question of a rotator cuff injury on the right. Dr. Kaplan recommended Methocarbamol and that Petitioner be seen by the Division of Physical Medicine & Rehab. Petitioner was instructed to follow up with Dr. Kaplan in four weeks. She was also put on restrictions of no lifting, pulling or pushing greater than 5lbs. for the next four weeks. (PX 2)

[2] Not a part of the record.

Petitioner underwent a right shoulder x-ray on February 26, 2013. It revealed minimal degenerative changes of the AC joint with slight irregularity of the articular surface of the clavicle. Dr. Kaplan reviewed the film and left instructions for Petitioner to be notified that the x-ray showed "a little arthritis" and that she should continue with the treatment plan they had previously discussed. (RX 4)

Petitioner was not working as of February 26, 2013.

Petitioner filled out a second First Report of Injury on February 27, 2013. At that time, Petitioner indicated that she had an injury to her right shoulder on January 23, 2013. She also indicated that she was not sure of the time of the accident. She stated that she used the date of January 24, 2013 because that was when she first saw the doctor. She reported that she felt some popping in her right shoulder when she would pick up baskets or pull anything that was heavy or stir the pots. (RX 2, dep. exhibit 3).

On March 1, 2013, Petitioner was evaluated by Dr. Jian Li at the Carle Division of Physical Medicine & Rehabilitation for her right shoulder pain. Petitioner reported that she was required to put pasta into a big basket and put the basket into hot water and then bring it up and pour it into a pan. She indicated that she performed that repetitively from 4:00a.m. to 8:00a.m. and that the pasta basket weighed between 15-20 lbs. She further reported that she felt a pop in her right shoulder when she was picking up a basket of pasta on January 23, 2013 and that she had been having pain in her right anterior shoulder since that time. She also reported tingling in her right hand with occasional numbness. Dr. Li reviewed the x-ray from February 26, 2013 which showed minimal degenerative changes of the AC joint in the right shoulder. Dr. Li's impression was right shoulder sprain/strain/rotator cuff syndrome. Petitioner was advised to undergo a course of physical therapy and instructed to use over-the-counter medications like Ben Gay topically as well as heat to help the pain. Petitioner was instructed to return in five weeks after she finished her course of physical therapy. (PX 2)

Petitioner was next evaluated by James Berkes, PA-C[3] at the Carle Division of Orthopedics on March 4, 2013. By history, Petitioner had previously undergone a reconstruction of her ECU tendon sheath of the right wrist per Dr. Sobeski. Petitioner was presenting with an unrelated issue on the 4th as she was now experiencing numbness and tingling in her right hand which would awaken her at night. She indicated that all the fingers on her right hand were going numb. On examination, Petitioner had a positive Tinel over the median nerve, a positive median nerve compression test, a positive Phalen's test, a positive Tinel over the ulnar nerve at the elbow, and a positive elbow flexion test. The ECU tendon was not giving her too much trouble and it appeared to have healed nicely. Mr. Berkes indicated that Petitioner likely had a carpal tunnel and cubital tunnel in her right upper extremity. Petitioner was advised to try night splints and a pad at the elbow. Petitioner was instructed to follow-up in 6-8 weeks.

[3] Dr. Sobeski's PA-C

Petitioner was fitted for right elbow pads, one which was to be worn during the day and the other at night. She was also given a cock-up splint for her wrist at night. (PX 2)

On March 6, 2013, Petitioner was evaluated by Dr. David Zeman at the Carle Orthopedic Department. Petitioner provided a history of right shoulder pain which she attributed to "pasta." Petitioner reported that she returned to work in December and that her shoulder pain has been hurting since then. She also reported some pain and swelling at her sternoclavicular joint while she was in the shower at home around February 26, 2013 but no other injuries had occurred. On examination, Petitioner had diffuse tenderness over the shoulder and impingement maneuvers were painful. Dr. Zeman's assessment was subacromial bursitis and he provided Petitioner with an injection of Depo-Medrol into the subacromial bursa. Petitioner was instructed to resume her physical therapy. (PX 2)

Petitioner presented for physical therapy at Carle on March 11, 2013 per Dr. Li. Petitioner reported burning and throbbing pain in the medial /anterior region of her right shoulder. Aggravating factors included driving and lifting. Decreased use of the shoulder and heat helped. Petitioner reported difficulty sleeping due to pain. The therapist noted Petitioner's right shoulder active range of motion and strength decreased by pain. All provocative testing was positive indicative of diffuse soft tissue involvement. Petitioner was noted to be limited in her ability to perform activities of daily living. Petitioner was to attend therapy two times a week for 6-8 weeks. (PX 2)

Petitioner attended physical therapy on March 18, 2013 and March 21, 2013. Her complaints focused on her right shoulder blade and included a burning and numbness sensation. On the 18th Petitioner mentioned a "new onset" of numbness and tingling in her right hand since the shoulder pain began. Lifting things, housework, and picking up her grandchild were most bothersome. (PX 2)

On March 21, 2013 Petitioner signed her Application for Adjustment of Claim in case # 13 WC 09757. She alleged that she was "injured at work" on January 23, 2013 sustaining injuries to her "right shoulder and body." (AX 2)

Petitioner worked for thirty minutes on March 28, 2013. (RX 2, dep. ex. 4)

Petitioner returned to Dr. Kaplan at Carle Family Medicine on March 29, 2013. At that time, Petitioner continued to complain of shoulder pain unrelieved by the recent injection. She reported "increase carrying of objects." The office note further states, "Patient told she needs to work everywhere in kitchen without restrictions if works." He also noted, "increased stirring at work." Dr. Kaplan's assessment was a right shoulder soft tissue injury. Dr. Kaplan encouraged Petitioner to keep her appointment with Physical Medicine & Rehab and indicated that she was restricted her from working until the end of April 2013. (PX 2)

Petitioner attended physical therapy on March 29, 2013 reporting that her shoulder pain had "flared up" but she didn't know why. She had seen her doctor earlier that day "and states job won't let her work with restrictions." The therapist noted that all exercises that day continued to give Petitioner pain in her anterior shoulder and numbness down into her right hand. (PX 2)

On April 2, 2013, Petitioner returned to Dr. Li. Petitioner reported ongoing pain in her right anterior shoulder which sometimes radiated to the dorsal aspect of her right wrist with associated pain in her hand with numbness. Dr. Li's impression was right shoulder sprain/strain/rotator cuff syndrome. Petitioner was advised to undergo an MRI of her right shoulder. Dr. Li was interested in whether Respondent would accommodate her restrictions. Petitioner indicated that she has not been able to work in the last month and that she was trying to apply for disability. (PX 2)

Petitioner attended physical therapy on April 4, 2013 reporting an upcoming MRI and noting that when she woke up in the morning her shoulder would be "really killing her." During passive range of motion exercises Petitioner noted popping in her clavicle. She continued to have pain with all exercises and described a burning sensation down her arm. (PX 2)

Petitioner underwent physical therapy on April 8, 2013 reporting her sleep was continuing to be disturbed and that she was unable to work. Petitioner asked about her right clavicle being higher than her left and the therapist noted it did appear more prominent. Petitioner related pain with all exercises. (PX 2)

On April 8, 2013 Petitioner called Dr. Li's office to inquire whether or not he had received a letter from Respondent regarding her disability. Dr. Li was subsequently given the paperwork. (PX 2)

Petitioner met with Physical Therapy on April 10, 2013 for an evaluation due to right shoulder pain. Petitioner reported occasional radiating pain down into her hand. She continued with poor posterior glenohumeral mobility and had not tolerated strengthening well. The therapist suggested further medical evaluation to rule out cervical pathology. She was to be seen two times a week for 4-6 weeks. (PX 2)

Petitioner returned to physical therapy on April 11, 2013 reporting her "whole body" hurt. Petitioner described pain with all movements. She was scheduled to undergo an MRI that afternoon. (PX 2)

Petitioner underwent her right shoulder MRI later that same day (April 11, 2013). The radiologist's impression revealed no evidence of a full thickness rotator cuff tear, mild degenerative tendinopathy related to the rotator cuff, and some mild hypertrophy of the AC joint and spurring of the distal acromion. (PX 2)

On April 12, 2013 Petitioner was contacted by Dr. Li's office and notified that Respondent would not process her disability request unless she had been off work for 61 days or more. Petitioner advised she would reach that point near the end of the month and that Respondent had recommended that she apply. Petitioner was also told that the doctor's office had received information in the form of a job description without any specific questions for the doctor to complete. (PX 2)

Petitioner attended physical therapy on April 15, 2013 reporting no change in her shoulder pain. The therapist noted that Petitioner continued to demonstrate symptoms suggestive of cervical pathology including burning/tingling down to her hand. (PX 2)

According to a medical note dated April 15, 2013 Nurse Skaggs (Dr. Li's office) spoke with Tricia Rothermel from Respondent's HR Department that day regarding an update on Petitioner's work status. Ms. Rothermel advised that currently it had a note from Dr. Li that Petitioner was to remain off work through the end of April but she also had another note from the doctor sating that Petitioner had to be off work because she reported that Respondent didn't allow her to work with restrictions. Ms. Rothermel wished to clarify the situation as Respondent was willing to try and accommodate restrictions but it needed to know what the specific restrictions were. A job description had been sent to the doctor to advise him of Petitioner's job duties so restrictions could be specified. Ms. Rothermel also reported that Petitioner would not qualify for disability until she had been off work for at least 61 days. Dr. Li subsequently issued a note on April 16, 2013 outlining restrictions. (PX 2)

Petitioner returned to physical therapy on April 18, 2013 reporting her shoulder was still the same and that the doctor thought she had biceps tendonitis. Petitioner was to undergo ultrasound and ionto to her shoulder. Wall push-ups were discontinued due to pain. (PX 2)

Petitioner returned to work for Respondent on April 22, 2013 with restrictions. She worked April 22, 23, 25, and 26th. (RX 2, dep. ex. 4)

Petitioner worked April 29 and 30, 2013. (RX 2, dep. ex. 4) Petitioner worked May 1, 2, and 3, 2013. (RX 2, dep. ex. 4)

On May 6, 2013, Petitioner returned to James Berkes, PA-C at Carle Orthopedic Department. Petitioner reported ongoing numbness and tingling in her right hand, mostly in the ring and small finger. On examination, she had a positive Tinel over the ulnar nerve, a positive Tinel over the median nerve at the wrist, and a positive median nerve compression test. Petitioner was advised to undergo a nerve conduction study and to return to Dr. Sobeski after the study. (PX 2)

Petitioner worked May 6, 7, and 8, 2013. (RX 2, dep. ex. 4)

On May 8, 2013, Petitioner underwent an EMG with Dr. Khosrowshahi at Carle Physicians Group. By history, Petitioner reported numbness and tingling of the fourth and fifth digits for two months after shoulder injury. Dr. Khosrowshahi's impression was a normal electrodiagnostic study of the right upper extremity with no evidence of ulnar or median entrapment neuropathy or other abnormalities. She reported numbness and tingling of digits 4 and 5 for two months post shoulder injury. (PX 2)

According to a May 10, 2013 Physical Therapy Discharge Note Petitioner was certified for shoulder therapy from May 10, 2013 through June 9, 2013. (PX 2)

Petitioner worked 7.4 hours on May 10, 2013. She then began her seasonal lay-off. (RX 2, dep. ex. 4)

Petitioner returned to see Dr. Sobeski on May 20, 2013. Dr. Sobeski reviewed the EMG, summarizing it as unremarkable. Petitioner indicated that she did not want to do anything further about it and Dr. Sobeski concurred. Petitioner was instructed to follow-up if needed. (PX 2)

On June 11, 2013, Petitioner was re-evaluated by Dr. Li at the Carle Division of Physical Medicine and Rehabilitation. At that time, Petitioner indicated that physical therapy had not really helped her shoulder pain. She indicated that she had been off work since the middle of May and was wondering if her restrictions would continue when she went back to work in the middle of August. She further indicated that she was able to do her job but it still hurt when she did things with her right arm, especially sweeping and mopping. Petitioner refused a cortisone injection. Dr. Li recommended additional physical therapy and a possible functional ability evaluation regarding her restrictions. Petitioner was instructed to follow-up at the beginning of August. (PX 2)

Petitioner underwent a physical therapy evaluation at Carle Therapy Services on July 9, 2013. In conjunction with the evaluation Petitioner completed a Penn Shoulder Questionnaire. By history, Petitioner reported ongoing right shoulder pain since January. Petitioner stated that her pain began with picking up pasta baskets at work repetitively. Petitioner described right-sided clavicle pain, "feels like it is on fire." The burning sensation was deep in the shoulder and along her right collar bone. She also reported elbow and wrist pain (carpal-tunnel like symptoms) which she felt unrelated to her current shoulder pain. Petitioner reported her shoulder pain had remained unchanged since her last therapy sessions in April stating that it "did help but it didn't." Petitioner also reported daily migraine headaches and periodic neck pain. Petitioner reported being able to perform activities of daily living albeit with pain. She was limited with heavier lifting due to pain and subjective weakness. Washing the bathtub out was painful and she would wake up during the night due to pain in her shoulder. Petitioner was noted to be employed by Respondent in food services which required repetitive lifting and carrying at waist level or above. On examination Petitioner was noted to have decreased cervical range of motion. The therapist noted concern for cervical pathology given the cervical

and right arm symptoms and the fact therapy had not previously helped Petitioner's symptoms. Petitioner was advised to undergo additional skilled physical therapy to address her ongoing complaints of right shoulder pain. (PX 2)

Petitioner underwent physical therapy on July 11, 2013 reporting she was doing fine with the ionto patch but it would fall off due to sweating. Petitioner reported constant numbness and tingling in her right 4th and 5th digits, more so at the end of the day. Petitioner also reported that her elbow would hurt when her fingers would go numb. The therapist noted Petitioner had cervical segmental hypomobility and symptoms suggestive of a nerve root or peripheral nerve root issue. Past EMG studies had been negative for ulnar or median nerve problems. It appeared unclear to the therapist whether Petitioner's shoulder symptoms were a separate issue or possibly being exacerbated by a cervical pathology. Ultrasound was performed to the biceps tendon area that day as she reported pain and tenderness in that region. (PX 2)

Petitioner attended physical therapy on July 19, 2013. She reported sleeping on her right side the night before resulting in a "really sore" shoulder with numbness and tingling down to her hand. Petitioner didn't feel ultrasound was very beneficial but found relief with the ionto patch; however, it didn't stay on due to sweating. Despite therapy that day, Petitioner's pain remained unchanged. (PX 2)

Petitioner reported to physical therapy on July 22, 2013. Her shoulder complaints remained and mid-afternoon and evening numbness and tingling was also noted. (PX 2)

At her July 25, 2013 physical therapy session Petitioner reported right shoulder pain but no numbness or tingling except in the mid-afternoon and evenings. With some of her exercises she did notice a decline in the frequency of her numbness and tingling. Over all, Petitioner felt therapy had been slightly helpful, but not significantly. The therapist noted Petitioner was not responding well to ultrasound so it was deferred at that session. Her symptoms were noted to be reproduced by cervical motions, including right side bends and right side bends with flexion/extension. Petitioner also had a positive Spurling's sign on the right. (PX 2)

On July 25, 2013 Petitioner's physical therapist called Dr. Li's office reporting on Petitioner's p.t. progress. She specifically noted that Petitioner had poor tolerance with ultrasound and increased cervical pain. She further noted that cervical motion caused an increase in Petitioner's pain so the therapist was uncertain whether Petitioner's pain was shoulder or neck related. The therapist further noted some neurological symptoms in Petitioner's right hand and wanted Dr. Li's thoughts. Dr. Li subsequently replied that the therapist could look at his notes and the EMG report. He would discuss the matter with Petitioner at their next appointment. (PX 2)

Petitioner returned to physical therapy on July 29, 2013 reporting ongoing shoulder pain. The therapist noted, "She states she was cuddling with her grandchild and had onset of increased [right upper extremity] numbness and tingling, along with pain." The therapist also

noted Petitioner continued to demonstrate neural tension in supine position that was most affected by cervical position. (PX 2)

Petitioner underwent physical therapy on August 5, 2013 reporting posterior shoulder pain. The therapist noted, "States she helped her daughter move over the weekend and she kept yelling at her to stop carrying things." Petitioner also reported seeing the doctor on Wednesday and would find out if she could return to work "or with modified lifting." (PX 2)

On August 7, 2013, Petitioner returned to Dr. Li. At that time, Petitioner reported that physical therapy was helping but that she still had pain in her right shoulder. Petitioner further indicated that she was returning to work on August 16, 2013 and wanted to discuss restrictions with the doctor. Dr. Li's impression was right anterior shoulder pain and he recommended Petitioner undergo a functional ability evaluation and follow-up with Dr. Zeman. Petitioner remained on a 10lb. weight restriction. (PX 2)

At Petitioner's August 8, 2013 physical therapy session, the therapist noted Petitioner had experienced fair to poor tolerance with ultrasound and was reporting increased pain, at times, with treatment. Petitioner was also unable to tolerate many of the scapular exercises. Petitioner reported pain averaging "6/10" in the right anterior shoulder. She was also reporting numbness and tingling in the 4th and 5th digits of her right hand and right elbow pain. Spurling's test was positive. Petitioner also had a positive ULTTA, and a positive response to cervical distraction, more consistently suggesting radiculopathy v. nerve compression or a true shoulder impingement of RTC issue. Further medical examination and inquiry was suggested. Additional therapy for the shoulder wasn't felt to be beneficial due to lack of progress. Petitioner was to undergo an FAA for functional assessment for return to work. (PX 2)

Petitioner resumed working for Respondent on August 16, 2013. She worked that day followed by August 19, 20, and 21. (RX 2, dep. ex. 4)

On August 21, 2013, Petitioner was re-evaluated by Dr. Zeman for ongoing right shoulder pain. Dr. Zeman's assessment was right shoulder impingement. Petitioner was advised to undergo additional therapy, including rotational strengthening for her right shoulder. (PX 2)

Petitioner worked August 22 – 26, 2013. (RX 2, dep. ex. 4)

At her August 27, 2013 physical therapy visit Petitioner reported having returned to work and noticing increased pain with work activities (repetitive lifting and draining of pasta baskets). Petitioner had been given updated orders to continue skilled physical therapy with a focus on strengthening. Pain with using her arm cross body and overhead was also noted. Petitioner reported numbness and tingling of her 4th and 5th digits of her right hand mostly at night which "comes and goes." (PX 2)

Petitioner worked August 29 through September 2, 2013 and September 5 – 9th . (RX 2, dep. ex. 4)

Petitioner attended physical therapy on September 10, 2013 reporting anterior-superior shoulder pain with good days and bad days. On a good day at work she felt her pain was a "5/10." On a bad day at work it could increase to "8/10" if lifting the pasta basket. (PX 2)

Petitioner worked September 12, 2013 and then September 19 through the 23rd. (RX 2, dep. ex. 4) During this time Petitioner took some time off for funeral leave. (RX 2, dep. ex. 4)

When Petitioner returned to physical therapy on September 24, 2013 she reported ongoing shoulder pain. (PX 2)

Petitioner attended physical therapy on September 25, 2013. The therapist noted Petitioner had only completed two visits in the past month. She was progressing well with her exercise progressions although her pain remained relatively unchanged. Petitioner reported that work activities continued to exacerbate her pain as she had returned to work and now her shoulder hurt again. Petitioner noted less numbness and tingling as it only occurred at night. The goal was to continue transitioning Petitioner to an independent program over the coming weeks. Petitioner reported her worst pain (8/10) with lifting pasta baskets at work. (PX 2)

Petitioner worked September 26 through the 30th, October 3rd and October 5 through October 7. (RX 2, dep. ex. 4)

Petitioner returned to physical therapy on October 8, 2013 reporting she was now in a different position at work and no longer working on the pasta line anymore. She was now in the soup station which required her to open many cans with a large can opener and it required a "repetitive rotary motion" on her shoulder at waist height. She was feeling a little better at the new station but still noticing pain. (PX 2)

Petitioner worked on October 10th and 11th. (RX 2, dep. ex. 4)

At her October 10, 2013 physical therapy session Petitioner reported speaking with her boss at work in an attempt to get a different position other than the pasta bar because every time she went back to work her pain worsened. Petitioner's hand numbness was getting better until two nights earlier when she woke up with bilateral hand numbness. Petitioner noted she had not done anything different the day before except for work. (PX 2)

Petitioner worked October 13th and 14th. (RX 2, dep. ex. 4)

Petitioner attended physical therapy on October 16, 2013 reporting she was still working at the "new position" at work and not lifting as much. She was feeling a little stronger. Petitioner

continued to report "burning" pain with exercises and bilateral numbness and tingling. She was advised to follow up with her provider regarding these symptoms. (PX 2)

Petitioner worked October 17th through the 21st and October 24 through the 26th. She also worked October 27th. (RX 2, dep. ex. 4)

On October 29, 2013, Petitioner attended physical therapy and was discharged from same. Petitioner reported that she was getting a little stronger and was doing better at work because she didn't have to lift the pasta buckets the same way. Petitioner reported performing her home exercises. From July 9, 2013 to October 29, 2013, she had completed fifteen sessions of physical therapy. At that time, it was determined that Petitioner had reached her maximum functional potential and that her job description had changed allowing her to avoid the aggravating activity of lifting pasta baskets which helped reduce her pain. Her pain level remained a "5/10." Petitioner was discharged to an independent home exercise program. (PX 2)

Petitioner's time records show she worked November 2 – 4th and November 14th – 19th. She also worked November 21 - 22 and December 1 and 2nd. (RX 2, dep. ex. 4)

After her discharge from physical therapy on October 29, 2013, Petitioner had no further medical care until she returned to Dr. Zeman on December 4, 2013 complaining of a burning pain in her right shoulder with symptoms going down into her forearm and hand. Petitioner was still working but finding it difficult to open cans and handle objects weighing more than 10lbs. On examination, she had good internal and external rotational strength and no instability with anterior or posterior stressing of the shoulder. Dr. Zeman's assessment was right shoulder pain which had been refractory despite extensive physical therapy and anti-inflammatory measures. Dr. Zeman released Petitioner with permanent restrictions against lifting more than 10 lbs. with her right upper extremity. Petitioner was discharged from his care. (PX 2)

Petitioner worked on December 4, 2013. (RX 2, dep. ex. 4)

Petitioner called Dr. Zeman's office on December 5, 2013 reporting that the doctor had seen her the day before and given her a note stating she could not lift more than ten pounds on a permanent basis. He had dated the note and Petitioner believed it looked like that would be the date her restriction ended. She needed an undated slip stating she had a permanent work restriction of 10 lbs. (PX 2)

Petitioner worked on December 5th and 6th. (RX 2, dep. ex. 4)

On December 7, 2013 Petitioner presented to the emergency room at Carle Clinic regarding hand pain. According to the history, Petitioner noted hand pain which had started two hours earlier while at work and "every time she was dipping vegetables at work [she] was getting shocking pain from [her] right hand to [her] elbow." Petitioner explained that she was experiencing intermittent numbness aggravated by repetitive motion. She reported right hand

numbness and waking up at night with numbness in the 4th and 5th digits of her right hand. Petitioner also reported some shooting pains up the right forearm. She denied any specific injury. Petitioner denied any history of carpal tunnel syndrome. On examination Petitioner had positive Tinel and Phalen signs in the right hand. The physicians' assistant believed Petitioner probably had carpal tunnel syndrome. Petitioner was given a wrist splint and released to modified work/school activity and told to avoid repetitive motion (5 or more per minute) of the right hand. (PX 2, pp. 4-10)

Petitioner worked on December 8, 2013. (RX 2, dep. ex. 4) On December 8, 2013, Petitioner filled out a First Report of Injury. Petitioner stated that she sustained an injury to her right hand on December 7, 2013 in the kitchen at IKE. Petitioner further stated that she was dipping up the veggies and got a sharp pain going from her hand to her elbow. (PX 6)

Petitioner worked on December 9, 2013. (RX 2, dep. ex. 4)

On December 11, 2013, Petitioner was evaluated by James Berkes, PA-C at the Carle Hand Surgery Orthopedic Department. Petitioner indicated that she was having ongoing trouble with her right upper extremity, including associated numbness and tingling in the ring and small fingers which would awaken her at night. She also stated that she found doing any type of repetitive use with her right arm caused a shocking pain up to her elbow and even into the shoulder at times. On examination, Petitioner had a positive Tinel over the median nerve at the wrist, a positive median nerve compression test, a positive Phalen test, and a positive Tinel over the ulnar nerve at the elbow. Mr. Berkes indicated that her exam and symptoms were consistent with carpal tunnel and cubital tunnel syndrome, that Petitioner had failed conservative treatment and that she was ready to proceed with surgical treatment. Petitioner was scheduled for surgery with Dr. Sobeski. (PX 2)

Petitioner worked on December 12, 13, 14, 15, and 16th, 2013. Petitioner did not resume working for approximately one more year. (RX 2, dep. ex. 4)

On December 17, 2013 an office note was entered indicating Petitioner was ready to schedule surgery. (PX 2, p. 65/106) A subsequent message stated that if Petitioner was pursuing workers' compensation she needed to speak with June Bryant in the office. Petitioner subsequently phoned back advising that she was scheduled for surgery with Dr. Sobeski on January 17, 2014 and was going to use her personal insurance as workers' compensation had denied her claim. Petitioner was later contacted and told a note with restrictions of "left hand work only" could be picked up. Petitioner then phoned back and stated "no longer work comp." (PX 2, pp. 64-65/106)

On December 30, 2013 Petitioner signed a new Application for Adjustment of Claim in case #14 WC 000012. Petitioner alleged an accident date of December 7, 2013 and claimed she was "injured at work" sustaining injuries to her "right hand, right arm and whole body." (AX 4)

Petitioner underwent a pre-operative exam at Carle on January 13, 2014. She was cleared for surgery at that time.

PA-C Berkes examined Petitioner on January 15, 2014 in regard to Petitioner's left elbow. He noted she was scheduled for surgery in the near future (right side). In light of her positive findings on the left side Mr. Berkes noted she probably had left carpal tunnel and cubital tunnel syndrome as well and might need surgery on that side too. She declined an injection for the left wrist. (PX 2)

On January 17, 2014, Petitioner underwent a right carpal tunnel release and right cubital tunnel release with subcutaneous ulnar nerve transposition per Dr. Sobeski at Carle Foundation Hospital. The pre-operative and post-operative diagnosis was right carpal tunnel syndrome and right cubital tunnel syndrome. Intra-operatively, Dr. Sobeski noted that there were no abnormalities visualized within the median nerve. (PX 2, p. 18)

Petitioner returned to James Berkes, PA-C , on January 29, 2014. At that time, Petitioner was 12 days status post right carpal tunnel release and right cubital tunnel release. Petitioner reported that she was doing very well and the numbness and tingling in her hand was improved. Petitioner inquired about physical therapy and Mr. Berkes indicated that Petitioner could contact them if she was interested in that option. Petitioner was restricted to left hand work only and was instructed to follow-up in four weeks. (PX 2)

Petitioner telephoned PA-C Berkes' office on February 17, 2014 requesting that an order for right elbow and hand therapy be put in line. An order was entered the next day. (PX 2, p. 73/106)

At the referral of Dr. Sobeski, Petitioner underwent a physical therapy evaluation at Carle Therapy Services on February 20, 2014. Petitioner reported ongoing achiness in her hands and stabbing elbow pain post-surgery. Petitioner was instructed to undergo skilled physical therapy 2-3 times a week for 4-6 weeks to work on scar massage, desensitization, and strengthening. (PX 2)

The February 25, 2014 Occupational Therapy note indicates Petitioner's overall pain complaints were rated "6/10." She was having difficulty brushing her hair and teeth. Petitioner reported elbow pain and marked hypersensitivity at the incisional sites for her wrist and elbow. (PX 2)

Petitioner attended occupational therapy on February 27, 2014 reporting her arm would hurt quite a bit at night. She described stiffness and achiness. "She states that at night if her body gets chilled, the chill goes to her arm and then it gets warm almost like there is a fever in it." Objectively, Petitioner had good range of motion of her elbow, wrist and forearm although she described ongoing pain and sensitivity. (PX 2)

Petitioner attended occupational therapy on March 6, 2014 reporting that her symptoms were unchanged since her last visit. Petitioner reported both hands were bothering her and the pain was worse at night. Petitioner had good range of motion and expressed the belief that if her elbow pain would go away she would be pretty happy. (PX 2)

Petitioner called Dr. Sobeski's office on March 11, 2014 regarding when she could return to work and under what restrictions. As of January 29, 2014 Petitioner had been limited to left hand work. The March 4, 2014 office note did not mention work or work restrictions. P.A. Berkes advised Petitioner that she could return to work if she wished. When the nurse notified Petitioner of the foregoing, Petitioner advised the doctor's nurse that she did not wish to go back to work until after completing her occupational therapy and seeing the doctor. A note was left for her to pick up. (RX 4; PX 2, p. 74/106)

According to the March 13, 2014 Occupational Therapy note for her hand, Petitioner was reporting pain in her shoulder that would "come and go." If she wrapped it up and had some compression on it, it felt better. Petitioner reported that she was seeking disability because of a right shoulder injury that occurred before she had surgery on her arm. According to Petitioner she was on a ten pound permanent lifting restriction and because of that she wouldn't be able to return to her job. (PX 2)

Petitioner presented for occupational therapy on March 20, 2014 in regarding to her elbow and hand. Petitioner reported that driving bothered her medial epicondylitis and her hands. (PX 2)

Petitioner presented to Occupational Therapy on March 21, 2014. Petitioner reported being off work due to a ten pound lifting restriction. Petitioner wished to get back to work. Petitioner was to be seen 2-3 times a week for three weeks. (PX 2)

Petitioner returned to Occupational Therapy on March 25, 2014 reporting the inability to lift a bottle of bleach or gallon of milk with her right upper extremity. Petitioner expressed concern about her scars' appearance. (PX 2)

According to the March 27, 2014 Occupational Therapy report, Petitioner's overall pain complaint score ("6-7/10") remained unchanged. Her pain was reportedly worse at night and the night before she felt like someone was stabbing her in the arm. (PX 2)

At her occupational therapy visit of April 3, 2014 Petitioner reported distal symptoms 75% of the day and increased pain when lifting grocery bags. Strengthening exercises were limited that day. (PX 2)

Petitioner again went to occupational therapy on April 7, 2014 reporting increased pain when pulling wet clothes out of the washer. She described the worst pain when sleeping as it frequently awakened her. Petitioner did not think her pain medication was working. (PX 2)

Petitioner telephoned PA-C Berkes' office on April 11, 2014 requesting that her Norco be increased to 7.5 mg and that an order be put in place for left arm therapy. The medication request was denied and the therapy request would be addressed at their next visit. (PX 2, p. 76/106)

On April 16, 2014, Petitioner was re-evaluated by James Berkes, PA-C. Petitioner reported that she was still having pain at the medial aspect of her right arm. Mr. Berkes indicated that she could either continue the physical therapy or transition into a home exercise program. He kept Petitioner off of work and instructed her to follow-up in six weeks. (PX 2)

On April 17, 2014, Petitioner returned to Dr. Zeman at Carle Orthopedics Department. Petitioner indicated that Respondent had sent her back to Dr. Zeman to confirm the restrictions. Petitioner reported ongoing right shoulder pain. On examination, Petitioner had maximum pain and tenderness in the area of her right acromioclavicular joint. Dr. Zeman's assessment was refractory chronic right shoulder pain with early acromioclavicular arthropathy. Petitioner was referred to Dr. Bane for a surgical evaluation. (PX 2)

On April 29, 2014, Petitioner was discharged from physical therapy. At that time, she had completed approximately one month of physical therapy. She reported ongoing pain in her elbow with marked hypersensitivity at the incisional wrist and elbow scars. Petitioner was instructed in a home exercise program of nerve gliding and stretching. (PX 2)

On May 8, 2014 Petitioner was diagnosed with a closed fracture of the middle or proximal phalanx or phalanges of a hand. (PX 2 – identified periodically in Petitioner's "Problem List")

Petitioner was examined by PA-C Danny McFarlin[4] on May 12, 2014 upon the referral of Dr. Zeman due to right shoulder pain described as a burning sensation mostly up over the anterior and superior aspect of the shoulder. Petitioner reported suffering an injury to her shoulder a little over a year before while working for Respondent. Petitioner stated she had to lift noodles, with her arms extended, out of the cooking apparatus and she injured her right shoulder doing so. Petitioner had undergone therapy and had received an injection by Dr. Zeman into the subacromial space. That had been some time ago. Petitioner noted she had some improvement in pain but then more recently underwent carpal tunnel and cubital tunnel syndrome with Dr. Sobeski and since then she had noticed increased pain in her shoulder area. Petitioner also complained of a little bit of pain on the opposite side with some occasional neck pain, again described as a burning sensation. Petitioner reported difficulty sleeping at night due to right shoulder discomfort. Hydrocodone was effective at taking the edge off and she was taking Lyrica for her fibromyalgia. She denied any left arm numbness or tingling. On examination Petitioner had some mild tenderness on palpation over her lower cervical spine and upper thoracic spine with mild tenderness on palpation of the right trapezius muscle. She had anterior

[4] Dr. Bane's PA-C

tenderness very specifically over the long head of the biceps tendon. She also had pain at the upper ends of each range of motion exercises and pain with flexion at the elbow against resistance over the anterior portion of the upper arm and shoulder. X-rays did not show significant arthritic changes. The AC joint looked a little wide. Her April 11, 2013 MRI showed mild hypertrophy of the AC joint and very mild tendinopathy. The biceps tendon and rotator cuff appeared normal. PA-C McFarlin's impression was right shoulder pain possibly coming from the biceps tendon. He also questioned if some of her pain was cervical in nature especially since she described burning pain. He recommended a cortisone injection over her biceps tendon which she was willing to try. If she saw no improvement McFarlin suggested a referral to Dr. Bane to determine if she had a shoulder v. neck issue. The cortisone injection was given. If she saw no improvement in two weeks, she was to call for an appointment with Dr. Bane. (PX 2)

Petitioner was examined by PA-C James Berkes of the Hand Surgery Division of Orthopedics on May 28, 2014. Petitioner was being re-examined for a recheck of her right arm and right finger. Petitioner reported her ring finger was doing much better although she still had a little stiffness in the PIP joint. X-rays showed no subluxation so she was advised to keep working on range of motion. No instability of the finger was noted. With regard to her arm, PA-C Berkes noted Petitioner still had some tenderness about the medial aspect of her elbow where her scar was located. She had already been to therapy but didn't want to do that again. Her numbness and tingling had resolved. The only thing still present was "a bit of pain and she does not feel like she has gotten all of her strength back yet." She was told to keep working on it and remain on her 10 lb. lifting restriction for the right arm. She was to return as needed. (PX 2)

Dr. Bane examined Petitioner on June 16, 2014. According to his office note Petitioner initially had an injury on January 23, 2013 while picking up a pasta basket weighing 15 to 20 lbs. to pour into water. She had undergone physical therapy and been treated by Dr. Zeman for subacromial bursitis. Petitioner had also undergone an injection. Dr. Zeman didn't feel Petitioner needed surgery based on Petitioner's MRI and recommended physical therapy. As of December 4, 2013 he imposed a permanent ten pound lifting restrictions and "Once those were placed her job was terminated." The doctor thought, based upon Petitioner's history to him, that she then continued on with her shoulder and her symptoms improved a little just with the rest from not working. Petitioner then had surgery with Dr. Sobeski and saw Dr. Zeman once more at which point he referred her to Dr. Bane. She also saw Dr. Bane's assistant, PA-C McFarlin on May 12, 2014 and he injected her shoulder which helped for a couple of weeks. Petitioner's May 12, 2014 x-rays showed no changes. He didn't have a new MRI to review. Dr. Bane felt her MRI showed some rotator cuff tendinopathy and some AC arthritic changes. Her exam was positive for tenderness over the bicipital tendon region and AC joint but no evidence of a frozen shoulder. She was uncomfortable with forward flexion and abduction. Dr. Bane wrote, "At this point [Petitioner] has been having a problem with her shoulder that seemed to start initially as a work related accident in January of 2013." He felt her permanent restriction was premature as he recommended arthroscopic surgery. He added, "I think she most likely sustained a strain of her rotator cuff at that time [the accident] that has triggered a bout of subacromial bursitis we have not be able to get better with conservative care. I think that

likelihood of success is reasonable and I do not think it would be fair for her at the age of 46 to simply put limitations on her at this time, without attempting this procedure." Petitioner wished to proceed and was going to use her regular insurance as it sounded like the "work comp aspect of this is still open." (PX 2)

On July 15, 2014, Petitioner underwent a pre-operative exam at Carle. At that time, Petitioner was cleared for surgery. (PX 2)

Petitioner was examined by Dr. Dru Hauter on July 21, 2014 at the request of Respondent. By history, Petitioner reported that she was working the pasta line and started noticing some pain in the right shoulder after dunking the 20lb. basket of pasta into the hot water at the food line. She further stated that the pain would come and go with lifting or with certain positions. Dr. Hauter reviewed several medical records and listed those in his report. Petitioner underwent a physical examination with Dr. Hauter. Dr. Hauter's impression was right shoulder hypertrophic degenerative disease causing impingement syndrome. He opined that there was no evidence of an acute injury and that her problem was degenerative and not a cumulative trauma condition. He opined that surgery was indicated but that the surgery was unrelated to her work for Respondent. Dr. Hauter further stated that the restriction of no above shoulder work was unrelated to Petitioner's work or an injury with Respondent. (RX 3)

Nurse Christine Manuel spoke with Petitioner on July 25, 2014. Petitioner reported being approved for her disability on June 19, 2014 but it had now been terminated as the company doctor stated she should be able to return to work until she had surgery on the 5th. She was trying to appeal the decision. Petitioner was wondering if Dr. Bane could issue a note on her behalf stating that she could not return to work before her upcoming surgery because she couldn't work with her arm. Dr. Bane replied to the inquiry stating, "there has been a lot of confusion on her case. Apparently Dr. Zeman put her on permanent restrictions and she was unable to work with that. All I can say is she has a 10 lb. lifting limit at this time and she should not do repetitive use of her shoulder or work over head. She will be having surgery on 8/5. Hopefully within 3-4 months post-op she would be able to return to regular work duties. I can't say she simply cannot work. I can say the above limitations and that if her employer is unable to accommodate them then she cannot work." Petitioner later called back needing clarification regarding the 10 lb. permanent v. short-term restriction. Petitioner was off work and had been told by "M Fitch" to call the doctor's office regarding a note indicating that she should remain off work as it could not accommodate her restrictions. Petitioner felt it made no sense to stop disability for one week and then restart it again after surgery. Nurse Manuel subsequently called "Melanie Fitch" and notified her of the doctor's position. Ms. Fitch stated nothing could really be done "but send her to a Functional capacity testing and by the time she get's [sic] scheduled for it, she will have had her surgery." Not much could be done except to let her undergo her surgery and re-apply for short-term disability. (PX 2, pp. 94-96/106)

Petitioner underwent right shoulder surgery on August 5, 2014. Petitioner underwent a right shoulder arthroscopy with subacromial decompression, distal clavicle resection, and

debridement of supraspinatus and superior labrum with Dr. Robert Bane. Dr. Bane's pre-operative and post-operative diagnosis was right shoulder partial thickness supraspinatus tear, a type 1 superior labral tear, and impingement and AC arthritis. (PX 2)

On August 12, 2014, Petitioner underwent a physical therapy evaluation at Carle Therapy Services for her right shoulder. As part of the process Petitioner completed a Penn Shoulder Questionnaire. Petitioner reported that she no longer had the burning pain she had been experiencing in her shoulder. At that time, Petitioner was instructed to undergo a course of skilled physical therapy two times a week for six weeks to address her right shoulder pain, range of motion, and strength. (PX 2)

Petitioner reported for physical therapy on August 14, 2014, noting her shoulder was hurting that day and she had taken some pain medication before coming. She was pretty tired after the last session. (PX 2)

On August 15, 2014, Petitioner returned to Dr. Bane. Petitioner reported that she was still fairly stiff and sore; however, her shoulder looked good clinically. Dr. Bane opined that Petitioner's shoulder problem was probably from her work-related exposure and he thought that her ultimate prognosis was good. Dr. Bane indicated that Petitioner would be off of work for approximately three months and instructed Petitioner to return for follow-up in four weeks. (PX 2)

Petitioner went to physical therapy on August 19, 2014. (PX 2)

Petitioner again reported to physical therapy on August 21, 2014 reporting that her right shoulder pain ("8/10") was affecting her sleep and waking her up at night. She wasn't taking any pain medication before her therapy session so she could drive. (PX 2)

At her August 27, 2014 therapy session Petitioner reporting a high level of shoulder pain that was still affecting her ability to sleep. She had also been doing more housework that had increased her pain. (PX 2)

When Petitioner went to therapy on September 3, 2014 she reported her scar was still sensitive and she was in moderate to increased pain depending on the day. She was continuing to notice a burning sensation in her shoulder. Functionally, she was able to do her hair. (PX 2)

That same day the therapist called the doctor's office indicating additional therapy would be appropriate as Petitioner's strength was still lacking. (PX 2, p. 98/106)

Petitioner attended therapy on September 10, 2014 reporting increased pain due to rain for the preceding last two days and difficulty sleeping. She was performing her home exercises as instructed. Petitioner remained functionally limited in lifting objects or carrying a gallon of milk. (PX 2)

Petitioner was examined by Danny McFarlin, PA-C, at Carle Orthopedic Department on September 12, 2014. Petitioner continued to complain of pain in her right shoulder. Mr. McFarlin's assessment was status-post arthroscopy of the right shoulder with ongoing pain. Petitioner was told to continue with her physical therapy. She was encouraged to decrease her medication intake. She was instructed to follow-up in six weeks. (PX 2)

Petitioner was seen in therapy on September 24, 2014 reporting that her exercises were going "okay" and her pain, while a "6-7/10" was going down. She had some trouble stirring while cooking the day before and had to be able to lift 25 – 30 lbs. for work as she could not perform light duty at work. She still complained of a burning sensation in her shoulder and reported difficulty holding her arm up to do her hair or lifting things around in her house. The therapist recommended decreasing the number of sessions per week to allow for the shoulder pain. (PX 2)

On October 8, 2014, Petitioner was discharged from physical therapy regarding her right shoulder. At that time, she had completed 9 sessions of physical therapy and had "no showed" for her last two appointments. She was discharged due to the physical therapy attendance policy. (PX 2)

Petitioner returned to Mr. McFarlin on October 24, 2014. Petitioner's Lyrica was refilled and she was instructed to return in four weeks.

Petitioner was examined by P.A. Swartz on November 18, 2014 in regard to hypertension and chest pain. Petitioner, who was familiar to P.A. Swartz as she had previously treated her for a number of years, was noted to have a long history of headaches, fibromyalgia and neuropathy in her legs. Petitioner was supposed to be on Lyrica but has issues getting it covered with her insurance. They discussed her blood pressure and heart issues with Petitioner reporting she couldn't get in to see Cardiology until January. She also mentioned straining her back doing some lifting about a week earlier. Back pain and leg tenderness was noted on exam. Blood pressure medication was prescribed and lab work ordered. (PX 2)

PA–C. McFarlin re-examined Petitioner on November 28, 2014 regarding her right shoulder. He noted she has "struggled with pain" which she described as a burning sensation over the anterior portion of her arm and shoulder. Petitioner related a history of neuropathy in her feet having once taken Lyrica with good results. Gabapentin caused headaches. A cortisone injection was offered but Petitioner declined it. On examination Petitioner had pain over the anterior portion of her shoulder and fairly good range of motion with flexion and abduction. Internal rotation was limited to the beltline. She was slightly decreased in flexion and in abduction due to pain but could get to 160 degrees, albeit uncomfortably. He noted no swelling. PA –C. McFarlin recorded that "they" were trying to get Lyrica cleared for her. He felt she was getting better and should continue to improve. He felt her restrictions should remain in effect. He

wished to see her again in six weeks. Petitioner was to apply ice or heat to her shoulder as needed. (PX 2)

On December 8, 2014, Petitioner called Dr. Bane's office indicating that she was scheduled to return to work on December 9, 2014 but was requesting a note to keep her off of work since her shoulder continued to give her a lot of pain. Mr. McFarlin indicated that Petitioner could return to work with restrictions. (PX 2, p. 21/97)

Petitioner resumed working on December 9th and 10th of 2014. (PX 2, dep. ex. 4)

Petitioner was contacted by Dr. Bane's office on December 15, 2014 regarding the off-work slip previously requested. Petitioner reported she was back to work within her restrictions but still hurting really bad. (PX 2, p. 21/97)

Petitioner returned to PA –C. McFarlin on January 9, 2015. Petitioner indicated that she was getting a little bit better. She was back on the Lyrica which helped. She was also back to work with restrictions which he felt was also helping. On examination Petitioner had some pain at the upper ends of range of motion but improving. She had nearly full range of motion in flexion and abduction. She still reported pain on palpation over the anterior portion of her shoulder. He observed no swelling or pain on palpation to her neck or paraspinal musculature. PA-C McFarlin advised Petitioner to get back into physical therapy since it had previously stopped because it was causing her more aggravation. Petitioner's light duty restriction of lifting no more than 10 lbs. was continued and she was instructed to return in six weeks. He gave her a script for Norco and told her to use it as infrequently as possible. (PX 2)

Petitioner worked January 18 - 21, 2015. (RX 2, dep. ex. 4)

Petitioner worked January 24 – 28, 2015. (RX 2, dep. ex. 4)

Petitioner underwent another physical therapy evaluation at Carle Therapy Services on January 27, 2015. Petitioner's complaints included ongoing shoulder pain which was aggravated by repetitive motions of cooking, combing hair, and putting on and taking off upper body garments. Due to difficulty sleeping Petitioner was sleeping on her right side with her right shoulder flexed more than 90 degrees and with her right wrist close to her right ear. Petitioner was instructed to undergo a course of skilled physical therapy two times a week for four weeks. Petitioner was working light duty with restrictions. (PX 2)

At her January 29, 2015 physical therapy session Petitioner reported right shoulder pain described as "10/10." (PX 2)

Petitioner worked January 31 and February 1, 2015. She also worked February 2 -4 and February 7 – 11, 2015. (RX 2, dep. ex. 4)

Petitioner attended physical therapy on February 6, 2015. (PX 2)

Petitioner was examined by P.A. Swartz on February 6, 2015 regarding bilateral foot pain, especially on the bottoms of her feet. Petitioner reported pain when waking up in the morning or if she has been sitting or standing. Petitioner had recently returned to work from a medical leave so she wasn't used to standing like that. Petitioner was also reporting bilateral hand pain and swelling. On examination Petitioner's hands displayed generalized swelling but no loss of strength. Her feet were tender to palpation on the bottom of both feet from her heels to the balls of her feet. She was diagnosed with plantar fasciitis, bilaterally, and instructed in the use of ice, stretching, and the need to refrain from going barefoot. Medication was given. (PX 2)

Petitioner worked February 14, 15, 16, and 18, 2015. (RX 2, dep. ex. 4)

On February 16, 2015 Petitioner returned to physical therapy reporting pain of "7/10." (PX 2)

Petitioner took a vacation day on the 17th (RX 2, dep. ex. 4)

On February 18, 2015 Petitioner again went to physical therapy with no changes being reported. (PX 2)

Petitioner was examined by PA-C. McFarlin on February 19, 2015 regarding her right shoulder. Petitioner reported no improvement from her physical therapy. Petitioner had good range of motion regarding flexion and abduction with pain being noted only at the upper ends. External rotation remained slightly decreased as was her range of motion internally with her arm behind her back. Petitioner also voiced pain over the anterior superior aspect of her shoulder. McFarlin suspected "a little adhesive capsulitis" possibly. Again, they discussed a Cortisone shot which Petitioner declined. Continued physical therapy was recommended as was the possibility of another MRI to make sure nothing was being overlooked. Petitioner wished to proceed with the MRI. Another possibility was a referral to a pain clinic for management of her chronic pain. He noted the Meloxicam, Ibuprofen, and Lyrica weren't helping her with the pain. (PX 2)

Petitioner worked from February 22, 2015 through February 24, 2015. (RX 2, dep. ex. 4)

Petitioner worked February 27 – March 4, 2015. (RX 2, dep. ex. 4)

Petitioner underwent a right shoulder MRI on March 5, 2015 that showed supraspinatus tendinosis with no evidence of rotator cuff tears and post-operative changes related to her prior surgery. (PX 2)

That same day, PA-C . McFarlin left a note for the office to contact Petitioner regarding her MRI. He stated, "Please notify the patient that there is no evidence of a rotator cuff tear. There is some tendonitis of the rotator cuff. There is nothing else we can offer for treatment. She has

refused cortisone injections." Petitioner was advised and inquired into a pain clinic. PA-C. McFarlin issued the referral. (PX 2, p. 37/97)

Petitioner worked March 7 – 11, 2015. (RX 2, dep. ex. 4)

On March 12, 2015, Petitioner was seen by Dr. Shabeera Rauther at Carle's Interventional Pain Department. Dr. Rauther noted he had last seen Petitioner in 2012 for hip pain. Petitioner reported pain on a scale of "7/10." She primarily hurt over her right shoulder and had previously undergone surgery which made her pain worse. She described a burning and throbbing sensation that didn't radiate anywhere into her arm or neck. Petitioner reported right shoulder pain which made it difficult for her to sleep and work. At work, Petitioner has to lift pans of food, "etc." and was finding that difficult. Petitioner related that physical therapy had helped "to some extent." She was doing home exercises as recommended. Lyrica wasn't helping very much. Hydrocodone had helped in the past. On examination Petitioner had some tenderness to palpation along the anterior aspect of her shoulder joint. Range of motion of the joint was noted to be fairly unremarkable. Petitioner had some weakness with abduction of the shoulder. Dr. Rauther's impression was right shoulder supraspinatus tendinitis. Dr. Rauther noted he was not an expert in shoulders but his review of the recent MRI was fairly unrevealing. He recommended a drug screen as Petitioner assured him she would only take the Hydrocodone as needed and not daily. She was planning on establishing general care with Dr. Hussain the next day. Dr. Rauther indicated that Petitioner should do so and discuss a small dose of Hydrocodone with him. They also discussed cortisone injections which Petitioner declined. (PX 2)

Petitioner worked March 14 and 15, 2015. She resumed working March 17 – 19, 2015. (RX 2, dep. ex. 4) Petitioner also worked: March 28 – 31; April 1; April 4 – 9; April 12 – 15; and April 18 – 22. (RX 2, dep. ex. 4) She worked April 23 and April 25-26 as well as April 27 (4.1 hours)

On April 28, 2015, Petitioner was examined by Dr. Jeffrey Coe at Occupational Medicine Associates of Chicago at the request of her attorneys. Petitioner provided Dr. Coe a history of working for Respondent as a cook in the Dietary Department for 40 hours per week for the past 15 years. Petitioner further reported that her work required relatively constant, forceful use of both upper extremities. Petitioner also reported that her customary work required lifting food, pots, and other materials frequently, cutting, and awkwardly stirring. She further reported that she was frequently assigned to the pasta station in which she lifted, reached, and pulled up baskets of pasta and stirred using a large paddle. Petitioner reported that she was required to work in particularly awkward situations due to her stature of 5 foot 3 inches. Dr. Coe provided an extensive chronology of the medical records he reviewed. An examination of Petitioner was completed at that time as well. Dr. Coe opined that Petitioner suffered repetitive strain injuries to her right dominant upper arm in her work as a cook for Respondent. Dr. Coe further opined that the repetitive strain injuries were a factor causing the development of Petitioner's right shoulder subacromial impingement (both acute and chronic shoulder pain) as well as her right carpal tunnel syndrome and cubital tunnel syndrome. Dr. Coe further opined that Petitioner

was in need of permanent work restrictions of no lifting more than 10 lbs. and limitation in the use of her right arm to shoulder height or below. (PX 1)

Petitioner worked on April 29, 2015. (RX 2, dep. ex. 4)

Petitioner worked May 2 – 6, 2015. She also worked May 10 – 14, 2014. (RX 2, dep. ex. 4)

Petitioner underwent a complete physical with P.A.Swartz on May 15, 2015. She was still experiencing foot pain despite wearing inserts. Her cough had improved. No shoulder or upper extremity complaints were noted. X-rays of Petitioner's feet were ordered and she was prescribed Lyrica for her foot pain. (PX 2)

On May 20, 2015, Petitioner returned to Dr. Rauther with ongoing pain in multiple areas but especially in her right shoulder and neck. Patient reported that she has continued to take Hydrocodone about three times a day as needed. Petitioner tried to cut back on her good days and when around her grandchildren. She denied getting pain medication from anyone else. On examination Petitioner was tender to palpation over multiple fibromyalgia points. There was some diffuse tenderness to palpation along the paraspinal muscles of the cervical and lumbar spine. Dr. Rauther's impression was right shoulder supraspinatus tendinitis and myofascial pain and fibromyalgia. Dr. Rauther refilled Petitioner's prescription for Hydrocodone and instructed her to follow-up in five weeks. Petitioner also mentioned an annoying and persistent cough despite being treated for it with so many things. No recommendations were made regarding the cough. (PX 2)

Petitioner was re-evaluated by PA-C. McFarlin on May 27, 2015. Petitioner reported that she felt her shoulder was getting better but the pain continued to persist particularly after working all day long. McFarlin was concerned that Petitioner was developing adhesive capsulitis. Petitioner was working with restrictions of no lifting over 10 lbs., no overhead work, and no repetitive use of her arm. She was "pretty much" performing her normal activities but noting a difficult time lifting anything "really heavy." Petitioner felt her shoulder was getting better but the pain persisted. Norco seemed to be taking the edge off and she was reportedly only taking it as needed. Her exam was consistent with her previous one in February. Petitioner's work restrictions were continued although the weight was increased to fifteen pounds and she was instructed to return in eight weeks. He again recommended the possibility of an MRI. (PX 2)

Petitioner worked May 27, 28 and 29, 2015. Petitioner also worked on June 1, 3, 4, and 5, 2015. Petitioner worked on June 9, 2015. Petitioner was then on seasonal lay-off. (RX 2, dep. ex. 4)

On/about June 15, 2015 Petitioner contacted PA-C. McFarlin's office regarding clarification of her work restrictions. Petitioner requested a new note stating she had a 15 pound weight limit and no overhead work. Petitioner advised that Respondent was not letting her work with

the repetitive use of her right arm and she had been doing that since returning to work in December. She needed the note by June 16, 2015 at 10:00 a.m. or she would lose her work hours. PA-C. McFarlin issued a note stating she could not lift more than 10-15 lbs., engage in overhead work, and should have limited repetitive use of her right arm. The restrictions were to remain in effect for eight weeks. (PX 2, pp. 54-55/97)

Dr. Rauther re-examined Petitioner on June 24, 2015 in the Carle Pain Center. Petitioner reported pain complaints regarding her low back and right shoulder which had been made "somewhat worse" after tending to her sister who had some surgery. She rated her pain at "8/10." Petitioner was taking the Norco three times a day as needed. On examination some slight tenderness to palpation over the right lumbar paraspinal muscles and over the iliac crest on the right were noted. Muscle strength was 5/5 in both her bilateral upper and lower extremities. Petitioner's diagnosis remained unchanged and Dr. Rather refilled her prescription for Hydrocodone. Petitioner was to return in a month for a routine medication check-up. (PX 2)

Petitioner worked June 28th and 29th for 8 hours. (RX 2, dep. ex. 4) She also worked 5.5 hours on July 2 and July 5th. Petitioner continued to work off and on during July of 2015. (RX 2, dep. ex. 4)

Petitioner was last seen by PA-C. McFarlin on July 23, 2015. At that time, Petitioner reported ongoing pain but positive progress with decreasing pain. She was working with restrictions and it seemed to be working out "pretty good" for her. Her exam remained unchanged, including continued pain with impingement testing, especially with internal rotation. Petitioner had limited range of motion trying to reach behind her back. McFarlin continued Petitioner's light-duty restrictions and instructed her to follow-up in eight weeks. Mr. McFarlin also noted that he had some concern that "some of this" could be coming from Petitioner's neck and at some point a cervical spine x-ray might be appropriate. (PX 2)

Petitioner did not follow up with Dr. Bane or PA-C. McFarlin within eight weeks as ordered.

Petitioner also presented to Dr. Rauther on July 23, 2015 regarding her pain management. Petitioner was complaining of right shoulder pain as well as bilateral foot and leg pain. Petitioner was noted to have fibromyalgia and diabetes. She reported that her blood sugars were "fairly very well controlled." She was taking Lyrica at bedtime and Hydrocodone up to three times a day if needed. Petitioner reported the medications were helping. Petitioner also reported "having a lot of heavy duty work to do lately." Physical findings on examination of Petitioner included some tenderness over her right shoulder joint line and pain with range of motion testing in her right shoulder. Dr. Rauther's diagnoses were right shoulder supraspinatus tendinitis, myofascial pain and fibromyalgia, and diabetes with possible diabetic neuropathy. He refilled her Hydrocodone for another six weeks. He also added Cymbalta to help with the fibromyalgia and diabetic neuropathy. Petitioner was to return in six weeks. (PX 2)

Petitioner worked some in early August of 2015. (RX 2, dep. ex. 4) She also worked August 17 – 20 and August 22 – 24, 2015. She worked August 26, 2015. Petitioner next worked on September 1, 2015. (RX 2, dep. ex. 4)

Petitioner returned to see Dr. Rauther on September 3, 2015 reporting bilateral hip pain and fibromyalgia pain. Petitioner had driven all the way to Dallas and back and secondary to the temperature changes, etc. she had noticed a lot of pain, especially in her feet, radiating to her legs. She had also been diagnosed with strep throat recently and wasn't doing very well. Petitioner told the doctor she had done well on 30 mg. of Cymbalta but couldn't tolerate a higher dosage. Dr. Rauther refilled her prescriptions. She was to return in four weeks. (PX 2)

Petitioner periodically worked in September of 2015. (RX 2, dep. ex. 4)

As instructed, Petitioner presented to Dr. Rauther on October 1, 2015. She reported multiple areas of pain, especially the right side of her low back. Petitioner had undergone a renal duplex exam on September 19, 2015 due to issues with hypertension and had been experiencing back pain ever since. She rated her overall pain as an "8/10." Petitioner was taking her hydrocodone and Lyrica but could no longer tolerate the Cymbalta. Dr. Rauther's examination was limited to Petitioner's low back. Her diagnoses were modified to include back pain. He recommended lumbar spine x-rays and cessation of the Cymbalta. He increased her hydrocodone to 7.5 mg. Petitioner was to return in four weeks. (PX 2)

Petitioner worked the following dates in October: 3 - 6; 7; 9 -13; 14; 17; and 19 – 21st. (RX 2, dep. ex. 4)

Petitioner returned to Dr. Rauther's office on October 29, 2015 regarding her low back and left hip pain. Her overall pain score remained the same as at her last visit. Petitioner was only taking the hydrocodone maybe once a day. Dr. Rauther examined her low back. He had her undergo a drug screen. In his office note he mentioned that Petitioner's lumbar spine x-ray showed minimal disc degeneration with minimal discs. She was to bring in her remaining pain pills to verify the count against her reported use. (PX 2)

Petitioner worked October 31 – November 4, 2015. (RX 2, dep. ex. 4) She also worked November 9 – 11, 2015. (RX 2, dep. ex. 4) Petitioner worked November 15 – 19, 2015. (RX 2, dep. ex. 4)

Petitioner again presented to Dr. Rauther on November 24, 2015. At this visit she had low back pain complaints. She reported that she had called the doctor's office reporting that some of her pain pills had been stolen as she had had a "get together" at her place and thereafter some of the pills were stolen. She reportedly kept them in her room and had locked her room but "somehow they still disappeared." She had filed a police report. Her previous drug screen was negative for hydrocodone. She brought her pills with her and she had 9 left over. Petitioner was complaining of a lot of discomfort in her low back and right lower extremity for which Dr.

Hussain had ordered an MRI. Her exam was limited to the low back. Dr. Rauther explained to Petitioner that the fact the pain medicine did not come up positive on the drug screen was a "big red flag" and very concerning. Since she filed a police report he was willing to excuse her. However, he advised her he would discharge her from care if there were any further discrepancies. He wished to see her in four weeks. (PX 2)

Dr. Rauther again examined Petitioner on December 22, 2015. At this visit she complained of low back pain and numbness in the lower extremity along with some right shoulder pain. The insurance company didn't approve the MRI without first attempting therapy for her back. That had been ordered and was to begin in January. Petitioner's low back was examined but not her shoulder. Her hydrocodone was refilled. (PX 2)

Petitioner presented to PA-C. McFarlin on January 7, 2016 regarding a complaint of left shoulder pain. Petitioner had been referred by Dr. Hussain[5]. She denied any injury but reported the pain had begun two months earlier. She described it as a burning sensation primarily located over the AC joint. Petitioner had been off work over the winter break and the pain had improved to some degree. Petitioner had a history of a similar problem on the right side for which she had undergone surgery. Petitioner reported some ongoing right shoulder pain but feeling much better since surgery. Petitioner also reported some back issues with radiation down her right leg. She was to begin physical therapy for that and was being treated by Dr. Rauther. She denied any numbness or tingling in her upper or lower extremities or neck pain. Petitioner reported taking hydrocodone for her chronic back pain. Petitioner was working as a cook for Respondent. Mr. McFarlin's impression was left shoulder acromioclavicular joint pain. He felt she should try some therapy for it. She was also given a cream to use. She did not want injections or surgery. He felt she could continue with the hydrocodone as needed. (PX 2)

Petitioner underwent a physical therapy evaluation on January 8, 2016 at the request of Dr. Hussain. Petitioner was complaining of chronic back pain which was causing difficulty walking, standing, and performing activities of daily living. Petitioner gave an onset date of August as she noticed back pain after work one day which had been progressing ever since. When lying on her right side, Petitioner would notice tingling in her buttocks, radiating down her leg. Petitioner reported problems getting in and out of a chair, difficulty with stairs, and problems lifting objects off the floor. Petitioner was working full duty for Respondent. She was to attend physical therapy two times a week for six weeks. (PX 2)

Dr. Rauther re-examined Petitioner on January 21, 2016. Her presenting complaints included bilateral shoulder pain and back pain with the left shoulder being more painful. Petitioner had undergone one consultation therapy session and one actual session with her right leg going completely numb after the actual therapy session. Her left shoulder and low back were examined. Dr. Rauther noted there wasn't so much tenderness on her right shoulder. Petitioner's hydrocodone was refilled. (PX 2)

[5] Don't believe Dr. Hussain's office note is in the record

Petitioner attended physical therapy on January 28, 2016 reporting she had been in the hospital for two days over the weekend secondary to chest pain. Petitioner reported back pain of "8/10" and that it only radiated when lying down. Petitioner further reported compliance with her home exercise program "when there's time." (PX 2)

Petitioner returned to therapy on February 9, 2016 due to chronic lower back pain. Petitioner reported her pain would "calm down" when she wasn't pushing/pulling at work. Petitioner wasn't taking her muscle relaxers due to the inability to take them when she really needed them. (PX 2)

The deposition of Carrie Anderson was taken on February 19, 2016. Ms. Anderson is the executive chef for Respondent's residential dining. She has held that position for 1 ½ years. Prior to that time Ms. Anderson was the production chef, a position she held for 12 years. Ms. Anderson testified that in 2013 she was a production chef and, as such, she was responsible for all administrative duties as they pertained to production of food in the kitchen. She was assigned to Ikenberry Commons. Ms. Anderson testified that there is one set of dorms, Nugent Hall, connected to Ikenberry. Ms. Anderson further testified that Ikenberry is a multi-venue location with seven different small restaurant concepts contained in the front and a main kitchen located in the back. She was responsible for all the restaurants and the kitchen and would supervise the storekeeper, head cook, cook, snack bar attendant, kitchen helper and food service laborer.

Ms. Anderson testified that Petitioner was a cook in 2013 and she had supervisory responsibility over Petitioner. Ms. Anderson testified that she could not recall if Petitioner ever described an acute injury to her which involved doing something as a cook and hearing her shoulder pop. She also could not recall if she filled out any type of accident or incident report for such an incident. (RX 1, pp. 1-7)

On cross-examination Ms. Anderson testified that she believed she probably oversaw about forty employees back in January of 2013. She did not recall what station or venue Petitioner was working at in January of 2013. She agreed there was a "Penne Lane" in 2013 and that Petitioner possibly worked there during that time. If she did, she would have been required to lift baskets of pasta and push carts; however, she would not be required to stir pasta in a pot if she was at the station. Ms. Anderson acknowledged that there were two 5 gallon kettles in Penne Lane and one might have contained a pasta sauce which would require stirring with a long-handled spoon or whisk. Ms. Anderson further acknowledged that Petitioner might have stirred the pasta sauce as a cook.

Ms. Anderson further acknowledged that she didn't know if Petitioner filled out incident or accident reports for February 24 or 27 of 2013. She did not know how much a basket of pasta would weigh but she didn't think it was 20 lbs. She felt they weighed under 5 lbs., if not 2 lbs.; however, that was just the weight of the basket. (RX 1, pp. 7-11)

The deposition of Keith Garrett was taken on May 24, 2016. (RX 2) Mr. Garrett is Respondent's food service administrator and has been so employed since November of 2002. As such, he oversees the whole dining hall, including 60 full-time employees and as many as 375 student workers. He has been assigned to Ikenberry since the summer of 2010. Mr. Garrett testified that Petitioner was one of the cooks at Ikenberry. He would have been responsible for Petitioner's work schedule which followed the academic calendar and included some "lay-off" periods such as Thanksgiving, winter break, spring break, and summer (mid-May to mid-August). (RX 2, pp. 1 – 6)

Mr. Garrett was shown Petitioner's accident report dated February 24, 2013 that concerned an accident date of January 24, 2013. He recalled Petitioner coming to him to fill out an accident report and that she claimed shoulder pain when something popped while working at "Penne Lane," the pasta destination in Ikenberry Dining Hall. Mr. Garrett testified that he didn't know about the alleged injury before Petitioner reported it on February 24, 2013. (RX 2, pp. 6-9)

Mr. Garrett testified that Respondent has a computerized timekeeping system called "Kronos" that requires employees to swipe their ID card through a machine to monitor time in and out. He identified deposition exhibit 2 as Petitioner's time records for January 20 – 26, 2013. According to it, Petitioner called in sick on January 24, 2013. He further identified deposition exhibit 3 as an accident report dated February 27, 2013, and dated three days after deposition exhibit #1 (the accident report dated February 24, 2013). Deposition exhibit 3 referenced an accident date of January 23, 2013, the day before Petitioner's originally claimed accident date of January 24, 2013. Mr. Garrett recalled that since her dates weren't correct Petitioner was asked to fill out another accident report. He further testified that on the 23rd Petitioner was not working at Ikenberry but she left the accident location as Ikenberry. According to her time records, Petitioner was working at Busey-Evans Hall. (RX 2, pp. 9-12, 17 - 19) Mr. Garrett testified that he didn't ask Petitioner to correct the second accident report even though he knew she wasn't working at Ikenberry on the 23rd. He could not explain why he didn't ask for a further correction testifying, "I believe I passed it on to our HR person." (RX 2, p. 20)

Mr. Garrett acknowledged that he did not witness an accident on January 23, 2013 involving Petitioner. He first learned of her alleged January 23, 2013 accident on February 24, 2013. He was also aware that Petitioner claimed a December 7, 2013 carpal tunnel injury. He first learned of that accident "right when she told him" as she filled out an accident report contemporaneously with the claimed accident. He testified that prior to December 7, 2013 Petitioner never complained to him about either of her hands. Mr. Garrett also testified that they could usually accommodate restrictions. He further identified deposition exhibit 4 as an Excel spreadsheet for employee time and that it showed days when Petitioner worked and didn't work. The time period in deposition exhibit 4 is for January 1, 2012 through November 19, 2015. Mr. Garrett believed that Petitioner began working for Respondent in 2000 or 2001 and that she had always worked as a cook. He did not work with Petitioner prior to Ikenberry. He believed Petitioner was formerly a cook at the Pennsylvania Avenue Residence Hall. (RX 2, pp.

12 – 17) Looking at deposition exhibit 2, Mr. Garrett testified that Petitioner worked full days at Ikenberry on January 20 and 21, 2013. On January 22, 2013 she was "OPP" which meant a work opportunity was attempted but they either couldn't get hold of her or she refused. She did accept six hours on the 23rd. (RX 2, pp. 19-20) Petitioner began working at Ikenberry on December 12, 2012. (RX 2, p. 21) Mr. Garrett testified that Petitioner would have been assigned different stations as a cook based on her restrictions. He testified that she had restrictions in December of 2012 and would have been told not to lift over 15 lbs. He believed her restrictions were related to her shoulder but he didn't know which shoulder. He further testified that the foregoing testimony was to the best of his knowledge as he would really need to review her file and dig through it. Mr. Garrett further testified that Petitioner could have been making soup or working in "Penne Lane" during that time frame. He believed baskets of pasta could weigh up to 25 lbs. Mr. Garrett also testified that Petitioner was always instructed not to "lift out" due to her restriction as there would have been a cook in the next station who could handle that for her. (RX 2, pp. 22-23)

Mr. Garrett testified that he had no independent recollection of any shoulder injury or accident prior to February of 2013 but they might be in her file if there were any. (RX 2, p. 23)

Petitioner's case proceeded to arbitration on June 8, 2016. The disputed issues were accident, causal connection, medical bills, temporary total disability, and nature and extent. Petitioner was the sole witness testifying at the hearing.

Petitioner testified that she started working for Respondent in February of 2001 as a cook. It was her job to prepare food for the students. Petitioner testified that she worked at Ikenberry Dining Hall.

Petitioner testified that she sought treatment with Dr. Kaplan at Carle on January 24, 2013 and that she was complaining of right shoulder pain. She acknowledged giving Dr. Kaplan a history of doing a lot of stirring at work and some lifting at work and it was causing right shoulder pain. Petitioner denied any problems, treatment or work restrictions with regard to her right shoulder prior to January 24, 2013.

When asked to describe the work activities that she was performing in January of 2013 which required her to seek treatment with Dr. Kaplan, Petitioner testified that she was cooking pasta and preheating pasta in a machine that was chest level. She would preheat it, pull it back out of the water, and put it in a pan. She estimated that a basket of pasta weighed 15 to 20 lbs. and she would engage in that activity 5 or 6 times per hour. Petitioner worked an eight hour day for Respondent.

Petitioner testified that Dr. Kaplan took her off work as of January 14, 2013. Thereafter, she continued to follow up at Carle for her right shoulder. She filled out an injury report on February 24, 2013 and included an accident date of January 24, 2013 because her supervisor, Carrie Anderson, had told her to use that date. Petitioner also testified that she returned to Dr.

Kaplan on February 26, 2013 and he put her on light duty/modified duty at that time. Petitioner further testified that she provided her work restrictions to Respondent and it did not accommodate her restrictions at that time.

Petitioner testified that on April 15, 2013 she spoke with "Trish" about going back to work with restrictions and she did so on April 22, 2013.

Petitioner further testified that she began treating with James Berkes at Carle in March of 2013 for right hand complaints and she underwent an EMG on May 8, 2013 which was normal. Thereafter she continued to treat for her right shoulder, underwent an MRI and physical therapy and was eventually referred to Dr. Zeman who injected her right shoulder in August of 2013. As of December 4, 2013 Dr. Zeman had issued permanent restrictions for Petitioner's right shoulder and arm and Respondent accommodated those restrictions.

Petitioner testified that she went to the emergency room on December 7, 2013 complaining of right hand pain and intermittent numbness up into her forearm. She testified that when she cooked for vegetables she had to use a big "tilt skilled" and as she would "dip it out doing the wrist motion back and forth," the handle would hit her hand for some reason and she would get a sharp electric pain from her hand to her elbow. Petitioner estimated she would go through, at least, six cases of vegetables an hour and engaging in that activity at least 10 to 15 times per hour. Petitioner reported the problem to Charlie and Stacie on December 7, 2013 and completed an accident report on December 8, 2013.

Petitioner testified that she underwent right wrist and elbow surgery on January 17, 2014 and that she was taken off of work at that time. Thereafter, she underwent physical therapy and was eventually released from care on May 28, 2014.

Petitioner testified that while treating for her right wrist and hand she continued treating for her right shoulder with Dr. Zeman. She also testified that Dr. Zeman referred her to Dr. Bane and that Dr. Bane took her of work as of June 16, 2014. Petitioner underwent right shoulder surgery on August 5, 2014 followed by physical therapy. She was subsequently referred to Dr. Rauther for pain management.

Petitioner testified that as of July 23, 2015 she was to refrain from lifting more than 15 lbs. and not perform any overhead work. She continues to work for Respondent as a cook and Respondent is accommodating her restrictions.

Petitioner testified that her bills have been paid by her group insurance or Medicaid. She further testified to some out-of-pocket expenses.

Petitioner acknowledged being sent to Dr. Coe by her attorney. She testified to telling him about her work duties and that her description was similar to what she testified to during the hearing.

Petitioner testified that she continues to see Dr. Rauther for pain management on a monthly basis. Dr. Rauther is providing pain management for Petitioner's low back, left hip, and right shoulder. Dr. Rauther has continued to prescribe Hydrocodone for pain management purposes. (PX 2)

Petitioner testified that she continues to experience occasional numbness and a burning sensation in her right shoulder with work activities and activities of daily living. She no longer is able to participate in her family bowling night because of the pain in her right shoulder. Petitioner further testified that she can't keep her right hand above her head for longer than ten minutes because it becomes too painful. This has limited her in her ability to style her hair. She continues to take the Norco that Dr. Rauther has recommended.

On cross-examination Petitioner acknowledged filling out an accident report with Keith Garrett and that there was some confusion regarding the accident date but that January 24, 2013 was the date of a doctor's appointment. Petitioner clarified that she hurt her shoulder on January 23rd and went to the doctor on January 24th. She also acknowledged that she was doing something with pasta when she felt a pop in her shoulder. When asked if that was when her pain began, Petitioner disagreed, explaining that she had been noticing pain and had been telling "them" about it but she thought it would go away and it didn't. Petitioner agreed that it was the popping that made her go to the doctor. She also acknowledged that it occurred while working at "Penne Lane" in Ikenberry.

Petitioner also testified that she only works when the students are in school. Generally, her job ends sometime in May and resumes again in August. She is also off during Christmas for about a month.

Petitioner denied any treatment for carpal tunnel syndrome in the past.

On redirect examination, Petitioner testified that she had been experiencing right shoulder pain for a few weeks before January 23, 2013 and that she noted it while working the pasta station.

The Arbitrator concludes:

C: Did an accident occur on December 7, 2013 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?

Petitioner failed to prove she sustained an accident on December 7, 2013 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being in her right hand/wrist and elbow was causally related to her accident or her work duties for Respondent. In so concluding the Arbitrator notes that she was not persuaded by the

opinion of Dr. Coe, Petitioner's examining physician. Furthermore, Petitioner was not an altogether credible witness.

In a repetitive trauma case, a claimant must show that the performance of her work involves constant or repetitive activity that gradually causes deterioration of an 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." There is no requirement that a petitioner must spend a certain amount of each day on a specific task before a finding of repetitive trauma be shown. *Edward Hines Precision Components v. Industrial Comm'n*, 365 Ill.App. 3d 186, 292 Ill. Dec. 185, 193-94 (Ill. App. Ct. 2005). It is axiomatic that the unique facts of each case must be closely scrutinized. Furthermore, the causation issue in repetitive trauma cases generally requires persuasive and well-informed opinions from medical experts.

Petitioner relies upon the opinion of Dr. Coe to support her claim herein. However, Dr. Coe did not have an accurate and complete understanding of Petitioner's job, job duties and history with Respondent, and/or Petitioner's history of medical care and treatment. He only examined her one time and at the request of Petitioner's attorneys. None of Petitioner's treating physicians were deposed or rendered causation opinions regarding Petitioner's carpal and cubital tunnel syndromes.

Dr. Coe assumed that Petitioner worked a forty hour week for the entire time she had worked for Respondent. That was incorrect. At a minimum, he did not consider the fact that Petitioner did not work for most of 2012 and that she had a significant amount of time in 2013 when she didn't work or worked restricted duty. While Dr. Coe noted that Petitioner associated her upper extremity complaints with her work duties associated with the vegetables he never explained how those activities/activity caused/aggravated her elbow, wrist and hand. His causation opinion is very generic with no detailed explanation or basis contained within his report. His opinion was more focused on her pasta duties then the "dipping" of vegetables. He did not review any records from Dr. Rauther or records from Dr. Sessions or PA Savage. His discussion of the medical records was limited to portions of the records that would support Petitioner's claim with no discussion or consideration of inconsistent histories or prior treatment. He did not address the therapy notes of March of 2013 in which Petitioner reported numbness and tingling when lifting things, performing housework and picking up her grandchild. While he did mention Petitioner's visit with PA-C. Berkes in March of 2013 at which time she was diagnosed with both right carpal tunnel syndrome and cubital tunnel syndrome, he failed to address the fact that Petitioner never attributed her complaints and symptoms to her work duties at that time.

Furthermore, when Petitioner presented to the emergency room at Carle on December 7, 2013 she gave an onset of two hours earlier which hardly seems consistent with a repetitive trauma theory which is generally based upon a gradual onset of symptoms over time.

Dr. Hauter noted in his Section 12 report that Petitioner's numbness and tingling in the right hand was attributed to carpal tunnel and cubital tunnel syndrome, but the diagnostic testing was negative. (RX 3) Even after her surgery, her symptoms continued. (RX 3) Further, Dr. Hauter opined that her job does not include ergonomically hazardous activity at levels known to cause carpal tunnel syndrome, and that this problem is not caused or aggravated by her work for Respondent. (RX 3) These opinions comport with the medical records indicating that Petitioner has had long-standing right hand complaints. Petitioner also suffers from fibromyalgia and diabetes. A history of diabetic neuropathy as well as left-sided hand/wrist complaints are sprinkled throughout the medical records but never addressed by Dr. Coe.

As an additional reason for denying Petitioner's claim, the Arbitrator finds that Petitioner was not an altogether credible witness.

Petitioner's credibility was undermined by her testimony regarding prior treatment to her hand/wrist. Petitioner testified that she had never been treated for carpal tunnel syndrome in the past. She further testified that she had never been diagnosed with carpal tunnel syndrome prior to December 7, 2013. However, the medical records contradict this testimony. Petitioner had undergone right wrist surgery prior to January of 2013 when Dr. Sobeski diagnosed her with ECU tendonitis. Petitioner presented to PA-C. Berkes on March 4, 2013 with complaints of numbness and tingling in her right hand. At that time Petitioner advised Petitioner that she probably had carpal tunnel and cubital tunnel syndrome on the right side. She was given splints and elbow pads to wear. Petitioner did not attribute these symptoms to her job. Rather, she stated she would wake up at night with numbness and tingling. Petitioner returned to see PA-C. Berkes in May of 2013 with ongoing complaints. Again, she made no mention of work duties or any problems attendant to those duties. She was referred for an EMG which was normal. Petitioner then returned to PA-C Berkes and indicated she wished to do nothing further about her symptoms. Petitioner attended therapy in the summer of 2013. While she reported right-sided wrist and elbow complaints she did not associate them with her shoulder injury (the subject of a companion claim) or her job duties for Respondent. Therapists and doctors would question whether her symptoms had a cervical component. Contrary to her testimony and her representation to Carle physicians on December 7, 2013 Petitioner had a history of right carpal tunnel syndrome.

Petitioner's credibility was further dampened by her representations to doctors and therapists about Respondent's ability to accommodate her work restrictions. Petitioner misrepresented her employment status to Dr. Bane, stating she had been terminated. Even more striking was her misrepresentation to Dr. Li and therapists that Respondent would not let her work with restrictions. Dr. Li's office note documents Respondent's efforts to correct this inaccuracy. While Petitioner testified to speaking with "Trish" in April of 2015 about returning to work her testimony was a little misleading given the doctor's documentation of what was really going on.

Based upon her review of the medical records, this Arbitrator found repeated efforts on Petitioner's part to try and remain off work as long as possible. Petitioner would tell doctors she

wasn't ready to return to work and request off work slips despite evidence to the contrary. Additionally, as noted above, she misrepresented Respondent's ability to accommodate restrictions so that she could be off work. The Arbitrator also noted a tendency on Petitioner's part to initiate treatment for another body part when nearing completion of treatment for a current one. For example, in late 2013 when she was being returned to work for her shoulder, she then presented for treatment to her hand and wrist. Once that was nearing resolution of treatment, she resumed care for her right shoulder. As her right shoulder treatment lessened, she began having issues with her feet, then her back, and then her left shoulder. Again, all of this suggests a possible desire to keep from having to go back to work as a cook. The Arbitrator also found Petitioner's pattern of seeing one doctor for right shoulder complaints and another doctor for upper extremity complaints concerning, especially in light of repeatedly expressed opinions of doctors and therapists that she might have a cervical problem.

For the reasons set forth above, the Arbitrator concludes that Petitioner failed to prove she sustained an accident on December 7, 2013 that arose out of and in the course of her employment with Respondent or that Petitioner's current condition of ill-being in her right wrist/hand and elbow is causally related to her employment or her accident.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

Michael Roach,

Petitioner,

vs. NO: 14WC 10779

City of Anna,

17IWCC0400

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 choice of physician, 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 14, 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.

17IWCC0400

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: JUN 27 2017
MJB/bm
o-6/20/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

ROACH, MICHAEL
Employee/Petitioner

Case# **14WC010779**

15WC021348

CITY OF ANNA
Employer/Respondent

17IWCC0400

On 6/14/2016, 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 0.40% 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

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MICHAEL ROACH
Employee/Petitioner

v.

CITY OF ANNA
Employer/Respondent

Case # 14 WC 10779

Consolidated cases: 15 WC 21348

17IWCC0400

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin** in Williamson County on May 13, 2015, and concluded in **Springfield**, Sangamon County on **March 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 **Choice of Physician**

17IWCC0400

FINDINGS

On the date of accident, **October 21, 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 **$28,400.00**; the average weekly wage was **$860.62**.

On the date of accident, Petitioner was **33** 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 **$26,565.41** for TTD, $- for TPD, $- for maintenance, and **$2,000.00** for other benefits (permanency advance), for a total **current** credit of **$26,565.41**. (See below regarding permanency).

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

ORDER

Respondent shall pay reasonable and necessary medical services of **$391,756.78**, as provided in § 8(a) and § 8.2 of the Act.

Respondent shall have credit for any amounts previously paid and shall indemnify and hold Petitioner harmless from claims made by any health providers arising from the expenses for which it claims credit. Respondent shall authorize and pay for the treatment recommended by Dr. Mall.

Respondent shall pay Petitioner temporary total disability benefits of $573.75/week for **62 1/7** weeks, as provided in Section 8(b) of the Act, less its credit for the $26,565.41 in TTD benefits already paid. The Arbitrator finds it premature to address permanency and holds the issue of credit for prepaid permanency in abeyance.

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.

Edward Lee
Signature of Arbitrator

6/5/16
Date

ICArbDec19(b)

JUN 14 2016

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL ROACH
Employee/Petitioner

v.

CITY OF ANNA
Employer/Respondent

Case # 14 WC 10779
15 WC 21348

17IWCC0400

MEMORANDUM OF DECISION OF ARBITRATOR

PREFACE

Petitioner's injury on October 21, 2013, bearing claim number **14 WC 10779**, initially came before the Arbitrator for hearing on May 13, 2015, on Petitioner's § 19(b) Petition, with disputed issues of causal connection, medical benefits, and temporary total disability benefits. (T.4, 11 [5/13/15]) After direct examination of Petitioner, an off-the-record discussion was held and the Parties agreed to continue the matter. (T.24, 25 [5/13/15]) However, Petitioner thereafter sustained an additional accident on June 1, 2015, bearing claim number **15 WC 21348**, against which Respondent disputes accident, notice, causal connection, reasonableness and necessity of medical charges, prospective medical care, and choice of physician. (T.6-7 [3/29/16]) Both matters were consolidated and preceded to hearing before the Arbitrator on March 29, 2016. (T.4-6 [3/29/16]). In the interest of clarity, a single summary of facts is warranted; however, the Arbitrator will render separate conclusions of law.

FACTS

Petitioner has been an assistant operator/general laborer for Respondent, the City of Anna, for over 15 years. (T.10 [5/13/15]) Petitioner testified that he routinely climbs ladders, moves manholes and installs/moves pumps and motors. (T.10, 11 [5/13/15]) The Parties stipulated that Petitioner sustained accidental injuries arising out of and in the course his employment as a general laborer on October 21, 2013, while climbing down a 13 foot ladder made of rungs affixed to a digester tank after checking the sludge level on top of the tank. (T.11 [5/13/15]) Petitioner testified that the he was two to three rungs down or 8 or 9 feet in the air when the welding on the rung he was stepping on "broke clean in two." (T.11-12 [5/13/15]) Petitioner described his fall:

> . . . The next thing I know I went down, hit my head, caught myself a couple different times, Long story short, before I hit the ground, I caught myself with my arms and legs. I was about knocked out. I had a boss and a co-worker standing there, and when I got up from the ground, I just remember walking with the rung, and they said I was going that way, and they were this way. (T.11-12 [5/13/15])

He later explained:

> Well, as I said, our chest is against the rung. I just stepped on the ladder and I came straight down and I hit my head underneath my jaw here, and I really – I can't tell you everything that happened – it's between two walls, and when I went back I caught myself, I fell again, I caught myself with my legs and arms. It's hard to explain when I got off, up off the ground I picked up the rung that was broke in two and I was walking staggering and I had two co-workers, one boss who grabbed ahold of me because I was light-headed and pretty out of it. (T.54 [3/29/16]).

Petitioner testified that shortly thereafter he began "feeling like [he] was in a car wreck" and went to the emergency room. (T.12-13 [5/13/15]) Respondent disputes causal connection with respect to Petitioner's cervical spine/hands/arms, past and prospective medical benefits related to treatment of the cervical spine/hands/arms, temporary total disability benefits, and choice of physician. (T.4-6 [3/29/16]) Petitioner stipulated that Respondent is entitled to credit for payments made under § 8(j) and $2,000.00 paid as an advance toward permanency. *Id.* Respondent also paid $26,565.41 in TTD benefits. (AX1) Petitioner testified to no prior workers compensation claims for injury to his shoulder, neck, arms, elbows, or any other part of his body. (T.14 [5/13/15]) Petitioner testified that outside of occasional chiropractic treatment for his shoulder or neck, he had no significant injury or treatment to his shoulder or neck. (T.14-15 [5/13/15]).

Bilateral Shoulder and Cervical Spine Treatment

Petitioner presented to Union County Hospital on October 23, 2013, where the precipitating cause of injury was noted as "fell from ladder" and later as "fall injury – neck and back." (PX3) The Union County Hospital records also note that Petitioner caught himself on the way down and was experiencing significant soreness. *Id.* Petitioner was noted to have contusions to his right arm, right leg, right foot, neck and reported pain throughout the entire right side of his body as well as bilateral mid and low back pain, neck pain, and posterior chest pain. *Id.* The triage assessment noted that Petitioner's general appearance demonstrated discomfort. *Id.* Petitioner was discharged with instructions to follow up with a "private physician" for "continuance of care." *Id.*

Petitioner followed his discharge instructions and reported to Dr. Connie High at High Chiropractic Center and reported a pain level of 6 to 7 on a scale of 10. (PX4) Records document hypertonicity and stiffness throughout Petitioner's neck, trapezius muscles, and his upper/mid/lower back, and Dr. High managed these complaints conservatively. *Id.* However,

when Petitioner's complaints did not improve, Petitioner testified Dr. High referred him to his family physician, Dr. Cerny, for additional treatment. (T.16 [5/13/15]).

Petitioner saw Dr. Cerny on January 14, 2014. (PX5, 1/14/14) Dr. Cerny noted that when Petitioner caught himself he experienced a "whiplash effect," and that Petitioner managed his complaints conservatively with Dr. High after being seen in the emergency room. *Id.* Although Petitioner denied neck pain on that visit, it was noting that he was managing his complaints with over-the-counter medication. *Id.* Petitioner reported worsening bilateral shoulder pain radiating down his arm. *Id.* Dr. Cerny's assessment was impingement shoulder syndrome and rotator cuff tendonitis versus rotator cuff tear of the left shoulder, and he recommended an MRI. *Id.* Petitioner's MRI of January 22, 2014, revealed moderate supraspinatus injury and tendinopathy with high-grade rim rent tear with possible full-thickness tearing, as well as tendinopathy of the infraspinatus and subscapularis with tearing of the subscapularis. (PX6) Dr. Cerny administered a left shoulder steroid injection, after which Petitioner reported some improvement. (PX5, 2/4/14) Although Petitioner was still in pain, he continued to work and moderated his pain with medication. *Id.* However, since Petitioner did not wish to rely on pain medication on a long-term basis, Dr. Cerny recommended that Petitioner see an orthopedist. *Id.*

Petitioner came under the care of Dr. Nathan Mall on February 26, 2014. (PX7, 2/26/14) Dr. Mall took the history of Petitioner's injury as follows:

> Mr. Roach is a gentleman who works for the City of Anna, IL and on October 21, 2013 he was on a ladder and the rung of the ladder broke and he was hanging by both arms and banged his head and cheek up against the ladder causing significant jaw and neck pain as well. He did report the injury a couple of days later. He had hoped that he would be able to just allow the pain to dissipate over time. He finally went to the doctor when he could not sleep at night. He went to his family doctor who did an injection which did improve his pain 80% to 90%, however, he did not do any physical therapy after that. His pain has returned in his bilateral shoulders, left side more than right side. He also has pain over the lateral epicondyle of both elbows with difficulty gripping objects. He describes a loss of range of motion and sharp pain with certain types of movement, especially difficulty with overhead lifting and difficulty sleeping and any movements out away from his body. He does have some pain down his biceps as well but the majority of his pain is in the posterolateral distribution. Again, the left side is worse than the right side. *Id.*

Both of Petitioner's shoulders demonstrated limited range of motion on physical examination and several positive orthopedic tests. *Id.* Dr. Mall also noted limited range of motion and tenderness to palpation along Petitioner's cervical spine along with positive Spurling's maneuver producing radiating discomfort down into the shoulders. *Id.* Dr. Mall reviewed Petitioner's MRI films showing a very high grade if not a full thickness rotator cuff tear of the left shoulder. *Id.* Based on his clinical assessment, Dr. Mall believed that Petitioner suffered a right shoulder

rotator cuff tear as well. *Id.* He also diagnosed biceps tendinitis and cervical spine pain. *Id.* He recommended an MRI of Petitioner's neck and right shoulder and stated:

> In terms of the neck, I think that an MRI would be warranted of his neck to assess for any evidence of disc herniation that could have occurred given the mechanism of injury that he describes in terms of the whiplash type of motion that occurred with banging his head against the rungs of the ladder. Clearly, someone at his age of 33 should not have rotator cuff disease as prevalent as he does in the left shoulder; therefore, I do believe that this work related injury did cause the rotator cuff pathology present as well as causing his symptoms associated with this. I think that because this is not a retracted full thickness rotator cuff tear that we should still try to treat this conservatively at first and that would entail a cortisone injection into the left shoulder and physical therapy. This was performed today in the office into both shoulders combined with a physical therapy prescription for both shoulders and both lateral epicondyles. This will consist of rotator cuff strengthening and subscapular strengthening as well as eccentric wrist extension strengthening. I will see him back in approximately four weeks. At that point, we will get an MRI of his right shoulder and of his neck to evaluate these areas as well. If he does not get any better with the left shoulder with these modalities then I do think a surgery would be likely necessary given the amount of pathology present in his rotator cuff. My hope is that this will respond well though and we should have a good idea at four weeks from now whether or not he is as least getting some improvement with this. Following the injection today, however, he did get good benefit from the cortisone injection today with at least 75% to 80% relief of his rotator cuff pain. He continued to have positive O'Brien's test which would be expected given the fact that he also has some biceps tendinitis issues that would not be addressed by the subacromial injection. *Id.*

Petitioner's MRIs were completed at MRI Partners of Chesterfield and showed disc bulging from C2-3 through C5-6 with central spinal canal stenosis at C3-4. (PX9) The MRI of Petitioner's right shoulder demonstrated distal supraspinatus tendinosis with an intrasubstance tear in the tendon insertion. *Id.*

Petitioner returned to Dr. Mall on March 24, 2014, following the MRIs of his right shoulder and cervical spine. (PX7, 3/24/14) The MRI of his right shoulder demonstrated a very high grade partial internal rotator cuff tear of at least 60% to 70% of the cuff fibers, and the MRI of his cervical spine demonstrated mostly central disc herniation at C2-3 and C3-4 with disc disease at C2 through C6. (PX7, 3/24/14) Dr. Mall believed that the cervical spine herniations were contributing to the headaches Petitioner was experiencing and referred Petitioner to Dr. Gornet. *Id.* He also Although Petitioner temporarily experienced improvement following his left shoulder injection, his pain returned rather quickly. *Id.* Since conservative treatment failed to improve Petitioner's condition, Dr. Mall recommended a left shoulder arthroscopy and rotator cuff repair with biceps tenodesis, continued physical therapy for Petitioner's right shoulder, and restricted Petitioner's work activity to no repetitive use of the upper extremities, no overhead reaching, no pushing or pulling over 15 pounds. no lifting over 5 pounds overhead or above chest, no lifting

more than 15 pounds from floor to waist or chest level, and restricted Petitioner primarily one-handed work with the most injured extremity assisting on light tasks. *Id.* He again opined that Petitioner's shoulder injuries occurred when he was "hanging from the ladder" as this was "known mechanism for rotator cuff injury." *Id.* He noted that Petitioner was only "33 years old and therefore should have a pristine looking rotator cuff and should not have the degree of partial thickness tearing that he has in the right or the left shoulder." *Id.* On April 24, 2014, Dr. Mall performed the recommended surgery. (PX7, 4/24/14) Petitioner was much improved following surgery and was referred for post-operative physical therapy. (PX7, 5/5/14).

Petitioner also saw Dr. Gornet on referral on May 5, 2014, with complaints of neck pain with headaches, pain into both the left and right trapezius, and pain between the shoulder blades. (PX11, 5/5/14) Petitioner's pain diagram in his intake form also indicates that Petitioner was experiencing numbness into his right and left hands and aching, burning and stabbing pain in his back. *Id.* He noted that Petitioner's problem began on October 21, 2013, when a ladder rung broke causing Petitioner to fall and strike his chin on one of the rungs, hyperextend his neck, and injure his shoulders and arms. *Id.* Petitioner candidly advised Dr. Gornet of his history of chiropractic care and brought the records of Dr. High with him. *Id.* Dr. Gornet noted that these were routine visits for non-significant issues. *Id.* He further noted that a significant amount of time had elapsed since Petitioner's last chiropractic visit prior to the injury, and that Petitioner required no prior cervical MRI. *Id.*

Dr. Gornet reviewed the cervical MRI of March 24, 2014, demonstrating an obvious central herniation at C3-4 extending out into the foramen on the left and a protrusion at C2-3. *Id.* Dr. Gornet noted that from his review of Dr. Mall's records, both he and Dr. Mall agreed that Petitioner's C3-4 herniation was abutting up to the spinal cord. *Id.* Dr. Gornet believed that Petitioner's C2-3 and C3-4 disc injuries were the result of the October 21, 2013 accident and recommended referral back to Dr. High for continued chiropractic care for an additional 6 weeks. *Id.* He believed that Petitioner remained temporarily and totally disabled. *Id.*

On July 7, 2014, Dr. Mall noted that Petitioner's left shoulder continued to be much improved, but he still suffered substantial right shoulder and neck pain and was under the care of Dr. Gornet for his neck complaints. (PX7, 7/7/14; PX10) Dr. Mall administered a cortisone injection into Petitioner's right shoulder to alleviate his right shoulder symptoms, after which Petitioner experienced immediate relief of his symptoms. *Id.* Dr. Mall performed O'Brien's testing after the injection, which was negative, and confirmed that Petitioner's right shoulder superior labral injury was the source of Petitioner's right shoulder complaints. *Id.* Petitioner, however, continued to experience symptoms related to his neck after the injection. *Id.*

Petitioner also returned to Dr. Gornet on July 7th, who noted consistent with Dr. Mall that Petitioner continued to have significant neck pain, headaches, pain to the base of his neck, pain between his shoulder blades, as well as paresthesias down into his hands. (PX11, 7/7/14) He again reviewed Petitioner's condition and postulated a current working diagnosis of structural

injury to the disc and disc mechanism at C3-4 with smaller protrusions at C2-3 and C4-5. Although Petitioner was also experiencing low back pain, this was "on hold" as Petitioner's neck was considered the "primary source of his pain." *Id.* Dr. Gornet requested approval for further conservative and chiropractic care, but this was denied by Respondent. *Id.* Dr. Gornet referred Petitioner to Dr. Granberg for injections at C3-4 and C4-5 and noted his continued belief that Petitioner's symptoms and need for treatment were related to the work injury of October 21, 2013. *Id.* Petitioner remained unable to work. *Id.*

On August 21, 2014, Dr. Mall performed a right shoulder superior labral repair with debridement, subacromial decompression and acromioplasty and open biceps tenodesis. (PX7, 8/21/14; PX10) During his post-operative visit on September 5, 2014, Dr. Mall noted, "Michael ***still*** (emphasis added) is complaining of significant numbness into his fingers. I think that this is related to his neck issues that are currently being addressed by Dr. Matthew Gornet. These seem to be worsening for him." (PX7, 8/21/14) Petitioner's left shoulder had good range of motion, but still demonstrated weakness. *Id.* Dr. Gornet saw Petitioner on September 11, 2014, and noted that Petitioner continued to have severe neck pain and headaches with tingling in his fingers. (PX11, 9/11/14) He noted that Petitioner tried and failed conservative measures including injections and therapy. *Id.* At this point, Petitioner's only option was to have the structural problem in his neck surgically addressed with disc replacement. *Id.* Petitioner remained unable to work. *Id.*

Respondent sent Petitioner to Dr. James Stiehl for an independent medical evaluation on September 10, 2014, who noted Petitioner's history of shoulder pain and his complaints of headaches, neck and low back pain, and numbness in the arms and legs. (RX5) He also reviewed Petitioner's records and believed that both Petitioner's cervical and shoulder MRI scans were "inconclusive as to abnormality." *Id.* He stated, "I believe that those scans were normal." *Id.* Dr. Stiehl also asked Petitioner as to why he waited for treatment of his shoulder and Petitioner's response was that he was "stoic and stubborn trying to work as long as he could." *Id.* Dr. Stiehl's assessment was that Petitioner suffered a "modest injury to his neck and possibly his lower back with a strain or contusion of the right side of his body . . ." *Id.* He characterized all of Petitioner's injuries as minor; however he admitted, "I do not have the operative reports and therefore could not attest to any other apparent pathology in either shoulder at this time." *Id.* He concluded, however, that Petitioner would have reached maximum medical improvement following the October 21, 2013 accident within two months. *Id.*

On October 3, 2014, Petitioner continued to report improvement from his shoulder surgeries despite the persistent weakness in his bilateral shoulders. (PX7, 10/3/14) Dr. Mall's physical examination demonstrated good range of motion despite lack of physical therapy due to Respondent's withholding approval for same. *Id.* Dr. Mall continued to recommend physical therapy. *Id.* Dr. Mall also reviewed Dr. Stiehl's independent medical review and noted the following:

Mr. Roach did bring his Independent Medical Evaluation performed by Dr. James Stiehl today and was asking some questions about this. Therefore, I did review this with him in the office. When reviewing Dr. Stiehl's Independent Medical Evaluation, the most glaring issue with this is that he clearly states that he has not seen the operative reports nor the operative photographs, and his impressions were made without these. Going through this page by page, on the first page, Dr. Stiehl states that he reviewed the MRI scan of the left shoulder and thought that this was normal. This contradicts both what the radiologist describes as well as the findings seen at surgery which more correlated with the radiologist's findings. The radiologist found that there was a moderate supraspinatus tendinopathy with a high-grade remnant tear indicating potential full-thickness tearing. The degenerative changes of the acromioclavicular joint are always present in the shoulder past the age of approximately 25 to 30 as the intra-articular disc present between the clavicle and the acromion degenerates at this age, or even sometimes younger. Again, the radiologist found that the MRI was not normal and the operative findings demonstrated similar abnormalities with a basically full-thickness rotator cuff tear at the supraspinatus and significant synovitis throughout the shoulder. There was bicipital tendonitis as well based on examination and evidence of severe redness along the biceps from the bicipital groove area.

On page two, Dr. Stiehl also mentions that he feels the cervical spine MRI was normal. However, I would suggest that multilevel disc bulges with almost complete loss of space for the cord at C3-4 is not a normal findings for a 34-year-old male. I certainly hope that my cervical spine does not look like this, and I would definitely suggest that this is not a normal finding. This is also not only my review of the scans but also on the radiologist's review of the scans as well as Dr. Matthew Gornet's review of the scans. Later, on that same page, Dr. Stiehl mentions that the patient has chronic neck pain and soreness with chronic headaches, and he makes mention of his medications, including OxyContin and Percocet. The patient does not take these on a daily basis. These were prescribed to him postoperatively, and OxyContin is only for three to four days after the surgery, and Percocet is stopped at two weeks following the surgery, and a lighter narcotic is provided.

On page three, Dr. Stiehl mentions that I, in my 7/7/14 note, mention that his O'Brien's test was normal. I want to make sure this is clarified that this is after the injection. This is part of the injection as I feel this is partly diagnostic in that I give the injection and then re-examine the patient afterward, and if their pain and symptoms go away, then clearly, the source of their symptoms was within the anatomical space that we injected. This was following an injection into the shoulder joint indicating this was an intra-articular anatomical structure, and if the pain and symptoms are not coming from the joint itself, these would not be relieved with the injection.

On page five, on question number two, Dr. Stiehl mentions that I have performed surgery for rotator cuff tendonitis and impingement syndrome. I do not think that

impingement syndrome was used in either one of my operative reports. The patient had a full-thickness rotator cuff tear. In a 34-year-old, this does not come from subacromial impingement. The tear is on the articular side, which is an indication of a non-impingement type of lesion. Impingement lesions are bursal-sided tears. Therefore, impingement is not the cause of his problem. The patient had a fall in which his arms were outstretched trying to catch himself. This is a classic mechanism of injury for both superior labral tears and for rotator cuff injuries. He then goes on to say the apparent pathology of the biceps tendon or the labrum of either shoulder is modest, if any. Again, Dr. Stiehl is at a disadvantage with forming his report in that he has not seen the operative photographs or read the operative notes; however, there was clearly a superior labral tear on the right shoulder, and the left shoulder had substantial biceps tendonitis that was noted both on physical examination and intraoperative findings of substantial redness along the biceps tendon itself, which is not a normal finding. In response to number three, I asked Mr. Roach why it was that he did not seek medical treatment for his shoulder immediately other than his emergency room complaint of right shoulder pain. He stated this occurred in the winter months, and at his work, they are not really doing much in the winter. He thought it would get better over time, and when it did not get better is when he decided to seek treatment for his shoulder. I explained to Mr. Roach this is a very common presentation amongst patients. I treat mostly private health insurance patients, and this is a very common scenario in which patient shave an injury three to four months prior to their presentation, however, they try to manage without it. I even had a patient with a massive rotator cuff tear that could not lift his arm up overhead, and the only reason that I was able to get him in and fixed at the two-month mark was because he came in with his son for another problem and just happened to mention it and stated that he was not planning on doing anything for another month if it had not gotten better at that point. Therefore, this is not an uncommon scenario, and again, I do not think it hurts this case in any way. *Id.*

When Petitioner returned to Dr. Mall on November 10, 2014, he continued to report bilateral elbow pain over the lateral epicondyles and some soreness in the superior aspect of the right shoulder and posterior aspect of his left shoulder, although this was much improved after surgery. (PX7, 11/10/14) Dr. Mall continued to recommend physical therapy and noted his belief that the majority of Petitioner remaining shoulder complaints were related to his cervical spine. *Id.* Petitioner also saw Dr. Gornet on the same day, who noted that he also believed that Petitioner's neck pain and headaches were discogenic in nature. *Id.* He noted that Petitioner's disc herniations were best seen on image #10 at C3-4 and C4-5. *Id.* He requested a new MRI and a CT myelogram to better visualize Petitioner's injuries prior to surgery, and to determine if perhaps Petitioner could "get by" with only having disc replacement at C3-4." *Id.* Dr. Gornet modified Petitioner's work status, placing him on a 20 pound limit with no overhead work, no repetitive bending or lifting, and instructions to alternate between sitting and standing. *Id.*

Respondent took the deposition of Dr. Stiehl on December 15, 2014, who noted that although Petitioner had some past chiropractic care and a motor vehicle accident in February of 2000,

there were no "obvious injuries there." (RX4, p.14) He again stated his belief that Petitioner sustained only soft tissue injuries from his fall. *Id.* at 18. He did acknowledge, however, that "he had, at the time of his original injury, complaints to his neck and back." *Id.* at 18. Yet, he assumed that the "MRI scans were probably normal" at that time because Petitioner had no fractures and Petitioner had a prior history of chiropractic care. *Id.* at 18. So his conclusion was that Petitioner "probably had a relatively minor injury that would have resolved fairly quickly" and he held to his belief that Petitioner would have reached maximum medical improvement two months after his injury. *Id.* at 18-19.

Dr. Stiehl testified on cross-examination that he performs 6 to 8 independent medical evaluations, all of which are performed for respondents, insurance companies, or employers, and 1 to 2 depositions per week, although 3 depositions for employers were scheduled during the week Respondent took his deposition in the instant matter. *Id.* at 21-23. Dr. Stiehl testified on cross-examination that he was unaware of any shoulder problems before the October 21, 2013 accident:

> Q. . . . Prior to the accident of 10/21/13, what shoulder complaints did this gentleman have?
>
> A. I am not aware that he had any complaints prior to this accident.
>
> Q. . . . Would that be either the right or left shoulder?
>
> A. That's correct.
>
> Q. Okay. Do you know if any shoulder x-rays or MRIs had ever been taken of this gentleman before 10/21/13?
>
> A. No.
>
> Q. Do you have any indication either from him, opposing counsel, or in any of the medical records you reviewed that this gentleman ever treated for his right or left shoulder before 10/21/13?
>
> A. No. *Id.* at 23-24.

He also acknowledged that there was no indication in any of the records that Petitioner was malingering. *Id.* at 29.

Although Dr. Stiehl felt that Petitioner's condition was non-emergent because he did not seek care with the emergency room until 2 days after the accident, he was unaware that Petitioner had to have authorization from Respondent prior to going to the emergency room and did not see the statement indicating same in the Union County Hospital ER record. *Id.* at 8, 24-26. Respondent did not provide him with the records of Dr. Granberg or the records from Rehab Unlimited. *Id.* at 28. Further cross-examination demonstrated that his statement that Petitioner did not seek treatment for his shoulders until four months after the accident was incorrect:

Q. Now, you indicated, sir, that my client's problems with regard to his shoulders didn't start till [sic] four months after the accident, is that correct?

A. That's correct.

Q. Yet we already went through the emergency room records and we see that my client did have shoulder complaints in the emergency room, correct?

A. Yes. *Id.* at 31, 32.

Dr. Stiehl further admitted that the trapezius muscle runs into the shoulder joint. *Id.* at 32. Although he mentioned Petitioner aggravating his symptoms by duck hunting on direct examination, he acknowledged that there was nothing in the records indicating that Petitioner's shoulders were aggravated by duck hunting. *Id.* at 8, 33. He was not even aware that Petitioner was managing his complaints with medication while treating with Dr. High, although it was on the first page Dr. Cerny's treatment note of January 14, 2014. *Id.* at 34-35. He also acknowledged that Dr. Cerny examined both Petitioner's left and right shoulders. *Id.* at 36.

Although Dr. Stiehl read the radiologists report into the record, finding moderate supraspinatus tendinopathy with high grade, possibly full thickness tearing, he still believed that Petitioner's scan was "inconclusive as to abnormality." *Id.* at 39, 40. He believed that Petitioner's right shoulder MRI was normal as well, and that the partial thickness intrasubstance tendon tear was "probably a normal finding for this particular age group patient." *Id.* at 40. When provided with the operative reports detailing the findings made by Dr. Mall during surgery, Dr. Stiehl admitted that Petitioner's right shoulder may have been aggravated by his fall, and agreed that the surgeries performed were reasonably necessary for the noted pathology. *Id.* at 42, 43. He also acknowledged that the last time Petitioner required any chiropractic care before the accident was December 10, 2012. *Id.* at 47, 48. Dr. Stiehl testified that he is not a cervical spine specialist and testified that he has never performed any neck surgery. *Id.* at 45-46.

On January 5, 2015, Petitioner presented with persistent left shoulder troubles and continued numbness in his median distribution. (PX7, 1/5/15) Dr. Mall's assessment was possible bilateral carpal tunnel syndrome with significant cervical spine involvement. *Id.* Dr. Mall expressed desire to see how Petitioner's symptoms fared following his neck surgery before recommending any further evaluation of his upper extremities. *Id.* He recommended an MRI arthrogram of Petitioner's left shoulder to make sure that his rotator cuff was healing appropriately. *Id.* Following the completion of same, Dr. Mall reviewed the MRI Arthrogram, which showed left shoulder small rotator cuff incomplete healing. (PX7, 3/2/15) Dr. Mall, however, did not feel this would create any functional limitation that would warrant surgical repair, and he continued Petitioner's physical therapy. *Id.*

Dr. Gornet reviewed Petitioner's new cervical MRI scan and noted on January 8, 2015 that, given the pathology seen at C3-4 and C4-5, the best recourse was to perform disc replacement at C3-4 and C4-5. (PX11, 1/8/15) Petitioner also continued to complain of low back pain and

reported that it was "progressing into leg symptoms" despite physical therapy. *Id.* His low back, however, continued to be "on hold" while focus was kept on treatment of the cervical spine and upper extremity injuries. *Id.*

On January 27, 2015, Dr. Gornet performed C3-4 and C4-5 disc replacement. (PX11, 1/27/15; PX14) At C3-4, he identified a large left sided disc herniation, which was removed in one fragment, and several other small fragments, including a small component on the right. *Id.* Once this area was decompressed and the prosthetic device placed, Dr. Gornet turned his attention to C4-5, where a moderate sized central left herniation was visualized as well as a foraminal herniation on the left. *Id.* This disc was also removed and successfully replaced. *Id.* Petitioner reported substantial pain relief to Dr. Gornet on February 23, 2015. (PX11, 2/23/15) Dr. Gornet kept Petitioner off work, prescribed range of motion exercises, and continued Petitioner's anti-inflammatory medication. *Id.*

Petitioner consistently continued to report improvement in his headaches and neck and shoulder pain to both Dr. Mall and Dr. Gornet after his surgeries. (PX11, 3/12/15, 5/4/15; PX7, 5/4/15) However, Petitioner continued to have problems with his hands and elbows. On March 12, 2015, Dr. Gornet recorded that Petitioner was experiencing tightness in his hands, which Dr. Gornet noted "seems more consistent with carpal tunnel." (PX11, 3/12/15) Dr. Gornet instructed Petitioner to begin formal physical therapy for his cervical spine with a lifting limit of 5 pounds. *Id.* Dr. Gornet released Petitioner with respect to his cervical spine beginning on May 11, 2015. (PX11, 5/11/15).

Respondent took another deposition of Dr. Stiehl in May of 2015 after having Petitioner examined a second time on May 20, 2015, for the purpose of performing an impairment rating and supplemental records review. (RX6, p.6) At the time of the second examination, Dr. Stiehl still did not have any records that contained any significant past medical history. *Id.* at 8. After reviewing the most recent imaging studies of Petitioner's neck and left shoulder and performing a physical examination, he formed a diagnosis of a bulging disc at C3-4 and C5, left shoulder rotator cuff tear, and right shoulder superior labrum tear and reiterated his belief that none of these conditions were the result of the October 21, 2013 accident. *Id.* at 10-12. Even though he did not feel that any of Petitioner's conditions were related to the accidental injury on October 21, 2013, Dr. Stiehl gave impairment ratings of 5% impairment of the whole person for the cervical condition and 1% of the whole person for each of the shoulders, totaling a final whole person impairment of 7%. *Id.* at 14.

Dr. Stiehl He testified on cross-examination that he is a general orthopedic surgeon and has not performed any spine surgery since 1981, although he testified in his prior deposition that he never performed neck surgery (RX4, p.45-46). *Id.* at 18. He has no fellowship training in sports medicine or spine surgery. *Id.* at 18. He also does not currently perform arthroscopic shoulder surgery in his practice, although he recalled performing such a procedure approximately 2 years prior *Id.* at 18. At the time of his second deposition, Dr. Stiehl testified that he was performing

between 5 and 10 examinations and/or ratings per week, still exclusively for respondents/insurance companies. *Id.* at 19. He estimated that this accounted for approximately 50% of his practice. *Id.* at 19. His total charge for his services in Petitioner's case amounted to $4,750.00. *Id.* at 21.

Dr. Stiehl testified that he agreed that the records at no point indicated that Petitioner's condition ever returned to baseline after his accident and prior to his surgeries. *Id.* at 21-22. Even though he received Dr. Gornet's operative report showing a significant herniation at C4-5 that was replaced, he "overlooked" these significant details and claimed in his supplementary report that Dr. Gornet failed to mention the C4-5 level in his operative report. *Id.* at 24-27. He again acknowledged a significant gap without treatment to Petitioner's neck before the October 21, 2013 accident. *Id.* at 28, 42. He further admitted to misstating that Dr. Mall sent Petitioner for two more weeks of work hardening in his report of May 4, 2015; that Dr. Mall actually stated he recommended additional physical therapy, and *after* Petitioner was released by Dr. Gornet he should do two more weeks of physical therapy followed by two weeks of work conditioning to see how his shoulder responds. *Id.* at 28-29. Petitioner was only to be released if his shoulder responded well to the additional therapy and hardening. *Id.* at 28-29. When asked why his report seemed to attribute some "modest at best" injury to the accident while he testified that none of the conditions which Petitioner's treating physicians attributed to the accident were at all related to the accident, he stated that he was simply "taking another view and my view is that it's probably not related and I have to justify that by some medical measure." *Id.* at 30. Although he has no other explanation for Petitioner's complaints, especially his shoulder complaints which are nonexistent before the accident, and although he admitted that the injury was "one possibility" for his neck and shoulder complaints, he stated:

> Again that's one possibility but I'd have to say I don't know why those conditions would have been caused because it was a relatively minor injury for which he wasn't found to have very much so I take the view that they probably aren't related. *Id.* at 31.

He continued to opine that Petitioner conditions were degenerative and entirely unrelated to the October 2013 accident, even though there was a significant gap between the last prior unrelated treatment and the accident with respect to his neck, no prior treatment with respect to his shoulders, no prior imaging studies, and no evidence that Petitioner wasn't able to work or function due to these conditions at any time prior to the accident. *Id.* at 31, 32, 46.

Dr. Mall testified by way of deposition on March 6, 2015, with respect to Petitioner's bilateral shoulder injuries. (PX17) Dr. Mall testified that he is a board certified orthopedic surgeon, with fellowship training in sports medicine and shoulder and elbow surgery, who regularly treats and operates on the shoulder, elbow, wrist and hand. (PX17, p.4-5) Dr. Mall noted that Petitioner's shoulder pain originated on one side but returned in his bilateral shoulders after treatment with his family care physician. *Id.* at 9. Dr. Mall testified that the vast majority of individuals who

come in with rotator cuff and shoulder injuries behave as Petitioner did and delay seeking treatment by avoiding activities that provoke pain during the day, but are ultimately forced to seek treatment due to worsening pain and lack of sleep because of shoulder pain awakening them during the night. *Id.* at 10. Dr. Mall noted that Dr. Stiehl incorrectly stated that Petitioner's gap in treatment for his left shoulder was six months rather than two-and-a-half months, and several other discrepancies between the evidence and Dr. Stiehl's testimony. *Id.* at 38-44.

Dr. Mall testified that he habitually examines the cervical spine when patients such as Petitioner present to his clinic because "there's a lot of overlap between the cervical spine and the shoulder." *Id.* at 12. Based on Petitioner's positive response from the injections he performed, however, Dr. Mall was certain that Petitioner's shoulders were causing a significant portion of his complaints. *Id.* at 14-15, 28. Dr. Mall's belief was confirmed by his intraoperative findings during his shoulder surgery, and Petitioner's reports of improvement postoperatively. *Id.* at 26-30. But since Petitioner did not experience complete resolution of his complaints and there were significant findings on his cervical MRI, Dr. Mall believed that Petitioner's cervical spine was responsible for some of Petitioner's pain as well and referred him to Dr. Gornet. *Id.* at 15-17. Dr. Mall expressed hope that Petitioner's remaining left shoulder symptoms would resolve with additional physical therapy or a cortisone injection if not resolved after Petitioner was released from Dr. Gornet's care for his cervical spine. *Id.* at 31-32.

In explaining his finding of causal connection, Dr. Mall stated:

> So in terms of his bilateral shoulders – I mean, traction injury to the shoulder is a very common problem, or it's a well-known injury mechanism for both superior labral and rotator cuff injuries. And so based on that and given his age of 33, as I mentioned just a second ago, the fact that that should be a fairly normal-looking rotator cuff in a 33-year-old was an indication to me that this was causally related with his work injury. Given the fact that he also told me that he did not have any prior shoulder complaints in either shoulder before that work injury, and therefore, based on the fact that he didn't have any pain beforehand, he had an injury mechanism that is consistent with superior labral and rotator cuff pathology and that of a traction type of injury to the shoulder, and the fact that he's very, very young for having these types of conditions in the shoulder – all indicate to me that this is causally related with his work injury. *Id.* at 20.

He testified that having a degenerative rotator cuff tear in the age between 20 and 40 is unheard of in the medical literature:

> Well, so basically we know from the medical literature that having a rotator cuff tear in the age between 20 and 40 is basically unheard of. I mean, there's – I think, looking at a recent review on it, maybe a four percent incidence of partial-thickness rotator tears and zero-percent incidence of full-thickness tears based on probably somewhere between five and 10 studies that either looked at ultrasounds, MRIs, or various different types of modalities to look at rotator cuffs in young patients. There's another study done out of Japan that basically showed a

> zero percent incidence of any rotator cuff pathology, a rotator cuff tearing, whether it be partial or full-thickness, below the age of 40. So in that situation he should have fairly normal-looking rotator cuffs. He may have some rotator cuff tendinitis or some grayness within the rotator cuff tendons, but he shouldn't have substantial partial-thickness or full-thickness tearing of his rotator cuffs. . . *Id.* at 21-22.

Some the medical literature/articles referenced by Dr. Mall were offered as Petitioner's Deposition Exhibits Two, Three and Four. *Id.* at 23-25.

With regard to Petitioner's cervical spine, Dr. Mall testified that it is his job as a shoulder specialist to recognize potential cervical spine issues; and since Petitioner did not have any significant cervical spine issues in the six months while working full duty prior to the injury, which he described as his "barometer in terms of looking at whether or not there could be a preexisting issue," there was a high likelihood that Petitioner's cervical spine problems were related to his work accident. *Id.* at 20-21. However, he deferred to Dr. Gornet on the issue of causation with respect to the cervical spine. *Id.* at 21.

Dr. Gornet testified by way of deposition on March 16, 2015, concerning Petitioner's cervical spine injuries. (PX19) He is a board certified orthopedic surgeon whose practice is devoted exclusively to evaluation and treatment of disorders of the spine. (PX19, p.5) Dr. Gornet testified that on his review of Petitioner's cervical spine MRI of March 24, 2014, there were no significant bony or degenerative changes. *Id.* at 8. Dr. Gornet testified that his "working diagnosis" was a disc injury based on Petitioner's response to the care and treatment of the shoulder. *Id.* at 9. Although his shoulder symptoms improved, Petitioner continued to suffer headaches and tingling down into his hands. *Id.* at 9-11. When asked about the so-called "normal" pathology on Petitioner's MRIs during cross-examination, Dr. Gornet explained that both of Petitioner's MRIs were abnormal:

> Q. Would bulges be within the common range for someone in their thirties, a lot like him?
>
> A. Well, I would say someone in their thirties, not necessarily. Again, if you really tease this down, both studies say that he has a disc bulge or protrusion, however you want to determine it, all the way up and effacing the spinal fluid intersection between that and the spinal cord, not indenting the spinal cord. So every single one of these would state there is some central narrowing of the spinal canal at C3-4 secondary to this disc pathology. Whether there's a frank herniation or simple protrusion disc injury, I think we're splitting hairs a little bit. I don't think – this is not a normal MRI. *Id.* at 19.

Dr. Gornet testified that after Petitioner ultimately failed conservative treatment and required disc replacement surgery at C3-4 and C4-5, the intraoperative findings confirmed the pathology visualized on the MRI. *Id.* at 11-12. Given Petitioner's history of the incident, the mechanism of injury, the clinical examination findings, the findings on the diagnostic films, and all of the

objective medical evidence, Dr. Gornet believed that the cause of Petitioner's disc injuries were directly related to the work fall accident of October 2013. *Id.* at 13.

Following his return to work, Petitioner noticed increased stiffness in his neck, particularly turning to the left, for which Dr. Gornet prescribed Meloxicam. (PX11, 8/17/15) Dr. Gornet noted that Petitioner was "working full duty in a fairly vigorous job" and recommended x-rays and a CT to make sure Petitioner's prosthetic disc replacements were in the appropriate position. *Id.*

Dr. Gornet saw Petitioner again for his final visit and reviewed the cervical spine films, he found that these films showed good positioning of Petitioner's devices and that Petitioner had minimal neck pain but still suffered with bouts of occasional headaches. (PX11, 1/28/16) He also noted that Petitioner still had tingling in his hands and arms which he noted to be "part of his original complaint." *Id.* He stated that Petitioner's upper extremity conditions were "best treated by Dr. Mall," left Petitioner in his care with regard to same, dispensed Cyclobenzaprine and Meloxicam for Petitioner's neck/head complaints, and placed him at maximum medical improvement with respect to his cervical spine. *Id.*

Upper Extremity Treatment

Petitioner began treating with Dr. Mall for specifically his hand complaints on June 1, 2015, at which time Petitioner reported to Dr. Mall that despite the significant improvement in his neck complaints following his surgery with Dr. Gornet, he continued to suffer persistent numbness into both hands. (PX7, 6/1/15) Dr. Mall's physical examination showed a positive flexion compression test at the wrists bilaterally. *Id.* Dr. Mall at this point felt Petitioner's symptoms were consistent with carpal and/or cubital tunnel syndrome. *Id.* He recommended an EMG and nerve conduction study and stated:

> In terms of causation, Mr. Roach developed symptoms in his hands and upper extremities in terms of numbness into his fingers upon his initial presentation to me. He developed these symptoms following his work injury, and upon his initial presentation to me, this was one of his complaints. Based on these symptoms, his cervical spine was evaluated, and we felt the cervical spine was part of his issue, as it was given his improvement following the cervical spine surgery. However, he continues to have symptoms involving the fingers with signs and symptoms that are consistent with carpal and cubital tunnel syndrome. Therefore, I would recommend evaluating this further, and I do feel that this further evaluation is causally related to his work given his symptoms and onset of his symptoms . . . *Id.*

Dr. Mall highlighted two potential causes for Petitioner's complaints, one of which was his employment with Respondent, City of Anna, and the other being a "double-crush" type injury were the nerves are being compressed in the cervical spine and the upper extremity. *Id.* Dr. Mall found Petitioner's employment with Respondent, which involved "construction and manual labor type of activities use of vibrational tools, a hammer, etc., with forceful gripping required for this"

the likely cause of Petitioner's development of carpal and cubital tunnel syndrome. *Id.* Dr. Mall recommended conservative treatment through bracing for a period of time to see if Petitioner's symptoms would improve. *Id.* Petitioner filed an additional Application for Adjustment of Claim with a date of accident of June 1, 2015, alleging alternatively that his hand/arm injuries were the result of repetitive trauma based on the hybrid causation opinion of Dr. Mall. (AX2).

On July 14, 2015, Dr. Mall reviewed the timeline of Petitioner's symptoms and complaints and noted that Petitioner improved during the time period during which he had been off work for his shoulder but worsened upon his return to full capacity work. (PX7, 7/14/15) Dr. Mall documented a more detailed description of Petitioner's job duties, which included using vibratory tools, using hammers, and forcefully gripping and grasping of objects. *Id.* He noted that Petitioner used a weed-eater for about 8 hours per week, which required elbow flexion, forceful gripping, and vibration. *Id.* He also noted that for about 30 hours a week Petitioner operated equipment using levers, which involved pushing, pulling and gripping, as well as vibration when operating equipment such as lawnmowers. *Id.* He further noted that Petitioner also engaged in shoveling of sludge and raking of sand, which also required forceful gripping. *Id.* Petitioner's physical examination now demonstrated positive flexion compression test at both wrists, positive Phalen's test at both wrists, positive flexion compression test at the elbows bilaterally, and positive Tinel's over the right wrist. *Id.* Petitioner's nerve conduction studies demonstrated bilateral carpal tunnel syndrome as well as ulnar compression at the left elbow. *Id.* Although Petitioner's right ulnar nerve was not remarkable on the electrodiagnostic study, it was clinically symptomatic. *Id.* Consequently, Dr. Mall's clinical assessment was bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. *Id.* Dr. Mall continued to manage Petitioner's condition conservatively. *Id.*

Petitioner's condition continued to progress despite conservative care. (PX7, 8/11/15) On August 11, 2015, Petitioner's physical examination reflected positive flexion compression test bilaterally, positive Phalen's and Tinel's over the wrist bilaterally, and positive Tinel's and flexion compression test at the elbow bilaterally. *Id.* Dr. Mall also noted mild bilateral epicondylitis during the examination. *Id.* He recommended a right carpal and cubital tunnel release/decompression with possible transposition of the ulnar nerve depending on its stability, followed by the same procedure on Petitioner's left upper extremity. *Id.* When Petitioner's epicondylitis symptoms became persistent, Dr. Mall recommended an MRI of the elbows. (PX7, 11/10/15) The MRI films confirmed the clinical findings of bilateral epicondylitis; thus, Dr. Mall recommended epicondyle debridement be done along with the carpal and cubital tunnel releases. (PX7, 3/8/16). Dr. Mall noted that all of the aforementioned conditions and prescribed treatments were causally related to Petitioner's job duties for Respondent. *Id.*

Respondent also had Petitioner examined by Dr. Mitchell Rotman, who evaluated Petitioner on August 10, 2015. (AX5, p.5) Dr. Rotman testified by way of deposition that Respondent requested that he determine whether Petitioner's bilateral carpal or cubital tunnel syndromes were work-related. *Id.* at 5, 6. He testified that he had no opinion as to causation with regard to

Petitioner's neck or shoulder injuries. *Id.* at 20. When asked how Petitioner described the fall that occurred on October 21, 2013, he testified:

> He described an injury with regards to being on a ladder. He started falling down the ladder, and he never got to the ground. He was able to stop his fall. He got twisted up in some ladder rungs and held himself from going all the way down, but he smashed his head on a tank and twisted his jaw on the way down. *Id.* at 7.

He also testified that Petitioner's job duties included "a lot of things" since he "takes care of all their [City of Anna] maintenance things" and cited activities such as climbing ladders, turning valves, operating equipment, using vibrating tools, "occasionally" lifting heavy objects, and "occasionally repetitively grip[ping] things." *Id.* at 7. He also testified that Petitioner's activities included writing things down, shoveling, walking, standing, lifting, pulling, using a weed eater, mowing, and working on sewer machines. *Id.* at 7, 8. He stated:

> Every day would be different. He might have to lift manhole covers. If it was the sewer job, that would be six to nine months out of the year. He might have to lift 30 to 40 manholes a day. That involves some heavy gripping, and then he did plant maintenance. He worked with waste water there for the City of Anna. He might have to shovel sludge and grip hoses, carry pumps and motors. It's a lot of different things. *Id.* at 8.

Dr. Rotman's physical examination was positive for bilateral carpal tunnel syndrome and cubital tunnel irritability. *Id.* at 11. Based on his own examination findings, Dr. Rotman's assessment was definite bilateral carpal tunnel syndrome and possible cubital tunnel syndrome. *Id.* at 12. He did not believe that Petitioner suffered from a "double crush" injury to the nerves at both the cervical spine and the ulnar/median location of the nerves because he believed the cervical nerve roots that were injured in the accident were "higher up" than the cervical nerve roots associated with the carpal and cubital tunnels. *Id.* at 12. He thus did not believe that Petitioner's carpal and cubital tunnel conditions were at all related to the ladder accident. *Id.* at 12, 13. He also did not believe that Petitioner's conditions were related to his employment with the City of Anna since Petitioner's symptoms worsened while he was off work for his neck and shoulder treatment. *Id.* at 13.

Dr. Rotman testified on cross-examination that he performs 4 to 5 IMEs per week at a rate of $1,800.00, and that he performs all of his examinations for defendants and insurance companies. *Id.* at 17. Dr. Rotman testified that he was aware that Petitioner's off work dates were March 15, 2014, through June of 2015. *Id.* at 19. He testified that he was unaware of whether Petitioner was having difficulty gripping objects prior to the time that he was taken off work for his cervical and shoulder injuries. *Id.* at 19. He testified, however, that if Petitioner was having trouble with gripping objects *before* he was taken off work, his causation opinion could change. *Id.* at 19.

Dr. Rotman acknowledged that Petitioner did not suffer from diabetes, gout, hypothyroidism, high blood pressure, or any rheumatoid process, and that Petitioner was "one of the more fit

individual's he'd ever met." *Id.* at 20-21. He openly admitted that Petitioner had no non-work-related risk factors that he could identify. *Id.* at 23. Although he believed that carpal tunnel syndrome was an "idiopathic condition" with no known cause in the medical profession, he admitted that Petitioner's job activities which he performed for 17 years were the type of activities that would "aggravate the carpal tunnel condition to the point where it may require surgical treatment." *Id.* at 23-24. He also agreed that Petitioner would benefit from surgery for his conditions. *Id.* at 22. He testified that he did not believe that Petitioner's hobbies of hunting, fishing, or any of his household activities were the cause or contributing factors to Petitioner's development of his bilateral compression neuropathies. *Id.* at 24, 25.

Dr. Mall testified again by way of deposition on December 14, 2015, with regard to Petitioner's upper extremity conditions. (PX18) Dr. Mall also treats individuals conservatively and surgically for carpal tunnel syndrome, cubital tunnel syndrome, and lateral epicondylitis. *Id.* at 7. Dr. Mall testified that when patients present with multiple problems, he initially focuses on treating the body part that is most irritated or sore, which in Petitioner's case was his shoulders. *Id.* at 5, 6. However, Petitioner reported difficulty gripping and grabbing objects when he first saw Petitioner in February of 2014. *Id.* at 4, 5. Dr. Mall also testified to his understanding of Petitioner's job duties for Respondent which he knew Petitioner had done for "several years":

> He does a lot of different things. He does a lot of work with the sewers, so a lot of manhole covers. He does use a lot of vibrational tools, hammers, a lot of forceful gripping and grabbing of objects. Basically, construction or manual labor type of job. *Id.* at 6-7.

Dr. Mall testified that Petitioner was still working full duty in February of 2014, and that Petitioner was adamant about continuing to work full duty for as long as possible, even though he wanted to give him restrictions. *Id.* at 7-8. Dr. Mall explained why he desired to have Petitioner's cervical spine evaluated first:

> Well, all the nerves that go down the fingers obviously start at the neck, and so if people are complaining of issues distal or downstream from that and/or neck pain, then I think it's valuable to work the cervical spine or at least examine the cervical spine. He was having some pain with cervical spine range of motion and tenderness to palpation. Therefore, when that's the case, that can also explain shoulder pain, elbow pain, wrist pain, finger numbness, all those types of different complaints, and so the cervical spine is a good place to start with some of that as well. *Id.* at 8-9.

As Petitioner continued to present with complaints despite the effective treatment of his shoulder and neck complaints, Dr. Mall began to form working diagnosis of Petitioner's complaints, beginning with lateral epicondylitis of the elbows, and ultimately bilateral carpal and cubital tunnel syndrome. *Id.* at 9-14. Eventually, Dr. Mall referred Petitioner for electrodiagnostic studies and directed his full clinical attention to Petitioner's bilateral hand and elbow complaints

and diagnosed Petitioner with bilateral carpal and cubital tunnel syndrome based on the positive findings on his physical examination and the electrodiagnostic studies. *Id.* at 14-15, 20-21.

When discussing the history of his upper extremity complaints, Petitioner advised Dr. Mall that he had been having these symptoms for some time but that he did not seek treatment or bring his complaints up to any of his physicians because he was "the kind of guy that doesn't like to go see the doctor, and he's kind of been like that the whole time." *Id.* at 17-18. Dr. Mall pointed to the fact that Petitioner waited several months to get his shoulders addressed and kept working full duty and basically only brought his complaints up since he was at the physician's office anyway. *Id.* at 17-18. Dr. Mall testified that Petitioner did not attribute his complaints to anything specific, but he noted that Petitioner's complaints improved somewhat while he was off work for his cervical and shoulder injuries and worsened when he returned to full duty work. *Id.* at 18-19, 40-41. Dr. Mall testified that the fact that Petitioner's complaints only modestly improved and yet persisted during his time off work and persisted despite conservative care indicated that Petitioner's problem would have to be surgically addressed. *Id.* at 19, 22-23.

Dr. Mall disagreed with the "semantics" of Dr. Rotman's statement that there was no known cause for carpal tunnel syndrome in the medical community:

> . . . It's really – I can see where he's coming from with that point in terms of what causes carpal tunnel syndrome, but we have very good literature that we know what things are attributed to, just like we don't necessarily know what causes heart disease, but we know lots of different things that are – that contribute to it. We don't know why that plaque builds up necessarily in the heart, but we know the different things that can contribute to that. So same kind of thing with this, is we know that – we know what things can contribute to carpal tunnel syndrome, and we know what things increase your risk of getting carpal tunnel syndrome, but we don't necessarily know exactly why it happens, but there's definitely some literature that suggests that it's repetitive flexion/extension of the wrist or repetitive flexion/extension of the elbow, keeping your elbow flexed for a long period of time, especially if there's vibrational issues. Heavy gripping has been shown even more so than typing to be a major issue, so kind of a forceful grip is one of the most recognizable contributions to developing carpal tunnel syndrome. So again, it really is more of a term of semantics in terms of what causes or what things are – that we kind of know will bring about the symptoms. *Id.* at 28-29.

Dr. Mall again provided medical literature at the time of the deposition to support his statements as to causal connection, as well as his clinical diagnosis of right cubital tunnel syndrome unconfirmed by electrodiagnostic studies. *Id.* at 29-33.

With respect to causation, Dr. Mall testified that Petitioner's job duties were exactly the type of activities that would cause or contribute to the development of carpal and cubital tunnel syndrome. *Id.* at 15-16. He stated:

> So I think the job duties that he described to me and that – I think has been very consistent throughout everything I've read in terms of Dr. Rotman's IME and other documents that I've seen – just that these are the types of activities that we would associate with carpal and cubital tunnel syndrome. And he has really no other risk factors for that. He's not overweight. He doesn't have any thyroid issues, does not have diabetes. So really, his job duties are really the only risk factor that we can attribute to his carpal and cubital tunnel syndrome. *Id.* at 16.

Dr. Mall testified that based on the factual evidence and all of Petitioner's clinical findings, his carpal and cubital tunnel syndromes as well as his epicondylitis, were caused, contributed to, or aggravated by his employment for the City of Anna. *Id.* at 21-22.

Petitioner testified during the hearing that his job duties include driving, turning several locks a day, opening doors, climbing a lot of ladders, running sewer maintenance which "involves 3,000 pounds of pressure with a hose at 600 feet long; pulling, jerking;" lifting manhole covers repeatedly every day, using drills and hammers, working with concrete, and puling motors and pumps located at the bottom of 20 foot aeration tanks for waste water. (T.15 [hereinafter 3/29/16]). Petitioner testified that a sewer machine is essentially a really big, heavy duty roto rooter that is "very vibrating" because it operates at 3,000 pounds of pressure to unclog roots, towels, and/or anything else clogging sewer lines. (T.18). He testified that the 600 foot hose that he has to "pull and prod" causes "a lot of pain." *Id.* Petitioner testified that he operates a skid-steer or front end loader, operates a backhoe, operates tractors, shovels daily, rakes sand and sometimes rock daily, works on motors using wrenches, drills, hammer drills, and even uses jackhammers. (T.19) Petitioner estimated that he uses his hands for 7 hours out of an 8 hour work day. (T.19) Petitioner testified that he experiences persistent pain, aggravation, discomfort, loss of sensation, difficulty gripping objects, and lack of sleep and would like to have the surgeries recommended by Dr. Mall. (T.21, 24-25).

CONCLUSIONS OF LAW
14 WC 10779

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

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 workers' compensation claimant's injury. *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, 976 N.E.2d 1 (2011).

Causal connection between accident and claimant's condition may be established by chain of events including claimant's ability to perform manual duties before accident, decreased ability to still perform immediately after accident, and other circumstantial evidence. *Pulliam Masonry v. Indus. Comm'n*, 77 Ill. 2d 469, 397 N.E.2d 834 (1979). A claimant's testimony should not be

expected to exactly mirror medical proofs due to the fact that the burden of proof is the preponderance of the evidence and inconsistency and error is inherent in the history taking process. *Blommaeet,* 06 I.W.C.C. 0682 (2006); *Danny Farris v. Phoenix Corp. of Quad Cities,* 11 I.W.C.C. 0610 (2011), aff'd by *Farris v. Illinois Workers' Comp. Comm'n,* 2014 IL App (4th) 130767WC, 22 N.E.3d 54, reh'g denied (Nov. 26, 2014).

The unrebutted evidence shows that Petitioner had no shoulder complaints whatsoever prior to the accident, and had not had any neck complaints for which he sought treatment for a significant number of months prior to the accidental injury. (T.14-15 [5/13/15]; RX12) While there appears to be a discrepancy between the history of the emergency room, which indicated that Petitioner caught himself with his right upper extremity, and the histories taken by later physicians, which indicate that Petitioner caught himself with both of his arms; the Arbitrator notes that there really is no discrepancy given that Petitioner testified without rebuttal and consistently during both hearings that he "caught himself a couple of times" on his way down the ladder. (T.11-12 [5/13/15]; T.54 [3/29/16]).

Nevertheless, the law holds that differences between a claimant's testimony and other parts of the records are not fatal to a claim. See *Danny Farris v. Phoenix Corp. of Quad Cities,* 11 I.W.C.C. 0610 (2011), aff'd by *Farris v. Illinois Workers' Comp. Comm'n,* 2014 IL App (4th) 130767WC, 22 N.E.3d 54, reh'g denied (Nov. 26, 2014); *Jennifer Stronz v. Alexian Brothers Medical Center,* 07 I.W.C.C. 0289 (2007); *Jamie Blommaeet v. Ford Motor Co.,* 06 I.W.C.C. 0682 (2006).

The Arbitrator finds the causation opinions of Dr. Gornet and Dr. Mall to be more persuasive than the opinion of Dr. Stiehl. The Arbitrator notes that Respondent did not have Petitioner examined by a cervical spine specialist, and the Arbitrator does not find Dr. Stiehl sufficiently qualified to speak persuasively on the issue of causal connection with regard to Petitioner's cervical spine. He testified during his first deposition that he never performed any spinal surgery, and during his second deposition that he did so once in 1981. (RX4, p.45-46; RX6, p.18). On the other hand, Dr. Gornet, a board certified orthopedic surgeon whose practice is devoted exclusively to evaluation and treatment of disorders of the spine, credibly testified that Petitioner's MRIs were not normal, and that he believed that Petitioner's disc injuries were directly related to the work fall accident of October 2013. (PX19, p.5, 13, 19). With regard to Petitioner's shoulders, Dr. Mall testified that given Petitioner's young age, his mechanism of injury, his lack of prior problems, and the objective evidence of injury consistent with Petitioner's mechanism of injury, Petitioner's shoulder conditions were related to his work accident. (PX17, p.20) Furthermore, the Arbitrator agrees with Dr. Mall that Petitioner's delay in seeking treatment was certainly not unreasonable, and notes that under the principle set forth in *Durand* that employees who diligently work through symptoms until they require treatment are not to be penalized. *Durand v. Indus. Comm'n,* 224 Ill.2d 53, 862 N.E.2d 918, 927, 930.

The Arbitrator finds Dr. Stiehl's opinion to be inconsistent with the evidence. He was the only physician to characterize Petitioner's MRI findings as "normal" in the face of documented disc bulging from C2-3 through C5-6 with central spinal canal stenosis at C3-4 in the cervical spine, rotator cuff tearing of the left shoulder, and SLAP tearing of the right shoulder. (PX9; RX5) The Arbitrator also finds Dr. Mall's reasoning regarding Petitioner's young age and the absence of such pathology without trauma in his age group to be persuasive and supported by the medical literature. Additionally, Dr. Stiehl admitted when provided with the operative reports detailing the findings made by Dr. Mall during surgery that Petitioner's right shoulder may have been aggravated by his fall, and agreed that the surgeries performed were reasonably necessary for the noted pathology, and acknowledged that Petitioner required no treatment for his spine for a significant amount of time prior to the accident, that Petitioner required no prior care for his shoulders whatsoever, and that Petitioner's complaints at no time returned to baseline following the accident. (RX4, p.14, 23-24, 42-43, 47-48). He also made several factually incorrect/inconsistent statements with respect to information contained in Petitioner's medical records and was often "lost" during cross examination when trying to find information in Petitioner's records. In light of the circumstantial evidence and objective medical evidence, the Arbitrator sees no basis to support Dr. Stiehl's causation opinion. Consequently, the Arbitrator finds that Petitioner met his burden of proof in establishing that his bilateral shoulder and neck injuries are causally related to the undisputed accidental work injury of October 21, 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): Is Petitioner entitled to any prospective medical care?
Issue (O): Did Petitioner exceed his choices of physician?

Based upon the above findings as to causal connection, the Arbitrator finds there is no evidence to support a dispute as to the reasonableness and/or necessity of Petitioner's care and treatment. Dr. Stiehl acknowledged during his deposition that he had no dispute as to the reasonableness/necessity of Petitioner's shoulder surgeries aside from the issue of causation. (RX4, p.43) With regard to Petitioner's neck complaints, Petitioner's MRIs clearly showed significant pathology, which Dr. Gornet related to the accident. (PX8; PX10; PX16) Although Petitioner's conditions did not improve with conservative measures, Petitioner's conditions improved significantly following surgery. Consequently, the Arbitrator finds that the medical care rendered to Petitioner was reasonable and necessary. Petitioner, however, has not reached maximum medical improvement and remains under the observation of Dr. Mall regarding his shoulders, particularly his left, and his upper extremities.

The Arbitrator finds that Petitioner did not exceed his choices of physician. Emergency care does not constitute a choice of physician, nor is any referral from an emergency care provider. *Nick Reynolds v. SOI/Pinckneyville Corr. Ctr.*, 13 I.W.C.C. 0484 (2013); *Jerold Winfield v. Charter*

Communications, 12 I.W.C.C. 0321 (2012); *Jill Quillin v. Wauconda Park District*, 11 I.W.C.C. 0957 (2011); *Patricia Thompson v. Jacksonville School Dist. # 117*, 05 I.W.C.C. 0401 (2005) (all holding that referrals from emergency care facilities are not choices, but extensions of that same emergency care). The fact that the emergency room visit occurs apart from the date of accident does not render the care non-urgent. *Michael Bonin v. Airline Towing, Inc.*, 09 I.W.C.C. 1194 (2009) (holding both of the claimant's separate visits to different emergency rooms to constitute emergency care and not choices under the Act). Additionally, a general referral is sufficient to extend the referral chain under § 8(a) of the Act. *Kane v. Abbott & Assoc.*, 09 I.W.C.C. 1193 (2010).

Petitioner first presented to the Union County Hospital Emergency Room. As established by law, this does not constitute a choice of physician. The emergency room referred Petitioner to a "private physician" for "continuation of care." (PX3) Petitioner followed these instructions and saw Dr. High, who referred Petitioner to Dr. Cerny. (T.16 [5/13/15]) Therefore, neither Dr. High nor Dr. Cerny constitutes a choice of physician. *See Reynolds supra* (wherein the Commission held that referrals from the Urgent Care facility to Dr. Haake, and from Dr. Haake to Dr. Wood for "management" did not constitute a choice of physician). The records show that Dr. Cerny referred Petitioner to an orthopedist, however, not the orthopedist that Dr. Cerny recommended. Consequently, Dr. Mall is Petitioner's first choice of physician. Dr. Mall referred Petitioner to Dr. Gornet for evaluation of his cervical spine, and Dr. Phillips for electrodiagnostic evaluation of the upper extremities. (PX6) Dr. Gornet in turn referred Petitioner to Dr. Granberg for injections. (PX10) All of Petitioner's ancillary medical and diagnostic services were obtained at the referral of Petitioner's providers, none of which fell outside of his allotted choices of physician under the Act. Consequently, the Arbitrator finds that Petitioner met his burden of proof on entitlement to payment of the submitted medical expenses.

The Arbitrator hereby orders Respondent to pay for the expenses in Petitioner's group exhibit and authorize and pay for any further reasonable and necessary care recommended by Dr. Mall.

Issue (L): What temporary benefits are in dispute? (TTD)

The Arbitrator finds that the first indication that Petitioner was incapable of performing his job duties was Dr. Mall's work status on March 24, 2014. (PX6, 3/24/14) Petitioner was released to full duty work on June 1, 2015. (PX6, 6/1/15). Accordingly, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for a period of 62 1/7 weeks. Respondent shall have credit for the $26,565.41 of temporary total disability benefits paid. (AX1).

This award shall in no instance be a bar to further hearing and determination of any additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael C. Sanders,

Petitioner,

vs.

NO: 14 WC 19364

17IWCC0409

Flanders Precisionaire,

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, prospective medical, causal connection, 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 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.

17IWCC0409

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: JUN 28 2017

o:5/17/17
LEC/mas
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

SANDERS, MICHAEL
Employee/Petitioner

Case# **14WC019364**

17IWCC0409

FLANDERS PRECISIONAIRE
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

1120 BRADY CONNOLLY & MASUDA PC
ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0409

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

- [ ] 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)

Michael Sanders
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # 14 WC 19364

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 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. [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 [ ] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **09/23/2013**, 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, the average weekly wage was **$360.00**.

On the date of accident, Petitioner was **27** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$6,695.87** for TTD, **$-0-** for TPD, **$-0-** for maintenance, and **$-0-** for other benefits, for a total credit of **$6,695.87**.

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

ORDER

The Arbitrator finds that the Petitioner sustained a work-related injury to his low back on September 23, 2013. The Petitioner's initial injury occurred on February 26, 2013, and was filed as 13 WC 22725. For reasons explained in the body of that decision all benefits are awarded under 13 WC 22725.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Robert E Johnson

Signature of Arbitrator

August 4, 2016
Date

ICArbDec19(b)

AUG 8 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael C. Sanders,

Petitioner,

vs.

NO: 14 WC 19365

17IWCC0410

Flanders Precisionaire,

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, prospective medical, causal connection, 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 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.

17IWCC0410

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: JUN 28 2017

o:5/17/17
LEC/mas
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

SANDERS, MICHAEL
Employee/Petitioner

Case# **14WC019365**

17IWCC0410

FLANDERS PRECISIONAIRE
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

1120 BRADY CONNOLLY & MASUDA PC
ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0410

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)

Michael Sanders
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # **14** WC **19365**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 12, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **03/05/2014**, 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, the average weekly wage was $**360.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained a work-related injury to his low back on March 5, 2014. The Petitioner's initial injury occurred on February 26, 2013, and was filed as 13 WC 22725. For reasons explained in the body of that decision all benefits are awarded under 13 WC 22725.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Robert E. Johnson

Signature of Arbitrator

August 4, 2016
Date

ICArbDec19(b)

AUG 8 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael C. Sanders,

Petitioner,

vs.

NO: 14 WC 19366

17IWCC0411

Flanders Precisionaire,

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, prospective medical, causal connection, 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 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.

17IWCC0411

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: JUN 28 2017

o:5/17/17
LEC/mas
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

SANDERS, MICHAEL
Employee/Petitioner

Case# **14WC019366**

17IWCC0411

FLANDERS PRECISIONAIRE
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
CHICAGO, IL 60604

1120 BRADY CONNOLLY & MASUDA PC
ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0411

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

- [ ] 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)

Michael Sanders
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # 14 WC 19366

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 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. [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 [ ] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **03/11/2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, the average weekly wage was **$360.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained a work-related injury to his low back on March 11, 2014. The Petitioner's initial injury occurred on February 26, 2013, and was filed as 13 WC 22725. For reasons explained in the body of that decision all benefits are awarded under 13 WC 22725.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Robert E Adams

Signature of Arbitrator

August 4, 2016
Date

ICArbDec19(b)

AUG 8 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael C. Sanders,

Petitioner,

vs.

NO: 14 WC 19367

17IWCC0412

Flanders Precisionaire,

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, prospective medical, causal connection, 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 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.

The party commencing 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: JUN 28 2017

o:5/17/17
LEC/mas
43

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

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

SANDERS, MICHAEL
Employee/Petitioner

Case# **14WC019367**

17IWCC0412

FLANDERS PRECISIONAIRE
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

0393 THOMAS R LICHTEN LTD
53 W JACKSON BLVD
SUITE 224
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ANDREW R MAKAUSKAS
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

17IWCC0412

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

- [ ] 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)

Michael Sanders
Employee/Petitioner

v.

Flanders Precisionaire
Employer/Respondent

Case # 14 WC 19367

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 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. [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 [ ] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **05/06/2014**, 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, the average weekly wage was **$360.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **1** dependent children.

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

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

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

ORDER

The Arbitrator finds that the Petitioner sustained a work-related injury to his low back on May 6, 2014. The Petitioner's initial injury occurred on February 26, 2013, and was filed as 13 WC 22725. For reasons explained in the body of that decision all benefits are awarded under 13 WC 22725.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Robert E Abrams

Signature of Arbitrator

August 4, 2016
Date

ICArbDec19(b)

AUG 8 - 2016

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROGELIO CORTEZ,

Petitioner,

vs. NO: 14 WC 21367

A.J. OSTER,

17IWCC0362

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, prospective medical care, temporary total disability and credit, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner worked for Respondent for 21 years, the last 18 as a Machine Operator. He carried various heavy parts to the machine and used an overhead crane.

2. On November 19, 2013 Petitioner was pulling a heavy item towards the crane so he could lift it up. The item weighed 300 pounds. While pulling, he heard a crack in his back but only noticed a little pain. As he kept walking, he also noticed a little pain down his right hip.

3. Petitioner reported the accident to his boss, who drafted a written accident report. Petitioner declined medical treatment because the pain "wasn't that bad." He then completed his shift. At home that night the pain increased, however. The next day he reported to work to make a report that he was unable to work. He was then referred to Cadence Occupational Health.

4. After an exam Petitioner was placed on light duty and prescribed medication. In November and December of 2013 Petitioner indicated that his symptoms ebbed and flowed. However, as he kept working, his symptoms worsened, and he was placed on restricted duty.

5. By June 2014 Petitioner was experiencing more hip pain. He was taken off of work. An MRI revealed bilateral labral tears in both hips. Petitioner's back pain persisted during this time.

6. Petitioner underwent right hip surgery July 15, 2014. However, the surgery failed to decrease his pain.

7. In October 2014 Dr. Kuo examined Petitioner and noted that his low back pain began after the accident in question. An MRI revealed fairly significant stenosis at L4-5 secondary to a herniated disc, causing significant compression at L4-5. Dr. Kuo opined that maneuvering objects while lifting, twisting and bending at work could have caused Petitioner's low back condition. A laminectomy was recommended and was performed November 10, 2014. However, the surgery was only successful in improving Petitioner's left leg pain.

8. Petitioner underwent a second back surgery in July 2015, but his symptoms worsened after physical therapy. He testified that he now is unable to perform activities of daily living with the exception of cooking meals.

9. Dr. Komanduri examined Petitioner and opined that his bilateral labral tears were causally related to his work accident. Petitioner was also diagnosed with femoroacetablur impingement (FAI), but Dr. Komanduri asserted that labral tears are not necessarily present just because someone has FAI, and that most FAI's are in fact asymptomatic. Thus, there is usually a traumatic event that leads to any accompanying injury.

17IWCC0362

10. Dr. Darwish opined that the work accident did cause Petitioner's condition, and led to the need for surgery. He stated that pulling a 300 pound object can cause stress on the lumbar spine and could lead to low back pain.

11. In March 2015, Dr. Domb examined Petitioner and noted the bilateral labral tears in his hips. He recommended left hip surgery and mentioned the possibility of revision right hip surgery. In April 2015 Dr. Domb referred Petitioner for a second opinion with Dr. Darwish.

The Commission affirms the Arbitrator's findings of causal connection, temporary total disability, prospective medical care and the finding that Petitioner did not violate the Two Physician rule.

The Commission also affirms the award for credit granted to Respondent in the amount of $14,169.12, which was paid for long term disability benefits. This amount was stipulated to by the parties, but was not expressly granted in the Arbitrator's award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is causally related to his work accident.

IT IS FURTHER ORDERED BY THE COMMISION that Petitioner is entitled to temporary total disability benefits for a period of 96-1/7 weeks (June 9, 2014 through April 13, 2016) at a rate of $482.52 per week.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care recommended by Dr. Domb.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner did not violate the Two Physician rule.

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. Credit shall include $14,169.12 for payment of short term disability benefits.

17IWCC0362

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $60,000.00. 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: JUN 15 2017
O: 4/27/17
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

CORTEZ, ROGELIO
Employee/Petitioner

Case# **14WC021367**

AJ OSTER
Employer/Respondent

17IWCC0362

On 4/29/2016, 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 0.40% 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:

1357 RATHBUN CSERVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

1408 HEYL ROYSTER
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 62205

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)

ROGELIO CORTEZ
Employee/Petitioner

v.

AJ OSTER
Employer/Respondent

Case # 14 WC 21367

Consolidated cases: _____

17IWCC0362

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **4-13-16**. 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 _____

FINDINGS

On the date of accident, **11-19-13**, 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 **$37,674.52**; the average weekly wage was **$724.51**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **3** 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 $ for other benefits, for a total credit of $.

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

ORDER

Respondent is liable for reasonable and necessary medical treatment evidenced by Petitioner's exhibit 1.

Respondent is liable for Petitioner's TTD period from 6-9-13 to 4-13-16, a period of 96-1/7 weeks, at a rate of $482.52 per week.

Respondent is liable for Petitioner's prospective medical treatment as discussed by Dr. Domb as set forth herein.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Robert E Johnson

Signature of Arbitrator

April 28, 2016

Date

ICArbDec19(b)

APR 29 2016

FINDINGS OF FACT

On the date of his hearing, Mr. Rogelio Cortez, Petitioner, testified that he last worked for A.J. Oster, Respondent, on June 2, 2014. Respondent is involved in producing copper and brass parts, and is located in Carol Stream, Illinois. Petitioner indicated he was employed as a machine operator and had worked for Respondent for 21 years. His position involved running a machine that required him to move copper and brass spools onto his machine with an overhead crane. Respondent called retired plant manager, Mr. Tom Nelson, who indicated the brass and copper spools could weigh anywhere from 50 to 300 pounds, and could have a diameter anywhere from 20 to 40 inches.

Petitioner indicated he was working as a machine operator on November 19, 2013. On that date, he indicated he was working full-duty with no restrictions of any kind, and was carrying out his typical job requirements. Mr. Cortez indicated he was using the overhead crane to maneuver a spool of material, and as he was pulling the material towards him by hand, he heard a "crack" in his back. Petitioner testified that he reported the accident to the assistant manager, Mr. Victor Flores. Mr. Nelson in his testimony confirmed that it was reasonable for Mr. Cortez to pull the material by hand in order to maneuver it, and that Petitioner did report the accident. Petitioner noticed pain in his lower back and right hip. However, the pain was not too bad and he finished his shift that day at 2:00 p.m. By the time he went home that evening, Petitioner indicated he noticed increasing pain in his lower back and right hip. Petitioner reported for his shift the following morning, but noticed increasing back and right hip pain that caused him to speak with one of the supervisors, either Victor Flores, Tom Nelson or Matt Demonte, another manager. At that time, Petitioner was given the option to seek medical treatment by Respondent at Cadence Occupational Clinic.

Mr. Cortez first reported to Cadence Occupational Health Clinic on November 20, 2013. (P2) Mr. Nelson testified that that he drove Petitioner to this appointment. At that time, Petitioner described the accident to the doctor and reported 6/10 pain in his right lower back radiating down his right leg. (P2) Following an examination, Dr. Adrienne Baksinski indicated Petitioner was suffering from a lumbar strain caused by work activities, and prescribed ibuprofen, cyclobenzaprine, and work restrictions. (P2) Following that, Petitioner returned to light-duty work, and indicated the medication was helping his symptoms.

Petitioner next returned to the Occupational Clinic on November 25, 2013. (P2) At that examination, in the History of Present Illness section of the doctor's report, it noted:

> "The patient's primary problem is pain located in the right lumbar paraspinous region. He described it as sharp. He considers it to be barely noticeable. It has been 6 days since the onset of the pain. The patient says that it seems to be constant. He has noticed that it is made worse by prolonged sitting or walking. He also notes that it is accompanied by weakness/heaviness into right leg is resolved. He feels it is resolving. He pain level is 0/10. He is here to review

> his x-ray studies. He states that he is 100% improved from his injury." (P2)

While the above notation is inconsistent on its face, indicating "sharp pain," "barely noticeable" pain, "constant" pain, "resolved" pain, and "resolving" pain, Petitioner explained that his pain was better at that time because of the medication he was prescribed. However, Petitioner testified that when he stopped taking the prescribed mediation, his lower back and right leg pain symptoms returned. Given that his symptoms returned, Petitioner returned to the Occupational Clinic on December 11, 2013. (P2) At that time, the doctor noted:

> "Lumbar pain. Patient states that since he has finished the Ibuprofen the pain has come back. He is currently not taking any medication. He has radiating pain down the front of his right leg in his thigh area. Bending makes it worse and if he sits for a long time. Standing also makes it worse. He also did not pass his return to work screen." (P2)

Following an examination, Dr. Bakinski diagnosed Petitioner with a worsening lumbar strain related to his work activities and prescribed additional medication, physical therapy, and work restrictions. (P2) During this period, Mr. Nelson confirmed Petitioner was working within his light-duty restrictions sweeping floors. Petitioner returned to Dr. Bakinski on December 18th with complaints of back pain at a 4/10, better with medication, along with pain down his right leg causing him to be unable to cross it over his left leg. (P2) Upon examination, Dr. Bakinski noted that Petitioner has positive tingling in his back and positive straight leg raising related to work activities. (P2) At that time, the doctor discontinued ibuprofen, prescribed prednisone and indicated an MRI may be necessary if no improvement. (P2) By his next appointment on December 27th, Petitioner continued complaining of sharp right lumbar pain and weakness/heaviness in his right leg. (P2) Upon examination, Dr. Bakinski again noted a lumbar strain related to work activities, and order a lumbar MRI. (P2)

Following his January 3, 2014 lumbar MRI, Petitioner returned to Dr. Bakinski who indicated he was suffering from a lumbar sprain, degenerative disc disease, and spinal stenosis. (P2) The doctor noted Petitioner had ongoing constant lower back pain and pain in his right hip and thigh with external rotation and referred him to physiatry for a consultation. (P2) Petitioner first saw Dr. Beth Froese at Cadence Medical Group on January 20, 2014. (P2) At that time, Petitioner reported his work accident and his ongoing lower back and right leg pain. (P2) Dr. Froese conducted a physical examination, reviewed his MRI, and indicated he was suffering from lumbar radiculitis, a central disc herniation at L4-5 with right foraminal stenosis, and right hip pain with a questionable right hip arthralgia. (P2) Based on the diagnosis, Dr. Froese recommended a trial of epidural steroid injections ×2. (P2)

At hearing, Petitioner indicated that despite the physical therapy and injections, he did not experience relief to his lower back and right hip symptoms. Petitioner remained on light-duty status at work and was sent by Respondent to a Section 12 examination with Dr. Alexander Ghanayem on March 31, 2014. At the time of the examination, Petitioner described his work

accident and indicated that he was suffering from lower back pain and right groin pain. (R3) Following his examination of Petitioner, review of the medical records, and diagnostic testing, Dr. Ghanayem opined:

> "His MRI shows a small disc protrusion at the L4-L5 level. It is possible that he may have sustained this small, nonsurgical disc protrusion from the same injury as he has described to me. At this point, I really see nothing else from a spine standpoint that would preclude him from returning back to work at regular duty." (R3)

Following his examination with Dr. Ghanayem, Petitioner testified that he continued to work light-duty for the Respondent. He further testified that during this time period, he continued to notice lower back pain and right hip pain. In addition, only after his examination with Dr. Ghanayem, he noticed some pain in his left hip. Given his complaints, Petitioner set an appointment with Dr. Mukund Komanduri at MK Orthopaedics.

Mr. Cortez first presented to Dr. Komanduri on June 9, 2014, with complaints of pain in his lower back radiating to his right leg and pain in both hips. (P3) Dr. Komanduri recorded Petitioner's description of the accident involving pulling coil towards himself while lifting coils with a pulley. (P3) Upon examination, Dr. Komanduri noted that Petitioner was having trouble weightbearing, increased pain with sitting and standing, groin and thigh pain, limitation of abduction on the right hip, and moderate low back pain. (P3) At that time, the doctor indicated that Petitioner had extensive femoroacetabular impingement and probable labral tears and ordered bilateral hip MRI arthrograms and physical therapy. (P3) Following the bilateral MRIs, Petitioner returned to Dr. Komanduri on June 25, 2014. (P3) Upon reviewing the MRI results, Dr. Komanduri indicated that Petitioner was suffering from bilateral hip labral tears, with the right hip being worse than the left, and scheduled surgery for the right side. (P3) Petitioner underwent a right hip arthroscopy with acetabular and femoral osteoplasty and labral repair on July 15, 2014, by Dr. Komanduri. (P3) Petitioner indicated that following the surgery, he continued to have lower back pain. Upon seeing the doctor on August 22, 2014, Petitioner reported that after stopping his medication, his hip pain had returned and that he continued to have lower back pain. (P3) By his next appointment with Dr. Komanduri on September 22, 2014, Petitioner continued to complain of right hip pain and lower back pain including some numbness and tingling. (P3) Dr. Komanduri indicated that Petitioner may be suffering from a traumatic disc injury and ordered a lumbar MRI. (P3) Following the MRI, Petitioner followed up with Dr. Komanduri again who indicated that the scan demonstrated that Petitioner had a significant stenosis at L4-5 and opined that the narrowing of his spinal canal might be causing Petitioner's hip and leg pain. (P3) Dr. Komanduri distinguished the difference between Petitioner's lower back and hip complaints, and explained that the numbness and tingling symptoms Petitioner had were not referable to his hip complaints. (P6 at 20) Dr. Komanduri put off any treatment on the left hip until Petitioner's lower back was examined. (P3)

Upon referral from Dr. Komanduri, Petitioner saw Dr. Rebecca Kuo (not Dr. Quell-misspelled in note-indicated by Dr. Komanduri via deposition testimony-P6 at 22) on October

10, 2014. (P3) At that time, Petitioner indicated that his current lower back pain started after his November 19, 2013, work accident that was currently at a 6/10 level. (P3) Following a physical examination, Dr. Kuo indicated, "MRI demonstrates fairly significant stenosis at L4-L5 secondary to herniated disc causing significant compression at L4-L5. I do disagree with the radiologist that I believe the stenosis is either moderate to severe." (P3) Dr. Kuo recommended that Petitioner undergo a L4-L5 laminectomy. (P3) Petitioner underwent an L4-L5 laminectomy on November 10, 2014, and followed up with Dr. Kuo on February 6, 2015. (P3) At that time, Petitioner indicated that he believed his right hip pain was the same and that he felt very tight. (P3) Petitioner continued with physical therapy at Doctors of Physical Therapy with therapist Audie Veloria but he continued to have lower back and right hip pain. Eventually, while at therapy, Petitioner reported that his left leg symptoms decreased after his back surgery but that he still had pain and trouble in his right hip. (P8) Petitioner testified that he spoke to his therapist about his ongoing hip complaints, and Ms. Veloria referred him to Dr. Benjamin Domb at Hinsdale Orthopaedics.

When Petitioner saw Dr. Domb for the first time on March 2, 2015, he reported his work accident and his ongoing lower back and bilateral hip complaints. (P17) At that time, he reported he noticed left hip pain after an examination maneuver when he saw Dr. Ghanayem. (P17) He further reported he had some relief to his left leg symptoms after his lumbar surgery. (P17) Following a physical examination, Dr. Domb indicated that Mr. Cortez had a recurrent right sided labral tear and a left sided anterior labral tear and recommended a left hip surgery and consideration of a right hip revision surgery. (P17) Petitioner returned to Dr. Domb on April 2, 2015. (P17) On that date, Dr. Domb reviewed Petitioner's MRI arthrogram of his right hip dated February 25, 2015, and his left hip MRI dated June 24, 2014, and indicated Petitioner had a recurrent right labral tear and a "subtle" left sided labral tear. (P17) Before proceeding with hip treatment, because of Petitioner's ongoing lower back pain, Dr. Domb referred him for a 2nd opinion with Dr. Ashraf Darwish, also at Hinsdale Orthopaedics.

Mr. Cortez saw Dr. Darwish for a 2nd opinion on his lumbar spine on April 3, 2015. At that time, he reported his November 19, 2015, work accident and indicated ongoing, stabbing, right sided lower back pain into his legs. (P17) Following a physical examination, Dr. Darwish indicated that Petitioner was suffering from back pain and radiculopathy and indicated he should undergo an MRI of his lumbar spine. (P17) Following his lumbar MRI, Petitioner returned to Dr. Darwish on April 9, 2015. (P17) After finding positive right and left sided straight leg raising and reviewing the MRI, Dr. Darwish indicated Petitioner was suffering from post-surgical changes at L4-5, disc osteophyte complex causing central and bilateral foraminal narrowing and lumbar pain with radiculopathy and recommended he undergo a L4-5 lateral lumbar interbody fusion with posterior fusion. (P17) Petitioner underwent lumbar fusion surgery by Dr. Darwish on July 1, 2015. (P17) Petitioner indicated after the surgery that he had a course of physical therapy, which did not help. He also indicated he did not return to Dr. Domb despite ongoing hip problems. Following the surgery, Petitioner indicated Dr. Darwish has kept him off of work and that he was referred for pain management with Pain Specialists in Woodridge. Despite

undergoing cortisone injections, Petitioner indicated he continues to have severe lower back pain.

. Respondent offered the testimony of safety director, Maria Salas. At hearing, Ms. Salas testified she reviewed Petitioner's employment file and identified his 1998 report of accident. She indicated Petitioner presented to her office after his November 19, 2013, work accident, and told her that his low back pain had been ongoing since his prior work accident. Ms. Salas indicated that both Matt Demonte and a translator, Jõse Hernandez, were present during this conversation. Ms. Salas could not say exactly when this conversation took place, but testified she wanted to make sure the foreman, Matt Demonte, was present when Petitioner spoke to her. Mr. Demonte was identified and present during the hearing, but Respondent chose not to call him to testify in order to corroborate Ms. Salas' testimony.

On the day of hearing, when asked what, if any, symptoms he notices about himself, Petitioner indicated he still has pain in his lower back and bilateral hips that limits him from performing most activities. He indicated because of severe low back and right leg pain, he cannot mow his grass, wash his car, purchase groceries, and a number of other activities. Further, although he can do other activities such as cook, he continues to have pain. As of the date of hearing, Petitioner indicated that he continues to have undergo pain management for his symptoms.

Petitioner testified that on the day of accident, he was working full-duty without restrictions of any kind. Prior to that date, he indicated he believed he had a back injury at work in either approximately 1994 or 1995. At that time, Petitioner testified that he sought treatment and was sent to physical therapy. Following completion of the therapy, Petitioner indicated that his symptoms went away and he returned to full-duty work. Mr. Cortez indicated that he has worked full-duty ever since, and has carried out his job duties. The only problems he indicated he noticed was some "regular" back pain that he classified as "tiredness" after hard work, for which he never sought treatment of any kind. Petitioner further indicated that the back pain he noticed after the November 19, 2013, injury was much "stronger" and in different places. As for leg or hip pain, Petitioner testified that he never noticed any of any kind prior to his date of accident.

CONCLUSIONS OF LAW

WITH REGARD TO ISSUES (C) (E) AND (F)WHETHER PETITIONER SUSTAINED AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT, WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING REGARDING HIS LUMBAR SPINE AND BILATERAL HIPS AND IS CAUSALLY RELATED TO HIS WORK ACCIDENT AND WHETHER PETITIONER GAVE APPROPRIATE NOTICE OF HIS NOVEMBER 19, 2013, WORK ACCIDEN, THE ARBITRATOR FINDS AS FOLLOWS:.

Petitioner testified he was maneuvering a 300 lb. coil while it was attached to an overhead crane. While pulling it towards him, he noticed immediate lower back and right leg pain. Petitioner testified he reported the accident immediately to Victor Flores on that day. He also spoke to Mr. Tom Nelson. At hearing, Mr. Nelson confirmed that Petitioner reported the accident to Mr. Flores, and that Petitioner described the accident to him the next day. Mr. Nelson further confirmed that the maneuver that Mr. Cortez performed while he was injured was a reasonable way to move the part. Mr. Nelson offered Petitioner medical treatment, and drove him to Cadence Occupational Health. The records at Cadence Health contain the Form 45, First Report of Injury, that indicates, "he hurt his lumbar back on 11/19/2013. He was lifting coils that were 300 lbs with a crane and he was trying to pull it and felt instant pain." (P2)

The primary issue before the Arbitrator is whether Petitioner's condition of ill-being regarding his lumbar spine and bilateral hips is causally related to the work accident suffered on November 19, 2013. The first discussion is in regards to Petitioner's lumbar spine. As discussed, Petitioner indicated he had some lower back pain immediately after the accident, but it became worse and necessitated medical treatment. As verified by Mr. Nelson, Petitioner was directed by Respondent to seek treatment from Cadence Occupational Health. Petitioner reported to Cadence the following day, November 20, 2013, where he reported sharp and severe right lumbar pain accompanied by weakness/heaviness into his right leg. (P2) The records demonstrate a consistent, ongoing, and uninterrupted course of treatment for Petitioner's lumbar spine from the date of accident to the present time.

On the issue of causation between the accident and Petitioner's lumbar spine condition, Petitioner relies on the testimony of Dr. Kuo and Dr. Darwish, as well as the records from Dr. Bakinski at Cadence Occupational Health. As discussed above, Dr. Bakinski noted throughout her progress notes that she believed Petitioner's back complaints were related to his work accident. (P2) In addition, Dr. Kuo also believed that Petitioner's lumbar complaints were related to his work accident. During her June 19, 2015, evidence deposition, Dr. Kuo testified that upon examining Petitioner for the first time, she also had the opportunity to review his lumbar MRI from October 3, 2014. (P10 at 8) Dr. Kuo testified that she believed, "the MRI demonstrated what I believe was significant stenosis at L4-5, secondary to a herniated disk." (P10 at 8) She explained the stenosis can be caused by anything narrowing the spinal canal and, "in this case I believe it came from a herniated disc at L4-5." (P10 at 8) Given she believed Petitioner's numbness in his leg, hip pain, and back pain were consistent with her diagnosis of stenosis, Dr. Kuo recommended Petitioner undergo an L4-5 laminectomy. (P10 at 10) When asked if pulling and maneuvering 300 pound coils while using a crane can cause Petitioner's spinal condition, Dr. Kuo answered:

> "I think any maneuvering—maneuvering heavy objects, even with assistive devices can be a significant stressor and could put a fair amount of force across the spine. So any motion like that, whether

> it's lifting, twisting, bending, can be associated with an injury such as a herniated disk."(P10 at 18)

Regarding the nature of the disc herniation, Dr. Kuo further explained:

> "Well, first of all, I don't have—I don't have a crystal ball, so I have—the history I have is based on what the patient tells me. Second of all, a herniated disc, I think I stated before, is often a more recent injury, a more acute type injury, and I felt that the herniated disc I saw was consistent with the mechanism made in Dr. Komanduri's note or report. So in regards to radicular symptoms, certainly I thought they could be related." (P10 at 42)

Dr. Kuo then explained that Petitioner's November 19, 2013, work accident also caused his need for surgical intervention and explained, "he had persistent pain, leg pain after the injury, and he had a herniated disc which appeared—which I saw on the MRI and thought or felt that the—that was consistent with his leg pain at that time also." (P10 at 18)

Following his initial surgery with Dr. Kuo on February 6, 2015, it was noted in Dr. Kuo's records, after a physical examination, Petitioner was having positive hip findings without radiculopathy coming from his back. (P9) As discussed, following his lumbar surgery with Dr. Kuo, Mr. Cortez was having ongoing hip complaints and was referred by his therapist at Doctor of Physical Therapy to Dr. Benjamin Domb. Upon seeing Dr. Domb, the doctor felt Petitioner should have a 2nd opinion on his lumbar spine, and referred him to Dr. Darwish. Petitioner indicated that Dr. Darwish eventually performed a spinal fusion. Dr. Darwish discussed his opinions regarding Petitioner's spinal condition during his September 14, 2015, evidence deposition. Upon first seeing Petitioner on April 3, 2015, Dr. Darwish recorded:

> "He had limited range of motion on flexion and extension due to pain. He had tenderness to palpitation over the paraspinal muscles in the lumbosacral region. He had pain that radiated down to the left buttock and lateral thigh on the left side with a straight leg raise. No weakness and no sensory deficit was noted. His wound from surgery was well healed with no evidence of infection. His reflexes were normal." (P14 at 10)

Following his examination, Dr. Darwish felt that Petitioner developed a recurrence of his low back pain with radiculopathy, and ordered an updated lumbar MRI. (P14 at 11) Upon review of the MRI, Dr. Darwish indicated Petitioner had post-surgical change at L4-5 with a disc osteophyte complex causing central and bilateral foraminal narrowing, and explained that the findings were causing Petitioner's ongoing symptoms. (P14 at 11) Regarding the findings, Dr. Darwish explained:

> "A laminectomy—the goal of a laminectomy is to make more space for the nerves. And when the—and you remember we're dealing with millimeters here. We're not making a lot of space because you have to be careful. If you take too much away, then you can cause instability. And you have to go back and do a fusion if you do that. And so how that compares to the MRI—I think the MRI looked like there was decompression there, but somehow there was now less space for the nerve than probably at the time of the decompression." (P14 at 11-12)

Regarding Petitioner, Dr. Darwish explained that the condition happens with time, but that Mr. Cortez did not do well with the initial surgery and that he offered an L4-5 fusion to address Petitioner's ongoing symptoms. (P14 at 13) Petitioner eventually underwent an L4-5 lateral lumbar interbody fusion on July 1, 2015. (P14 at 14) When asked if Petitioner's original accident on November 19, 2013, caused the lumbar condition he diagnosed, Dr. Darwish responded, "I believe it caused the condition that ultimately causes low back pain and lower extremity radiculopathy, needing the initial lumbar decompression." Dr, Darwish further explained, "I think that pulling an object that weighs 300 pounds can cause a significant amount of stress and strain on the lumbar spine." (P14 at 21-22) Regarding the relationship between the work accident and the fusion surgery he performed, Dr. Darwish explained:

> "The patient had the exact symptoms after the—nine months after the original surgery that he had before the surgery. He had pain coming from L4-5, which is obvious by the fact that he improved after that L4-5 fusion. I think they're all related." (P14 at 22)

As discussed, following his initial surgery, Mr. Cortez had some relief of his back symptoms. Dr. Kuo associated his complaints at his post-operation visits with his ongoing hip condition, for which is sought treatment. Unfortunately, Petitioner indicated that his lower back symptoms returned, requiring him to seek treatment from Dr. Darwish.

Respondent disputes causation between Petitioner's work accident and his condition of ill-being regarding his lumbar spine based on the opinions of Dr. Ghanayem and the testimony of Respondent's safety manager, Ms. Salas. In his examination report dated March 31, 2014, Dr. Ghanayem indicated that petitioner had reached maximum medical improvement and did not need further treatment of any kind. (R3) However, Dr. Ghanayem also noted, "His MRI shows a small disc protrusion at the L4-5 level. It is possible that he may have sustained this small, nonsurgical disc protrusion from the same injury as he has described to me." (R3) However, Dr. Ghanayem further opined that Petitioner's bulging disc, "does not cause neurologic compression." (R3) In addition, although Dr. Ghanayem admitted he thought that the Petitioner was "straightforward" with his injury and how he got hurt, he does not explain how or why Petitioner was having the symptoms he complained about. (R1 at 16)

Dr. Ghanayem's opinions are not supported by the evidence submitted. His opinion is in distinct opposition to Dr. Bakinski's, Dr. Komanduri's, Dr. Kuo's, and Dr. Darwish's opinion and it is also in direct contrast to Petitioner's January 3, 2014, lumbar MRI that Dr. Tariq Alam, the radiologist, reviewed. (P3) At the L4-5 level, Dr. Alam indicated:

> "There is disc degeneration with loss of T2 signal and height, with a mild diffuse bulge eccentric laterally on the left. There is a superimposed slightly right paracental protrusion with annular fissure, but without significant mass effect. There is moderate ligamentous and facet degenerative hypertrophy with a degenerative right facet joint effusion. Mild spinal canal stenosis. Mild left neuroforaminal stenosis."

Following the above MRI, Petitioner returned to Cadence Occupational Clinic at which time Dr. Bakinski reviewed the MRI and indicated, "MRI—diffuse bulge L4-5 and L5-S1 with degenerative changes and stenosis. MEDICAL CAUSATION: The cause of this problem is related to work activities." (P2) Upon review of that MRI, the reading radiologist, Dr. Alex Krasny, indicated that there existed at L4-5:

> "Mild disc desiccation. Annular tear in the posterior aspect of the disc. Shallow, broad-based central disc protrusion. This measures 1.9 cm transvere by 0.3 cm AP. It causes mild impression upon the thecal sac. The disc approaches the descending L5 nerve roots in the paracentral regions bilaterally. Mild spinal stenosis. Underlying diffuse broad-based disc osteophyte complex with leftward predominance contributing to mild right foraminal narrowing and mild to moderate left foraminal narrowing."

Following this MRI, Petitioner followed up with Dr. Komanduri on October 8, 2014, who indicated:

> "I had last seen him September 22, 2014. I had ordered a lumbar MRI and confirmed that there is significant stenosis at L4-5. There is facet hypertrophy and arthritis. I am worried that he has significant narrowing of the spinal canal and I think that is what causing his leg pain and hip pain. I have set him up with a follow with Dr. Quell (dictation error-Dr. Kuo) I anticipate he may need urgent surgical management."

Dr. Komanduri's above opinion coincides with Dr. Kuo's testimony that she believes the October 8, 2014, MRI demonstrated significant stenosis secondary to a herniated disc at L4-5. (P10 at 8) During his deposition testimony, Dr. Darwish also confirmed that he believed the MRI demonstrated stenosis at Petitioner's L4-5 level. (P14 at 11) Clearly, Petitioner had a herniated

disc that was causing stenosis, as evidenced by his January and October 2014 lumbar MRIs, as well as the opinions of Dr. Bakinski, Dr. Komanduri, Dr. Kuo and Dr. Darwish. Given this, Dr. Ghanayem's opinion is not credible.

Respondent further disputes causation between Petitioner's accident and lumbar spine condition based on the allegation that Petitioner had a pre-existing lumbar spine condition and that the injury suffered, if any, resolved by his November 25, 2014, appointment with Cadence Occupational Health. This is not supported by the evidence. As discussed, at hearing, Petitioner testified that on the date of accident, he was working full-duty and carrying out all of his work duties. This was confirmed by Respondent's former plant manager, Mr. Tom Nelson. Petitioner indicated he had suffered one work accident prior to 2013 involving his lumbar spine. Petitioner believed it was 1994 or 1995 that he reported the injury. He indicated after some physical therapy he was returned to full-duty work and worked full duty ever since that time. Respondent submitted an accident report regarding Petitioner's lumbar spine dated 1998. Regardless if it was 1995 or 1998, there is no evidence or medical documentation that Petitioner received any treatment of any kind or reported to a doctor for back problems in either 15 or 18 years. Even if Petitioner had some low back pain prior to his work accident, Dr. Darwish testified his opinion on causation would not change. (P14 at 24)

Petitioner candidly reported to Occupational Health after his work accident that he had occasional back pain over the years. When asked about this at hearing, Petitioner associated the pain with "tiredness" or "regular" back pain after hard work. He further indicated that after the work accident the back pain was much "stronger" and did not go away. Respondent offered the testimony of safety director, Maria Salas. At hearing, Ms. Salas testified she reviewed Petitioner's employment file and identified his 1998 report of accident. She indicated Petitioner presented to her office after his November 19, 2013, work accident, and told her that his low back pain had been ongoing since his prior work accident. Ms. Salas indicated that both Matt Demonte and a translator, Jose Hernandez, were present during this conversation. Ms. Salas could not say exactly when this conversation took place, but testified she wanted to make sure the foreman, Matt Demonte, was present when Petitioner spoke to her. Mr. Demonte was identified and present during the hearing, but Respondent chose not to call him to testify in order to corroborate Ms. Salas' testimony.

At hearing, Mr. Nelson testified Respondent had Petitioner sweeping while he was on light-duty. Mr. Nelson stated as of May, 2014, Respondent allowed Petitioner to return to work being a helper, as opposed to his former position, because of a downturn in business. He stated that this position required more physical activity and more lifting than Petitioner's prior position. Petitioner worked that position until ceasing working on June 2, 2014, because of doctor's restrictions.

Finally, Respondent argues that whatever lower back injury Petitioner suffered on November 19, 2013, it resolved by November 25, 2013, when he saw Dr. Bakinski at Cadence Occupational Clinic. Respondent takes issue with Petitioner's description of his symptoms

during his November 25, 2013, visit with Dr. Bakinski wherein he indicated that he felt his symptoms were resolving and he was 100% improved from his injury. (P2) Respondent argues that because Petitioner felt that he was improved on that date, there is no causation between the accident and his current condition. It is noted above that there were clearly contradictory statements regarding Petitioner's physical condition contained within the treatment note of that date. However, it is clear Petitioner's spinal condition was not at maximum medical improvement at that time because by December 11, 2013, Petitioner returned to the Cadence Occupational Clinic with the same types of complaints he had at his November 20, 2013, visit. During the December 11th visit, Petitioner reported he finished the previously prescribed ibuprofen and his pain returned. Petitioner also testified without contradiction that the medication relieved his symptoms, but that when he finished the course of medication, the symptoms returned. (P2) At that time, Dr. Bakinski documented that she believed Petitioner's symptoms were related to his work accident, prescribed additional ibuprofen, cyclobenzaprine, physical therapy, and light-duty work restrictions. (P2) From that point forward, Petitioner's lumbar treatment continued as described above.

During her deposition testimony, Dr. Kuo indicated Petitioner's reports of improvement on November 25, 2013, did not change her causation opinions. When asked about Mr. Cortez reporting his symptoms returned after completing the ibuprofen, and the role that played in Petitioner's symptoms, Dr. Kuo explained, "High dose ibuprofen or, what do you call it, Medrol dose pack or some other oral steroid can often decrease inflammation to decrease pain, that's exactly what it's for." (P10 at 41) Given the above, Dr. Kuo concluded that Mr. Cortez's symptoms had not resolved on November 25th because they returned as soon as the medication wore off. (P10 at 42) Based on the record as a whole, and specifically noting the above, the Arbitrator finds that Petitioner's condition regarding his lumbar spine is causally related to the accident alleged herein.

The second issue of causation before the Arbitrator concerns Petitioner's bilateral hip condition. At hearing, Petitioner testified that in addition to the aforementioned lumbar complaints, he noticed pain into his right leg. From the onset of his treatment with Cadence Occupational Health, all the way through his treatment with Dr. Domb, Petitioner had ongoing and consistent symptoms involving his right leg. Petitioner also indicated that he first noticed left hip pain following his examination with Dr. Ghanayem. Petitioner received treatment for his bilateral hip condition from Dr. Komanduri and Dr. Domb. Both doctors agreed that Petitioner had bilateral hip labral tears. Petitioner only had surgery on the right side with the left side not treated surgically to date. During his February 12, 2015 evidence deposition, Dr. Komanduri discussed Petitioner's bilateral hip condition in great detail. Dr. Komanduri indicated that upon his first examination of Petitioner, he felt that he suffered from FAI, or femoroacetablur impingement, and labral tears in both hips, with the right being worse than the left. (P6 at 10) Dr. Komanduri explained this condition:

> "So the actual disease process, the presence of a Pincer and a CAM lesion, those are the bone spurs, the Pincer's usually on the

> acetabular side, a CAM lesion's usually present on the femoral neck, they meet and pinch. They literally grind against each other in hip flexion that blocks motion when they're enlarged. The actual presence of Pincer and CAM lesions is actually either a congenital process or a preexisting process. By itself it did not-it was not caused by the accident, though the consequence is that he's predisposed. So in deep flexion or in a squatting maneuver or in heavy lifting, the labrum takes a beating from these bone spurs and can rip and tear. The tearing of the labrum exposes the underlying joint cartilage to wear and tear so it becomes a critical event and requires restoration." (P6 at 11-12)

Dr. Komanduri was then asked what role did Petitioner's November 19, 2013, accident play in his condition of ill-being regarding his hips; CAM lesions, impingement and labral tears. To this, Dr. Komanduri explained:

> "Right. So at least historically that's what he's telling me. I don't have any other reason to believe that another injury occurred. The patient came in having been treated at an outside facility with rehab and conservative treatment for several months. So there's no—no doubt in my mind that, you know, he was injured. I'm not the only physician that saw him that thought he was injured and that that injury led to an aggravation of his femoroacetabular impingement, which I clearly told you is preexisting and which resulted in a labral tear. Labral tears by themselves are not guaranteed because someone has FAI and most patients with FAI are asymptomatic. So usually there's a traumatic event and the FAI predisposed them to injury." (P6 at 32)

Dr. Komanduri offers the same opinion regarding Petitioner's left hip condition, but notes that the left is not as painful or severe as Petitioner's right hip. (P6 at 33)

To dispute causation regarding Petitioner's bilateral hip condition, Respondent offers the testimony of Dr. Thomas Gleason. In his report dated April 21, 2015, Dr. Gleason opines, "There is no current condition of illness of his hips causally related to the claimed accident of November 19, 2013."(R4) Based on that, Dr. Gleason indicated no further treatment or restrictions were necessary or related to Petitioner's hip conditions.

Petitioner had no complaints of right or left hip pain prior to his date of accident on November 19, 2013. Respondent offered no evidence of any kind to demonstrate that Petitioner had any condition of ill-being related to his hips prior to his date of accident. Given this, considering Dr. Komanduri's causation opinion is based largely on when Petitioner's right and left hips became symptomatic, it is clear that Petitioner only had hip problems following the

documented work accident. Petitioner's right hip complaints were especially prominent immediately following the work accident.

Considering the above, and based on the greater weight of the evidence, the Arbitrator finds that Petitioner suffered a work accident on November 19, 2013, and gave proper notice pursuant to the Act. The Arbitrator further finds that Petitioner's current condition of ill-being involving his lumbar spine and bilateral hips is causally related to his compensable work accident. The Arbitrator specifically notes that the opinions of Dr. Bakinski, Dr. Kuo, Dr. Darwish and Dr. Komanduri are more credible than the opinions offered by Dr. Ghanayem and Dr. Gleason.

WITH REGARD TO ISSUE (J) WHETHER THE MEDICAL SERVICES RENDERED TO PETITIONER WERE REASONABLE AND NECESSARY AND CAUSALLY CONNECTED TO THE ACCIDENT AS ALLEGED HEREIN, THE ARBITRATOR FINDS AS FOLLOWS:.

The Arbitrator incorporates herein by reference thereto the findings as set forth above. Given the Arbitrator's findings above regarding accident and causation, the Arbitrator finds that Respondent is liable for Petitioner's reasonable and necessary medical treatment. Regarding the reasonableness and necessity of treatment, Petitioner offers the opinions of Dr. Kuo, Dr. Darwish and Dr. Komanduri. Regarding the need for the surgery she performed, Dr. Kuo testified that the accident caused the need for surgery as evidenced by his herniated disk and ongoing low back and leg pain. (R10 at 18) She also indicated that Petitioner's lower back treatment prior to seeing her was reasonable and necessary because, "physical therapy and injections are part and parcel of treating herniated discs." (P10 at 19) Dr. Darwish further testified that the surgery he performed on Petitioner was related to his accident, and necessary given that he had a recurrence in his symptoms following the laminectomy surgery. (P14 at 23) Dr. Darwish also opined that Petitioner's previous surgery and treatment was reasonable and necessary because he did not have relief of his symptoms following the work accident. (P14 at 24) Regarding the necessity and treatment regarding his hips, Petitioner offers the testimony of Dr. Komanduri who indicated that the medical treatment provided for his hips was reasonable and necessary. (P6 at 33)

Based on the greater weight of the evidence, the Arbitrator awards Petitioner all reasonable and necessary medical treatment as outlined in Petitioner's exhibit 1. Respondent is awarded any demonstrable credit for medical bills paid through its group insurance plan. All bills are to be paid according to the medical fee schedule.

WITH RESPECT TO ISSUE (L) WHETHER RESPONDENT IS LIABLE FOR PETITIONER'S TEMPORARY TOTAL DISABILITY BENEFIT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator incorporates herein by reference thereto the findings as set forth above. Given the Arbitrator's findings above regarding accident and causation, the Arbitrator finds that

Respondent is liable for payment of Petitioner's temporary total disability benefits as follows. The parties agree that Petitioner's TTD period began and June 3, 2014, and continues through the day of hearing on April 13, 2016. From June 3, 2014, to the present time, Petitioner has either been kept off of work by his treating physicians or kept on light duty. While treating at Cadence Occupational Health, Dr. Bakinski kept Petitioner on light duty status. (P2) This continued when Petitioner Dr. Froese on January 22, 2014. (P3) Both Mr. Cortez and Mr. Nelson testified that Petitioner worked light-duty at Respondent. Petitioner was then taken off of work by Dr. Komanduri after seeing him on June 9, 2014. (P3) Petitioner was kept off of work by Dr. Kuo during treatment for his lower back, and again by Dr. Komanduri when he returned for hip treatment. (P3, P5, P9) Neither physician returned Petitioner to work. Petitioner then had continued restrictions from Dr. Darwish that were no lifting over 15 pounds as of August 14, 2015. (P13) These restrictions were never lifted, and the doctor testified that it was his hope he could return Mr. Cortez to full duty work at 12 months after surgery, July 2015. (P14 at 19 & 20) He further indicated that he would consider ordering that Petitioner undergo work conditioning and/or a functional capacity evaluation. (P14 at 20) As of his last appointment with Dr. Domb, dated December 3, 2015, Petitioner had not reached maximum medical improvement and was referred to treatment with Dr. Thomas Pontinen at Midwest Anesthesia and Pain Specialists. (P16) Petitioner confirmed that he has been undergoing treatment with Midwest Anesthesia.

Based on the greater weight of the evidence, the Arbitrator awards Petitioner unpaid temporary total disability benefits from June 3, 2014, through the date of hearing. Respondent is entitled to any demonstrable credit for amounts paid through its non-occupational disability plan.

WITH REGARD TO ISSUE (O) WHETHER PETITIONER'S TREATMENT VIOLATED THE ACT'S LIMITATION ON CHOICE OF DOCTOR, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator incorporates herein by reference thereto the findings as set forth above. Given the Arbitrator's findings above regarding accident and causation, the Arbitrator finds that at hearing, Petitioner and Mr. Nelson confirmed that Petitioner's first treatment was at Cadence Occupational Health by request of the Respondent. Petitioner then treated with Dr. Bakinski, who then referred him for a physiatry consult. (P2) Pursuant to this referral, Petitioner then saw Dr. Beth Froese for epidural injections. (P2) Petitioner then chose treatment with Dr. Mokund Komanduri, who then referred him to Dr. Kuo for spinal treatment. (P5) Following his right hip and spinal surgeries, by Dr. Komanduri and Dr. Kuo respectively, Petitioner underwent physical therapy at Doctors of Physical Therapy by referral of those doctors. Petitioner indicated that he continued to have pain, and upon discussion with his therapist, testified that he was referred by his therapist to Dr. Domb for his hip condition. Upon seeing Dr. Domb, Petitioner was then referred to Dr. Darwish for a second opinion regarding his lumbar spine. (P17) After having ongoing lumbar and bilateral hip complaints, Dr. Darwish referred Petitioner for pain management treatment at Midwest Anesthesia and Pain Specialists. (P17) Mr. Cortez confirmed that he continues to undergo treatment at Midwest Anesthesia. Given this, following his treatment at Cadence, Petitioner had an unbroken chain of treatment from Dr. Komanduri

forward through treatment with Dr. Kuo, therapy at Doctors of Physical Therapy, Dr. Domb, Dr. Darwish, therapy at Athlecito and pain management with Midwest Anesthesia.

The Act allows a claimant two choices of doctors in the situation where the Respondent directs them for medical care. Here, it is unrebutted that Respondent directed Petitioner to Cadence Occupational Health. However, Respondent offered no evidence that Cadence Occupational is part of a Preferred Provider Program within the definition under the Act. Here, the Employer/Respondent did not, "in writing, on a form promulgated by the Commission, inform the employee of the preferred provider program." Section 8(a)(4). Given this, Section 8(a)(4) does not apply to the current matter and, as such, Section 8(a) subsections (1)(2)(3) apply. In this scenario, Petitioner's treatment at Cadence Occupational was not his choice, therefore his treatment with Dr. Komanduri would be Petitioner's first choice of treatment. This chain includes Dr. Kuo, and subsequent therapy at Doctors of Physical Therapy. Mr. Cortez's second chain of treatment would then begin with Dr. Domb and includes Dr. Darwish, therapy at Athletico and his treatment with Midwest Pain and Anesthesia.

Based on the greater weight of the evidence, the Arbitrator finds that Petitioner did not violate the Act's provisions on choice of doctor and, as such, Respondent is liable for all reasonable and necessary medical treatment.

WITH RESPECT TO ISSUE (O) WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL TREATMENT AS OUTLINED BY HIS TREATING PHYSICIANS, THE ARBITRATOR FINDS AS FOLLOWS:

At hearing, Petitioner testified that he has ongoing symptoms related to his lumbar spine and bilateral hips. He is currently treating at Midwest Anesthesia, but has not been released from any of his physicians. Dr. Domb indicated Petitioner may benefit from additional hip surgery. (P17) Dr. Darwish indicated that, in addition to the current pain management treatment, work conditioning and/or a functional capacity evaluation may be necessary. (P14 at 20) Given the Arbitrator's findings on accident and causation, Respondent is liable for work conditioning and FCE should Petitioner undergo same. Dr. Domb's indication regarding possible hip surgery is too nebulous at this time to award same.

Based on the greater weight of the evidence, the Arbitrator awards Petitioner prospective treatment, as indicated by Dr. Domb.

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

Jeff Wiese,

Petitioner,

vs.

NO: 14 WC 23411

City of Springfield,

17IWCC0373

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 caustion, medical, permanent partial disability, occupational disease, 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 3, 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: JUN 19 2017

Charles J. DeVriendt

Joshua D. Luskin

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CJD/rlc
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DISSENT 17IWCC0373

A claimant who suffers from a pre-existing condition may recover benefits under the Act where an accident aggravates or accelerates his condition. *International Vermiculite Company v. The Industrial Commission*, 77 Ill. 2d 1 (1979). Further the accident must be a factor which contributes to the disability. *Caterpillar Tractor Co. v. The Industrial Commission*, 92 Ill. 2d 30 (1982). Mere correlation of symptoms is not enough as causation between the accident and the resulting disability must exist. *Long v. The Industrial Commission*, 76 Ill. 2d 561 (1979). No such causation exists. Therefore, I respectfully dissent.

Petitioner testified he felt pain in his lower back when he threw a ten pound log into his truck, twisting left to right. T. 21. Petitioner sought treatment from Midwest Occupational Health Associates on April 24, 2014, following his accident complaining of low back pain. A low back strain was diagnosed. PX7. An MRI was performed on May 9, 2014 evidencing mild spondylolisthesis and bilateral spondylolysis at L5-S1 and no herniations were noted. PX7. Dr. Ferguson evaluated Petitioner on May 12, 2014 and advised him as to the degenerative findings and continued to recommend physical therapy which Petitioner declined. PX7.

Petitioner opted instead to commence treatment with Dr. Payne. Dr. Payne provided his causation opinion *vis-à-vis* his evidence deposition taken on January 29, 2015. PX8. On direct examination Dr. Payne testified the work accident contributed to Petitioner's pain. When asked to explain how, Dr. Payne speculated the accident caused a small herniation which compressed Petitioner's nerves from which Petitioner could not recover. PX8, p. 13. This opinion, though, did not hold up on cross-examination. When confronted with his July 28, 2014 operative report, Dr. Payne testified during the spinal fusion surgery, no herniated disc material was found to exist. Instead Dr. Payne testified Petitioner suffered from a pseudo-bulge which was caused by the spondylolisthesis. PX8, p. 33. Further, Dr. Payne testified such condition preexisted Petitioner's April 24, 2014 accident. PX8, p. 34. On re-direct examination, Petitioner's attorney attempted to rehabilitate Dr. Payne's causation opinion by posing a hypothetical question to which Dr. Payne responded by speculating as to Petitioner's twisting motion and its potential cause of pain and abandoning his original opinion. PX8, p. 44.

In contrast Dr. deGrange provided his opinion as to the lack of causation *vis-à-vis* his evidence deposition taken on December 16, 2014. Dr. deGrange testified Petitioner's April 24, 2014 accident did not aggravate Petitioner's underlying degenerative condition. RX1, p. 22-23. Dr. deGrange testified Petitioner suffered from a lumbar strain which resolved, and Petitioner's need for treatment was due to his underlying condition of spondylolisthesis. *Id.* Dr. deGrange went on to explain a temporal relationship between Petitioner's accident and his pain complaints does not infer causation but instead confuses correlation with causation. RX1, p. 40.

"While the existence of prior back problems does not deprive the claimant of the right to an award (*International Vermiculite Co. v. Industrial Com. (1979), 77 Ill. 2d 1*), the

17IWCC0373

connection between the employment and subsequent problems must be established. The mere fact that the employee was at work or engaged in some work-related activity when the episode occurred is not alone sufficient [*219] to support an award. [citation]." *Caterpillar Tractor Co. v. The Industrial Commission*, 83 Ill. 2d 213, 218-9 (1980). Petitioner failed to prove a causal relationship between his work accident and his subsequent treatment as it relates to his underlying degenerative condition- spondylolisthesis. The majority in adopting the decision of the arbitrator affords greater weight to the opinion of Dr. Payne apparently due to his status as a treating physician. The fact Dr. Payne is Petitioner's treating physician confers no special status to his opinion. *Pollard v. The Industrial Commission*, 91 Ill. 2d 266, 274 (1982). ("[T]here is no requirement that the testimony of a treating physician be given greater weight that the testimony of a physician who has examined the employee solely for the purposes of testifying.")

I would afford greater weight to the opinion of Dr. deGrange. Petitioner's mechanism of injury- twisting and turning- is consistent with the development of a lumbar strain- straining his back muscles. While treating for his work-related lumbar strain, an incidental finding was revealed- his degenerative spondylolisthesis. This condition and the subsequent treatment for the same *i.e.* the spinal fusion bears no causal relationship to Petitioner's employment. As Dr. deGrange noted "his formal stenosis was so severe, so advanced, that anything that this young man could have done was likely to bring about the symptoms. He was, if you want, on the precipice, just waiting to become symptomatic." RX1, p. 43-44.

As the Court noted in *Sisbro Inc. v. The Industrial Commission*, 207 Ill. 2d 193, 212-13 (2003):

> Every employee whose disease or preexisting condition disables him while at work is not automatically entitled to a recovery under the Workmen's Compensation Act. In *Carson-Payson Co. v. Industrial Com. (1930), 340 Ill. 632, 639, 173 N.E. 184*, this court said, quoting from Lord Chancellor Loreburn's opinion in *Hughes v. Clover, Clayton & Co.* (1910), 102 L.T.R. 340, 342, *aff'g* (1909) 2K.B. 798, 101, L.T.R. 475: "In each case the arbitrator ought to consider whether, in substance, as far as he can judge on such a matter, the accident came from the disease alone, so that, whatever the man had been doing, it would probably have come all the same, or whether the employment contributed to it. In other words, did he die from the disease alone, or from the disease and employment taken together, looking at it broadly. *County of Cook, 68 Ill. 2d at 31-31.*"

Petitioner's current condition of ill-being was caused by his degenerative condition and not his work-related lumbar strain. I would find Petitioner at MMI as of May 24, 2014 based upon the opinion of Dr. deGrange and deny any medical expenses and temporary total disability benefits thereafter. I would award benefits pursuant to Section 8(d)2 of the Act for 15 weeks or 3% loss use of the person as a whole. Accordingly, I dissent.

L Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIESE, JEFF
Employee/Petitioner

Case# **14WC023411**

CITY OF SPRINGFIELD
Employer/Respondent

17IWCC0373

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:

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SPRINGFIELD, IL 62704

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17IWCC0373

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

Jeff Wiese
Employee/Petitioner

Case # 14 WC 23411

v.

Consolidated cases: _____

City of Springfield
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 **Springfield**, on **January 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 17IWCC0373

On **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 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 **$54,584.24**; the average weekly wage was **$1,051.62**.

On the date of accident, Petitioner was **47** years of age, married with **1** dependent children.

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$5,908.85** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,908.85**.

Respondent is entitled to a credit of **$40,668.83** under Section 8(j) of the Act.

ORDER

Medical benefits

Respondent shall pay for reasonable and necessary medical services as set forth in Petitioner's Exhibit 9, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $40,668.83 for medical benefits that have been paid by group health, 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.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $701.08/week for 31 and 1/7 weeks, commencing April 30, 2014 through May 11, 2014 and commencing June 12, 2014 through January 5, 2015, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $5,908.85 for temporary total disability benefits that have been paid.

Permanent Partial Disability

Respondent shall pay Petitioner permanent partial disability benefits of $630.97/week for 150 weeks, because the injuries caused a 30 % loss to the person as a whole, pursuant to Section 8 (d) 2 of the Act.

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

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

D. Glenn McCarty

Signature of Arbitrator

2/2/2016

Date

FEB 3 - 2016

STATEMENT OF FACTS

Petitioner is a forty-nine year old employee of the Respondent. Petitioner graduated high school in 1985, and has had no further education or trade training. Prior to working for the Respondent, the Petitioner worked in a variety of delivery and stocking type jobs. All of his prior positions have been either delivery or involved physical labor.

Petitioner began working for Respondent in April of 2003. He began his employment with Respondent as a union janitor. As a janitor, he was required to lift mop buckets and move office chairs. He worked in the janitorial position for approximately five years, at which time he transferred to Lake Services, where he maintained parks and mowed grass. In his position with Lake Services, he was required to lift garbage bags out of garbage cans and lift tailgates. Petitioner subsequently transferred to the Water Department, where he performed janitorial duties for one year. He then moved to his current position at the Groth Street facility, where he works in the yard maintenance department.

Petitioner has been in his current position for six years. His job duties include cutting grass, taking care of substations, repairing damaged yards, and picking up logs from trees cut for telephone maintenance. He testified that he performs lifting of logs, dirt with shovels, and wheelbarrows. Petitioner testified that his job requirements include being able to push, pull, and drag at least 100 pounds.

Petitioner testified that prior to his April 24, 2014 date of accident, he had not suffered any injuries to his back and had not had any back pain or problems prior to that date. He testified that he had treated with a chiropractor in his late twenties or early thirties for six to eight weeks for some back soreness. After completing this treatment, his back symptoms resolved. He has not received any chiropractic treatment since that time. Prior to April 24, 2014, he was able to perform all of his job duties with Respondent without difficulty.

On April 24, 2014, the Petitioner was working his normal 7:00 a.m. to 3:30 p.m. shift. He was assigned the duty of picking up logs on a property on Griffith Street after trees had been trimmed. He was performing this job with his foreman, Dennis Venturini. Petitioner testified that he was picking the logs up from the ground and throwing them over the edge of the truck. He testified that the logs ranged in weight from 10 to 50 pounds each. He was lifting the logs up from the ground, up to chest or shoulder level, twisting from left to right, and throwing them into the back of the truck. At the time of his injury, he had been moving logs for approximately twenty minutes and had moved thirty to thirty-five.

Petitioner testified that he lifted a log weighing approximately 10 pounds, twisted his body from left to right and threw it over the side of the truck when he noticed a sharp pain in his back radiating down his left leg. He testified he had never felt any shooting or radicular pain in his leg prior to this time. Petitioner immediately returned to the Groth Street office, without lifting any additional logs, and filled out an accident report with his supervisor, Carl Tega. He testified the report was filled out at approximately 11:00 a.m.

Petitioner was sent directly to MOHA by Respondent, where he was evaluated by a nurse practitioner and given a Toradol injection and pain medications. Petitioner testified he received very little relief from the Toradol injection. Petitioner was further placed on work restrictions of no lifting greater than 10 pounds, no pushing or pulling, no operation of motor vehicles such as driving a lawnmower or tractor, no repetitive waist bending, no shoveling and sit down as needed. Petitioner testified that he was allowed to return to work within these restrictions.

On April 30, 2014, Petitioner returned to MOHA and was seen by Dr. Matthew Yociss. Petitioner reported no significant change in his condition. PX 7. He noted that he had been in bed the entire weekend which did not

help his symptoms. PX 7. He further stated that he has been sitting the majority of the time at work and was performing frequent position changes as prolonged sitting or standing aggravated his symptoms. PX 7. Physical examination revealed tenderness on palpation to the left lower lumbar area in the L3-L5 distribution. PX 7. Examination further revealed increased discomfort with extension. PX 7. Dr. Yociss rendered a diagnosis of acute lumbar strain on the left. He continued Petitioner's prescription for tramadol and further prescribed skelaxin. PX 7. Petitioner testified that the skelaxin did not relieve his symptoms. Dr. Yociss further continued Petitioner's work restrictions. PX 7. Also, Dr. Yociss referred the Petitioner for physical therapy. PX 7. Petitioner testified that he did not participate in physical therapy as he wanted to obtain a second opinion as to his back condition.

Petitioner returned to Dr. Yociss on May 8, 2014, reporting an increase in pain and a pulling and burning sensation when he bends over. PX 7. He further reported that he was having trouble lying down and sitting up. PX 7. Examination revealed tenderness of the paraspinal musculature of the left lumbar spine radiating down into the left buttock, as well as 4/5 strength on the left leg compared with 5/5 on the right. PX 7. Dr. Yociss recommended a stay on physical therapy due to increased symptoms and ordered an MRI of the lumbar spine. PX 7. Dr. Yociss further continued Petitioner's work restrictions. PX 7.

On May 9, 2014, the Petitioner underwent an MRI of the lumbar spine without contrast. PX 7. The MRI revealed mild spondylolisthesis with bilateral spondylolysis at L5-S1, as well as severe left and moderate to severe right neuroforaminal stenosis at L5-S1. PX 7. The Petitioner testified that subsequent to receiving his MRI results, his claim was placed in denied status.

Petitioner returned for his final visit with MOHA on May 12, 2014. He had the same level of pain as reported in his earlier visits. The Doctor he saw at the time, Dr. Ferguson, noted that the MRI showed a degenerative condition and that the petitioner's pain was likely related to his chronic changes. Petitioner was instructed to follow up with his regular physician for further restrictions, and was discharged from care. PX 7.

On May 14, 2014, Petitioner presented to PA Mindy Sanders, the physician's assistant to his primary care physician, Dr. Lanzotti. PX 3. He reported that on April 24th he was picking up wood, turning to the side and throwing, when he felt a tweak in his low back. PX 3. He reported that his back pain was no better. PX 3. PA Sanders reviewed Petitioner's MRI, noting it showed neural foraminal stenosis in the lumbar spine. PX 3. She prescribed prednisone and cyclobenzaprine. PX 3. She further referred Petitioner for evaluation by Dr. William Payne. PX 3. Petitioner was placed on a no work restriction. PX 1.

Petitioner presented to PA Jennifer Nichelson, a physician's assistant for Dr. Payne on May 22, 2014. Dr. Payne testified via his evidence deposition, entered into Evidence as Petitioner's Exhibit 8. Dr. Payne is a board certified orthopedic surgeon who focuses his practice on spine surgery. On May 22, 2014, Petitioner noted he was experiencing lower back pain that radiated into his left leg that had been ongoing for approximately one month. PX 3. He rated his pain as severe and explained that it was getting worse. PX 3. Physical examination revealed some tightness in the back of the left leg on straight leg raise, but not as much pain as standing. Further, PA Nichelson noted weakness in the left leg generally, more so in the tibialis anterior and gastrocsoleus on the left side. Petitioner noted pain in his back with flexion and extension and was noted to have decreased range of motion with flexion and extension. PX 3.

PA Nichelson reviewed Petitioner's MRI and took standing x-rays with flexion and extension in office. The x-rays showed grade 2 lytic spondylolisthesis at L5-S1, and the spondylolisthesis looked more pronounced on the x-ray than the MRI due to maneuvering. PX 3. Dr. Payne testified that he reviewed the MRI studies independently and also noted lyctic spondylolisthesis at L5-S1 with severe foraminal stenosis. PX 8, p. 9.

Petitioner was diagnosed with L5-S1 grate 2 lytic spondylolisthesis and bilateral foraminal stenosis, most severe on the left, with left sided L5 radiculopathy. PX 3. PA Nichelson recommended Petitioner undergo an epidural steroid injection, and that Petitioner meet with Dr. Payne for surgical consult if the injection was not successful. PX 3.

On May 27, 2014, the Petitioner underwent a left-sided L5-S1 transforaminal epidural steroid injection with Dr. Gary Western. PX 3. Petitioner testified that the steroid injection did not provide any relief.

On June 12, 2014, Petitioner presented to Dr. Payne. Dr. Payne noted the Petitioner had not received relief from the epidural steroid injection and that he was experiencing significant L5 radicular pain. Dr. Payne noted Petitioner had grade two slippage. Dr. Payne recommended Petitioner undergo an L5-S1 fusion. PX 3. Dr. Payne testified that fusion is the only standard treatment for lytic spondyolisthesis with radicular pain. PX 8, p. 14. Petitioner consented to the procedure and Dr. Payne referred Petitioner back to Dr. Lanzotti for pre-operative clearance. PX 3. Dr. Payne further restricted Petitioner from work pending surgery. PX 1.

Dr. Payne testified that a person can have lytic spondylolisthesis with severe foraminal stenosis and have no symptoms. PX 8, p. 9. In fact, Dr. Payne testified that 80% of people with lytic spondylolisthesis go through life without knowing they have it. PX 8, p. 10. Dr. Payne testified that lytic spondylolisthesis is caused by a chronic stress fracture that a patient generally incurs during childhood. PX 8, p. 11. Most people do not have any problems with these injuries. PX 8, p. 10. Dr. Payne testified that, assuming the Petitioner had only had occasional aches and pains and no radicular complaints prior the accident and assuming that on April 24, 2014, Petitioner was picking up wood and twisting his trunk while throwing wood into the back of a trunk when he felt pain in his lower back that radiated down to his left buttock and ultimately left side, that this activity contributed to Petitioner's pain. PX 8, p. 12-13. Dr. Payne testified that "anytime you are twisting in the lumbar spine, we know that the orientation of the fibers of the outer layers of the discs are oblique, and they kind of cross each other, and twisting puts them at their - - kind of their weakest point." PX 8, p. 43. Due to the preexisting foraminal stenosis, the twisting motion compresses the nerve dynamically as Petitioner twists, which could irritate the L5 nerve root. PX 8, p. 44. He testified that Petitioner had been living with stenotic neural foramen at L5-S1 for a long time and his nerves were used to it. PX 8, p. 13. Something occurred when he twisted and lifted that caused symptoms. PX 8, p. 13. After the injury, his nerve was irritated and could not recover. PX 8, p. 13.

Petitioner underwent a pre-surgical clearance evaluation on July 1, 2014. The evaluation included laboratory studies, a chest x-ray, and an EKG. Petitioner was further referred for cardiac clearance with Dr. Yasmin Hamirani, which took place on July 24, 2014.

On July 28, 2014, Petitioner underwent lumbar surgery with Dr. Payne. Dr. Payne performed a laminectomy of L5, posterior fusion of L5-S1 with segmental instrumentation, transforaminal lumbar interbody fusion with case at L5-S1, allograft bone, and aspiration of the left iliac crest. PX 5. A 12 millimeter by 22 millimeter cage, a 5.5 rod and a number of solera pedicle screws were placed into Petitioner's lumbar spine. PX 5. The Petitioner testified that the surgery alleviated the numbness in his legs, but he continued to have ongoing lumbar pain.

On July 31, 2014, a call was placed to Dr. Payne's telenurse by Petitioner's wife, indicating that Petitioner had experienced three severe headaches in the previous 24 hours, rated 10 out of 10 on a pain scale. PX 3. He was not receiving any relief with Norco prescribed post-surgically. PX 3. Petitioner was instructed to use Norco and Ultram alternating and to follow-up the next day. PX 3. Petitioner subsequently followed up with PA Sanders and Dr. Payne for his headaches on August 1, 2014. PX 3.

Petitioner returned to Dr. Payne's office for follow-up on August 14, 2014. Petitioner was not having any pain in his legs, but was having significant pain in his lower back. PX 3. Dr. Payne testified that the lack of leg pain indicated a positive surgical result. PX 8, p. 19. An x-ray was performed in office which showed reduction of the spondylolisthesis and good cage placement. PX 3. Petitioner was prescribed a three week supply of Percocet, as he was not receiving relief from Norco, and instructed to return in one month. PX 3.

Petitioner was seen by Dr. Payne on October 23, 2014. X-rays were taken in office which showed appropriate post-surgical alignment. PX 3. Petitioner reported difficulties with bending and twisting. PX 3. Dr. Payne referred Petitioner to physical therapy. PX 3.

Petitioner began physical therapy at Springfield Clinic on November 7, 2014. He continued to receive physical therapy until December 18, 2014. PX 6. Petitioner testified that physical therapy had helped as it strengthened his back and legs. However, upon discharge from physical therapy continued to report back pain at 4 to 5 out of 10.

On January 5, 2015, Petitioner was returned to work without restrictions by Dr. Payne. PX 1. Petitioner testified that he did ask Dr. Payne to return him to full duty work. He testified that since obtaining his MRI prior to surgery, his claim had been denied and he was not receiving temporary disability benefits. Early on, he had used his vacation pay, sick time, and other benefits to receive payment while he was restricted from work. He testified that those benefits were exhausted around late August or early September 2014. Petitioner testified that from that time until he was returned to work by Dr. Payne on January 5, 2015, he had no income. He had been informed he could not return to work until his work restrictions were lifted. Petitioner testified that this was the reason he asked Dr. Payne to return him to work full duty. However, Petitioner testified that he continued to have symptoms when he returned to work.

Petitioner presented to Dr. Donald deGrange, an orthopedic surgeon, on October 20, 2014 at the request of Respondent for an Independent Medical Evaluation. Dr. deGrange's evidence deposition was entered into evidence as Respondent's Exhibit 1. Respondent reported that on April 24, 2014 he was picking up limbs and branches from a recently-felled tree and throwing them into the back of a truck. RX 1, p. 7. He reported he picked up a 10-pound piece of wood, lifted and twisted, and threw the wood into the truck. RX 1, p. 7. He reported instant onset of low back pain. RX 1, p. 7. Petitioner further reported low back pain going into the left leg to Dr. deGrange. RX 1, p. 9. Dr. deGrange performed a physical examination that revealed decreased range of motion of approximately 80 to 90 degrees. His extension was also decreased by about 50 percent. RX 1, p. 10.

Dr. deGrange reviewed the MRI taken on May 9, 2014, noting isthmic spondylolisthesis at L5-S1. RX 1, p. 13. He noted this is the same thing as a lytic spondylolisthesis, and was a chronic stress fracture in the area of the L5 lamina that never fully healed. RX 1, p. 13. He testified that the initial fractures commonly go undiagnosed as initial symptoms do not manifest as back pain in children. RX 1, p. 14. Dr. deGrange testified as a result of the fracture not healing, there is instability in the spine and ongoing micromotion over the years results in accelerated wearing out of the L5-S1 disc, causing foraminal stenosis. RX 1, p. 16.

In his evaluation, Dr. deGrange further found lack of any bony fusion, and opined Petitioner may not have a solid fusion. RX 1, p. 24-25. He testified Petitioner's ongoing complaints were consistent with a lack of a solid fusion. RX 1, p. 26., Dr. deGrange opined that if Petitioner continued to have a non-bony fusion it would result in a pseudarthrosis and will likely continue to have the same instability and symptom presentation as on the October 20, 2014 evaluation. RX 1, p. 26.

Dr. deGrange diagnosed Petitioner with a lumbar strain as a result of the April 24, 2014 accident. RX 1, p. 20. Dr. deGrange further testified that the mechanism of lifting, twisting, and throwing a ten pound log could

not cause the spondylolistetic condition to be aggravated to the point it would require surgical intervention. RX 1, p. 22. However, Dr. deGrange did agree that a person with spondylolisthesis can be asymptomatic and that the Petitioner had no history of radicular complaints in the left leg prior to April 24, 2014. RX 1, p. 36-37. Dr. deGrange further testified that Petitioner would not be a surgical candidate without symptomology. RX 1, p. 37. Dr. deGrange testified that there was a temporal relationship between the presentation of radicular complaints and the April 24, 2014 accident, but opined that the April 24, 2014 trauma would not have caused the underlying spondylolisthesis to become symptomatic and that "a temporal association does not infer causation". RX 1, p. 40.

Dr. deGrange indicated Petitioner could return to light duty work with a 15-pound lifting restriction without repetitive bending or twisting. RX 1, p. 21. He further testified that the treatment that Petitioner received for his spondylolistesis was appropriate. RX 1, p. 24.

After his IME, Petitioner returned to Dr. Payne on March 26, 2015 for evaluation for possible nonunion. Dr. Payne noted a non-union was possible as Petitioner continued to have daily axial back pain that was worse in the evening after activities. PX 3. X-rays were performed in office which showed the hardware was in place. PX 3. Dr. Payne ordered a CT scan of the lumbar spine to rule out pseudoarthrosis. PX 3.

Petitioner underwent a CT scan of his lumbar spine on April 6, 2015. PX 3. Petitioner returned to Dr. Payne on April 7, 2015 to review his CT results. Upon review of the films, Dr. Payne noted that the CT showed a non-solid fusion of the disc space. PX 3. Dr. Payne discussed the possibility of revision surgery with Petitioner. PX 3. However, Petitioner testified that he opted not to undergo the surgery.

Petitioner last saw Dr. Payne on July 29, 2015 for his one-year surgical follow up. PX 3. Dr. Payne noted that back pain was still a significant daily problem for Petitioner. Petitioner did report that he was better than before surgery, but that he had not received the amount of relief he had hoped. PX 3.

On October 6, 2015, Petitioner presented to Dr. Koteswara Narla, a pain management specialist, upon referral from Dr. Payne. Dr. Narla placed Petitioner on Zanaflex and Ultram. PX 3. Petitioner testified that these medications did not provide any relief.

Petitioner presented to Dr. Timothy VanFleet, a spine surgeon, on October 30, 2015, for a second opinion with regards to his lumbar spine. PX 4. Petitioner reported pain in the lower back that had been ongoing for a year. He rated his pain as a 7 out of 10 and indicated it was constant and exacerbated by walking, sitting, standing, and activity. PX 4. He classified the pain as sharp, burning, and achy. PX 4. Physical exam showed difficulty with extension. PX 4. Dr. VanFleet reviewed Petitioner's earlier CT scan, noting no evidence of solid fusion in the interspace and evidence of pseudarthrosis. PX 4. He further noted that there was evidence of the L5 screws violating the L4-5 facet joints bilaterally. PX4. Dr. VanFleet recommended Petitioner try a bone stimulator to help establish a solid fusion. PX 4. Dr. VanFleet further recommended a revised spinal fusion for pseudoarthrosis, but noted he had a 50/50 chance at best of having improvement in his current symptomology. PX 4. To date, Petitioner has not undergone either of these treatments. Petitioner testified he did not want to undergo a second surgery because it only had a 50/50 chance of providing relief.

Petitioner has returned full duty to his position with Respondent, working the same hours and performing the same tasks as he did prior to his accident. He is still making the same or greater that prior to his accident. Petitioner testified that, depending on the work he performs, he becomes very sore in his back. He further testified that he tries not to lift over 25 pounds without assistance. If he does lift over 25 pounds, he notices a lot of pain in his back.

Petitioner's leg symptoms have resolved. His current pain is located in his lower back, above the belt line. He characterized his pain as constant, localized, and sharp. At his best is pain is 6 out of 10; at his worst it is 8 to 10. He continues to take Tramadol for his pain as prescribed by Dr. Narla. He testified that he currently takes two Tramadol per day; one in the morning and one before he goes to bed. Petitioner testified the he is really sore and sometimes cannot move when he wakes up in the morning. After finishing a day of work, he is very fatigued and hurts a lot. He places heat or ice on his back every day when he gets home from work. Petitioner further testified that he has lost 25 pounds since his accident.

Dr. Payne testified that the fusion at L5-S1 places extra stressors on the space above at L4-5, which can cause adjacent level disease. PX 8, p. 24-25. Dr. Payne testified Petitioner already has a little degeneration at L4-5, and opined that Petitioner had about a 10 percent chance of getting spondylolisthesis at L4-5 from arthritis in ten to twenty years. PX 8, p. 24-25.

CONCLUSIONS OF LAW

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

After a review of the totality of the evidence, the Arbitrator finds that Petitioner did sustain an accident arising out of and in the course of his employment with Respondent. Petitioner testified that he lifted a ten pound log, twisted his body from left to right and threw the log over the side of a work truck. He testified that he immediately noticed sharp pain in his back radiating down his left leg. He immediately stopped working and reported and injury to his supervisor, who subsequently sent him for immediate medical treatment.

The medical providers agree that Petitioner did sustain an injury as a result of lifting, twisting, and throwing the ten pound piece of wood. Dr. Payne, Petitioner's treating orthopedic surgeon, opined that Petitioner sustained a permanent aggravation of his preexisting lytic spondylolisthesis, requiring surgery. While Dr. deGrange disagreed with Dr. Payne's diagnosis, he did testify that Petitioner sustained a lumbar strain as a result of moving the piece of wood. RX 1, p. 20.

Further, Petitioner was moving the wood upon direction by his employer, and it was within his regular job duties to move tree branches cut down by the city. For the above reasons, the Arbitrator finds Petitioner did sustain an accident arising out of and in the course of his employment with Respondent.

F. Is the 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 the work injury of April 24, 2014. The Arbitrator primarily relies on the testimony of the Petitioner and Dr. Payne, as well as the medical records, in rendering this decision. The Petitioner testified that he was lifting a 10-pound log, twisting is midsection, and throwing the log into the back of a truck when he noticed a sharp pain in his lumbar spine that radiated into his left leg. Petitioner further testified that he had been performing the same task for approximately 20 minutes before the accident occurred. Petitioner immediately reported his injury and immediately thereafter sought medical attention. No testimony has been presented to contradict Petitioner's testimony as to how the accident occurred and the Arbitrator finds the Petitioner's testimony to be credible.

The medical records show that Petitioner consistently suffered pain in the lower back and left leg from the date of the accident until his fusion surgery on July 28, 2014. After undergoing surgery, the medical records show the Petitioner has consistently complained of ongoing pain in his lower back, although his leg symptoms have resolved. Petitioner has at no time had a resolution or recurrence of symptoms.

There is no dispute that Petitioner's condition stems from a pre-existing lytic spondylolisthesis which has likely been present for the majority of Petitioner's life. However, Petitioner testified that prior to April 24, 2014, he suffered only occasional soreness in his back, for which he has not received any type of treatment for over ten years, and had never suffered any radiculopathy into either leg. As Dr. Payne explained, it is incredibly common for an individual with Lytic spondylolisthesis to be asymptomatic. PX 8, p. 8-10. Dr. Payne further testified that twisting of the back causes compression of the nerve dynamically onto the preexisting foraminal stenosis, which could irritate the L5 nerve root. PX 8, p. 44. Dr. Payne testified it was his opinion that Petitioner' lifting, twisting, and throwing of wood contributed to Petitioner's pain, causing a permanent irritation of the nerve. PX 8, p. 12-13. The Arbitrator finds the testimony of Dr. Payne to be credible and consistent with Petitioner's ongoing pain complaints since the date of the accident.

Testimony from Dr. deGrange, Respondent's IME physician, was also presented into evidence. Dr. deGrange agreed that with Dr. Payne regarding Petitioner's diagnosis and need for surgery and medical treatment, but testified it was his opinion that the accident did not cause Petitioner's current condition of ill-being. Specifically, Dr. deGrange testified that the trauma of lifting and twisting with 10 pounds was not enough to necessitate a spinal fusion. RX 1, p. 22. Dr. deGrange agrees that Petitioner did become symptomatic due to the April 24, 2014 accident. RX 1, p. 44.

The Arbitrator finds the testimony of Dr. Payne to be more credible, and places more weight on the opinions of Dr. Payne as a treating physician. The Arbitrator further finds the testimony of Dr. Payne to be more consistent with Petitioner's onset of symptoms and ongoing symptomatology than those of Dr. deGrange.

For the reasons set forth above, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the work accident of April 24, 2014.

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

Both Dr. Payne and Dr. deGrange have testified that the treatment that Petitioner received up until the date of their depositions was reasonable and necessary. RX 1, p. 24. Additionally, Dr. deGrange testified in his deposition that if there was a delayed union Petitioner would need a bone-growth stimulator and if the bone in the fusion had dissolved, he would require a revised fusion. RX 1, p. 55-56. Subsequent to his IME, Petitioner returned to Dr. Payne for evaluation and was found to have a non-fusion. RX 3. Petitioner underwent some consultation with Dr. Payne regarding possible revision surgery and sought a second opinion with Dr. VanFleet to see if anything else could be done for his non-fusion short of surgery. PX 3, PX 4. Petitioner eventually opted not to undergo surgical recommendations.

Based on a review of the totality of the evidence, the Arbitrator finds that all of Petitioner's medical treatment has been reasonable and necessary. Petitioner's medical bills were entered into evidence as Petitioner's Exhibit 9. The Arbitrator finds that Respondent has not paid all appropriate charges for reasonable and necessary medical services.

Respondent is ordered to pay the outstanding medical bills set forth in Petitioner's Exhibit 9, directly to the providers, according to the fee schedule as set forth in Sections 8(a) and 8.2 of the Act. The Respondent shall receive an 8(j) credit for medical bills paid by its' group health insurer, Healthlink, and will indemnify and hold Petitioner harmless for any subrogation claims made against him by Healthlink for bills for which it receives a credit.

Additionally, Respondent has paid $250.00 in out-of-pocket medical expenses. Respondent is ordered to reimburse Petitioner in the amount of $250.00 for out-of-pocket medical expenses.

K. Is the Petitioner due any temporary total disability benefits?

The Arbitrator finds that the Petitioner is due temporary total disability benefits as his current condition of ill being is causally related to his April 24, 2014 accident. The parties are in agreement that Petitioner was temporarily and totally disabled, or under unaccommodated work restrictions, from April 30, 2014 to May 11, 2014 and from June 12, 2014 through January 5, 2015, for a total of 31 and 1/7 weeks. Therefore, Respondent is ordered to pay Petitioner $701.08 per week for a period of 31 and 1/7 weeks in temporary total disability benefits.

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

For accidents occurring after September 1, 2011, the Arbitrator must look to the five factor test in determining permanent partial disability. The first factor is impairment rating according to the AMA Guidelines 6th Edition. In this case, an AMA Guidelines rating was not performed.

As to the second factor, nature of the employment, the Petitioner continues to work in his former position and has returned to full duty work. However, Petitioner testified that certain job duties cause his back to become very sore. He also does not lift over 25 pounds without assistance, and if he does he notices a lot of pain in his back. After work he is fatigued and in pain. He testified that he places heat or ice on his back every day after work. Petitioner has a high school education and has consistently worked in delivery and physical labor positions throughout his adult life. The Arbitrator finds it significant that Petitioner continues to have significant pain and symptoms associated with his work, though he is able to perform the work as indicated. The Arbitrator feels the evidence supports the Petitioner's claim for permanency.

With regards to the third factor, age, the Petitioner was 47 years old on the date of his accident, and is currently 49. The Arbitrator finds that the Petitioner has a significant number of working years ahead of him, during which he will endure ongoing pain. As such, the Arbitrator places significant weight on this factor.

With regards to the fourth factor, future earning capacity, Petitioner has returned to his prior position with Respondent, earning the same or higher pay. At this time, it is unlikely that Petitioner will sustain a decreased earning capacity in the future based on his injuries. The Arbitrator gives this factor very little weight in support of the claim.

Finally, with regards to the fifth factor, evidence of disability corroborated by treatment records, the Petitioner testified that he has ongoing, constant, localized and sharp back pain in his lumbar spine that he rates as a 6 to 8 out of 10. He continues to take Tramadol twice daily. He sometimes has trouble moving in the morning due to soreness. Further, his work causes him to be sore and fatigued, requiring daily heat or ice. Petitioner's ongoing back complaints are consistent with the medical records and testimony of Dr. Payne and Dr. deGrange, which consistently show that Petitioner has had ongoing back pain since the date of his accident. In fact, Dr. deGrange testified that if Petitioner did not have additional medical treatment to address the non-fusion in his lumbar spine, he would in all likelihood continue to have ongoing pain complaints in his back. RX 1, p. 26. In addition, the evidence shows that the Petitioner has continued to seek treatment in hopes of obtaining some additional pain relief. In July 2015, he reported significant daily back pain to Dr. Payne. (PX 3) His pain level remained at six out of ten in October of that year when he saw Dr. Narla. (Id) Finally, he told Dr. Van

Fleet on October 30, 2015 that his pain was aggravated by walking sitting and standing. The doctor noted objective findings on the various diagnostic studies and recommended that the Petitioner try a bone stimulator. (PX 4) The evidence shows that the Petitioner has a fusion at one level of the lower lumbar spine which has not healed satisfactorily and which certainly could account for his ongoing symptoms. The Arbitrator finds that the Petitioner's ongoing complaints are supported by the medical evidence and places significant weight on this factor.

Taking the evidence and the five factors into consideration, the Arbitrator finds that Petitioner has sustained a 30% loss of the person as a whole as a result of the April 24, 2014 accident. Respondent is ordered to pay Petitioner $630.97 per week for a period of 150 weeks, representing a 30% loss of the person as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEFANIE CURRAN,

Petitioner,

vs.

NO: 14 WC 26864

THE DRAKE HOTEL,

17IWCC0388

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 causation, medical expenses, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

Respondent paid temporary total disability (TTD) benefits from August 6, 2014 through December 4, 2014, in the amount of $6,957.21 plus $1,859.05 as an advance against any permanent partial disability award. We agree with the Arbitrator's decision that Petitioner failed to prove that her current low back condition is causally related to her work injury. However, we find the evidence shows that Petitioner's TTD benefits should have begun on July 22, 2014, because her work restrictions were not accommodated by Respondent. It is undisputed that Petitioner fell at work towards the end of her shift on July 21, 2014. She presented to the Northwestern Hospital emergency room around midnight on July 22, 2014. Petitioner testified that she left a voicemail for Respondent's human resources director, Maria Garcia, and texted her supervisor, Christina Shubert, on July 24th after her follow up visit with Northwestern Corporate Health. Petitioner testified that she made other attempts to contact Ms. Garcia and finally spoke with her on August 4th. Petitioner testified that Ms. Garcia informed her that it didn't matter if her restrictions could be accommodated because Petitioner had been terminated as of July 28, 2014. We therefore modify the decision to

17IWCC0388

award TTD from July 22, 2014 through December 4, 2014 for a period of 19-3/7 weeks, with Respondent receiving credit for all amounts paid.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $412.37 per week for a period of 19-3/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that 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: JUN 26 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 5/17/17
49

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

CURRAN, STEFANIE
Employee/Petitioner

Case# **14WC026864**

THE DRAKE HOTEL
Employer/Respondent

17IWCC0388

On 1/11/2016, 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 0.50% 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:

0009 ANESI OZMON RODIN NOVAK ET AL
HAYLEY GRAHAM SLEFO
161 N CLARK ST SUITE 2100
CHICAGO, IL 60601

1872 SPIEGEL & CAHILL PC
PHILLIP JOHNSON
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

17IWCC0388

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)

STEFANIE CURRAN
Employee/Petitioner

v.

THE DRAKE HOTEL
Employer/Respondent

Case # 14 WC 26864

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **David A. Kane**, Arbitrator of the Commission, in the city of **Chicago**, on **December 16, 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. [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 _____

17IWCC0388

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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**32,164.60**; the average weekly wage was $**618.55**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **0** children under 18.

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

Respondent shall be given a credit of $**6,957.21** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**1,859.05** for other benefits, for a total credit of $**8,816.26**.

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

ORDER

The Arbitrator finds that the Petitioner has failed to prove by a preponderance of the evidence that her present condition of ill-being is casually related to the accident of July 22, 2014. Prospective medical is denied. All other issues are moot.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

David A. Kane
Signature of Arbitrator

January 8, 2016
Date

ICArbDec19(b)

JAN 11 2016

17IWCC0388

``BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEFANIE CURRAN	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No: 14 WC 26864
	)	
THE DRAKE HOTEL	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

PETITIONER'S TESTIMONY

The petitioner testified on December 16, 2015. The petitioner testified that, at the time of the arbitration hearing, she was 33 years of age, and that on July 22, 2014, she was employed by the respondent, the Drake Hotel, Chicago, as a pastry cook I. Petitioner testified she had worked for the respondent approximately two years. Petitioner testified that she regularly worked a nine hour shift but it was flexible depending on the work activities. Her hours of work would vary depending on the holidays, the weddings which were planned, and any other special activities. Normally, the petitioner worked a five days a week.

As a pastry chef I, the petitioner testified she did a lot of prep work. Part of her job activities were to bring materials for cooking from the "other" side of the hotel and bring it back to her work area on a pushcart. Petitioner testified that she would fill up a card with anywhere between 100 to 400 pounds of goods depending on the function she was assigned to that particular day. Petitioner testified the material was stored in bulk and that the weight of the material was between 20 to 30 pound boxes or buckets. Petitioner testified that she would be required usually to lift some material once per day, however, if work was busy she may be required to make a second trip at approximately 4 o'clock in the afternoon.

Petitioner testified she would lift material from three different heights, one approximately knee height, one approximately chest height, and one overhead. Petitioner testified that the heaviest objects you would lift were approximately 70 pounds. Petitioner testified that the process of lifting material and bringing it to the work area occurred every day and that there were certain rotations of items which were used depending on the job. Petitioner further testified that the cart she used was a big pushcart which was the size of a cart in a big box store. Petitioner testified that there was a metal push bar which was approximately chest height. Petitioner testified that she was required to push the cart approximately a city block from one end of the Drake Hotel to the other. On occasion, she would be required to push the cart up to four times per day (up and back) to obtain and return materials for her assignment. Petitioner testified that there were four different restaurants in the hotel and they were on different levels, and therefore, an elevator was necessitated. Petitioner testified that, because of the age of the building, the elevator heights would vary, and on occasion, she would have to lift the front of the cart in order to accommodate uneven areas in the elevator and floors. Petitioner testified that she did not sit down during the course of the workday and that chairs were not provided in the kitchen area.

Prior to working for the respondent, petitioner had worked at the Fairmont Orchid Hotel in Hawaii for approximately one year. Petitioner testified that her job duties at the prior employer were approximately the same as for the respondent. In the prior employment, petitioner testified that she also was involved with high-volume parties, weddings and large corporate events.

On July 22, 2014, the petitioner testified that she was at work and towards the end of the shift she slipped and fell on some grease around a trashcan. The area she fell was at the back of the pastry kitchen. Petitioner testified she fell on her back and injured her wrist (right wrist) trying to catch her fall. Petitioner testified that she felt instant pain. Petitioner testified that she felt a shock and went to pull herself up and realize that she had injured her right wrist. Petitioner testified that she used her left hand to stand up. She took a few steps after the fall thinking the pain was temporary, but, it was not. Petitioner testified she was approached by Robert who had asked her if she needed assistance. Petitioner testified that she went to security to file the accident report. Petitioner testified that Robert is a nighttime server and a co-employee. Petitioner reported to the security desk that she had slipped and fallen and filled out an accident report. Petitioner testified that the security guard provided some money for a taxi and he actually hailed a taxi and instructed the taxi to take the petitioner to the

emergency room at Northwestern Hospital. Petitioner testified she arrived at the hospital approximately 12:00 AM on July 22, 2014. Petitioner gave the emergency room staff a history of how she had injured herself. Petitioner also testified that she gave the emergency room the history of chronic back pain which had been present following surgery several years earlier. Petitioner further testified that she told the emergency room physician that she was wearing an opioid patch at the time of the fall.

The petitioner testified that the emergency room physicians gave her a physical examination, took x-rays of her right wrist and her low lumbar spine. Petitioner testified that she was diagnosed with a right wrist sprain and a back contusion.

The petitioner was discharged from the emergency room and was advised to follow up with Northwestern Corporate Health Department in 3 to 5 days. On July 24, 2014, petitioner returned to the Northwestern Corporate Health Department. Petitioner was seen by Dr. Meredith. Petitioner again gave the history of the injury at work and told the doctor that she was, prior to the fall, taking Fentanyl, Norco, and Mobic for chronic back pain. At the time of the doctor's visit, petitioner reported her back pain is 7 on a scale of 1 to 10. Petitioner reported wrist pain as a 5.

Petitioner testified that the doctor gave her a physical examination and released her to work with restrictions regarding the right hand petitioner testified that she was also released with restrictions of no pushing, pulling, bending over, reaching, and no lifting of anything over 10 pounds. She further testified that she was not to use her right wrist. Petitioner testified she was allowed to move freely as needed, sitting, standing or similar activities. Petitioner testified that she had notified the Drake Hotel (respondent) of the restrictions. Petitioner was told that she was advised by the Northwestern Health facility that their protocol was to fax over to her employer the next appointment date and the restrictions. Petitioner testified she also did call the Drake Hotel and left a voicemail and a text message for her supervisor as well as the Human Resources department. Petitioner testified that she had left a voicemail message for Maria Garcia in Human Resources regarding her work restrictions. Petitioner also testified that she notified Chef Christina who was her immediate supervisor. Petitioner testified that she did not hear back from Ms. Garcia.

Petitioner testified she returned to Northwestern Memorial Corporate Health on July 31, 2014. Petitioner indicated that she was placed under the same restrictions as before and was given a brace for her wrist. As of July 31, 2014, the petitioner had not heard back from the respondent regarding work restrictions. Petitioner then testified that the Northwestern Health facility advised her that they were sending Human Resources the work restrictions along with the next appointment.

Following the July 31, 2014 visit to the health facility, petitioner testified she left a voicemail message again with Human Resources regarding the incident and her restrictions and she further called the Northwestern Corporate Health to determine whether or not they had notified her employer as to her restrictions. Petitioner testified that she spoke to Daniel Briggs from the Northwestern Corporate Health who advised her that he had left messages for Maria Garcia regarding her condition. Petitioner testified that her first conversation with Ms. Garcia took place on or about August 4, 2014. Petitioner testified that she requested whether or not the restrictions could be accommodated and was advised that it did not matter because she had been terminated. Petitioner testified that the date of her termination was July 28, 2014. Petitioner further testified that she had not returned to work for the respondent since the date of incident through the date of her testimony and the arbitration proceedings.

Petitioner testified that on August 5, 2014 she saw Dr. Bathla who is a pain specialist. Petitioner also testified that this was not her first visit to Dr. Bathla and that she had been seeing him since January 2013 for pain management. Petitioner testified that Dr. Bathla was treating her for pain management for conditions related to her lower back. Petitioner testified that prior to seeing Dr. Bathla, she had had two back surgeries for her lower back, one in January 2009, and a second in January 2010. Petitioner testified that she was managing her pain with the assistance of Dr. Bathla through the date of her incident in 2014. Petitioner testified that she was able to perform all of her duties as a pastry cook. Petitioner testified that she never lost any time from work due to issues involving her pain. Petitioner testified that she never received assistance from any other employees regarding her work duties. Petitioner testified that she never called off work due to pain in her back prior to the 2014 incident.

Petitioner testified that when she saw Dr. Bathla for the first time he performed a physical examination and made a recommendation for an MRI study of the lumbar spine. Following the

incident in 2014, the petitioner indicated that Dr. Bathla had increased her pain medication and recommended physical therapy. At that time, Dr. Bathla placed the petitioner on sedentary work. Petitioner testified that, on August 20, 2014, she completed an additional MRI study as recommended by Dr. Bathla.

Petitioner returned to Dr. Bathla on September 8, 2014 at which point Dr. Bathla recommended an epidural steroid injection along with sedentary work restrictions. Petitioner testified it that she completed a left L45 and L5 S1 transforaminal epidural steroid injection on September 9, 2014. Petitioner returned to Dr. Bathla on September 24, 2014, at that time, the petitioner indicated that the epidural steroid injection had provided no relief for changes in her condition and she felt her pain was increasing.

The petitioner testified that the pain she was feeling after the 2014 incident was "shooting" in two different places. Petitioner testified she was feeling pain in her back and that everything was increasing in pain whether it was day or night did not matter. Petitioner testified she was unable to do anything and was literally at home and in pain while taking the medication.

Dr. Bathla directed the petitioner to a neurosurgeon. On October 28, 2014, petitioner saw Dr. James Mok at the University of Chicago. At that time, the petitioner gave Dr. Mok a history of how she had injured herself. Petitioner testified she also told Dr. Mok about the previous laminectomy which had provided some relief. Dr. Mok recommended a CT scan and x-rays. Following a visit to Dr. Mok, petitioner returned to Dr. Bathla in November 2014.

Petitioner was kept off work by Dr. Bathla. On January 22, 2015, petitioner again return to Dr. Bathla at which point she was kept off work. On February 12, 2015 the petitioner completed a CT scan of the lumbar spine along with standing x-rays.

On February 17, 2015, the petitioner testified she returned to Dr. Mok. Petitioner testified that she never told Dr. Mok that she was pain-free prior to the fall in July 21, 2014. Dr. Mok recommended a lumbar interbody fusion.

As of the date of arbitration, petitioner testified that she has not completed lumbar surgery. Petitioner testified she returned to Dr. Bathla on May 27, 2015. He continued her restrictions. Petitioner testified that, as of May 27, 2015, her pain was increasing. Petitioner testified she returned to Dr. Bathla in July and August 2015. At which time petitioner was kept off work.

On September 9, 2015, petitioner returned to Dr. Bathla. She testified that the pain in her back was constant, but she was not sleeping. The pain had gone down into the left lower leg. Petitioner testified she was kept off work. Petitioner then returned to Dr. Bathla on October 7, 2015 at which point she was continued off work. Petitioner saw Dr. Bathla November 4, 2015 and was to remain off work. The last visit to Dr. Bathla was on December 2, 2015. Petitioner testified that as of December 2, 2015, the pain was the same.

Petitioner testified she had issues with her legs. Petitioner testified that her pain was constant pain was in the lower part of her back which shoots down into the left leg, behind her knees, which sometimes went as far down as her left ankle. Petitioner testified she has a lot of pain going down both for legs and swelling. Petitioner testified that Dr. Bathla kept her off work as the date of her last visit.

Petitioner testified that, as of the date of arbitration, she was in pain. Petitioner testified she cannot do anything without pain, even though she is taking a lot of pain medication. Petitioner testified she cannot walk, cannot sit and she cannot sleep. Petitioner testified that the pain varies from day to day. Petitioner testifies that at times she would have shooting pain throughout the day which comes and goes. Petitioner testified she did not understand what triggered her pain and that the pain shoots around the lower back and sometimes does not go all the way down the leg but just to her hip. Petitioner testified if she takes a wrong step, she at times can have shooting pain for the next hour and need to lie down.

CROSS-EXAMINATION OF PETITIONER

The petitioner testified that from 2009 through 2010, during the period of time that she had undergone her surgery, that she was had pain in her back. Petitioner testified that she was using pain medication from 2009 through 2010 when she had her second surgery. Following completion second

surgery, petitioner testified she was still in pain. Petitioner testified that, at the time of her surgeries in 2009 and 2010, she was living in Oregon and immediately prior to the surgery in 2009, she had been working for the Bon Appetite Restaurant. Petitioner testified that she did recover monies for the surgery to her back in that it pertained to a work-related incident in 2009. Petitioner testified that she believe she recovered approximately $51,000.00 but she did not have total recall as to how the money was allocated. She further testified that the settlement was made under the State of Oregon Workers' Compensation Act.

Petitioner testified that, at the time, she was working at the Drake Hotel she was taking pain medications which were all prescription medications. Petitioner testified that she could not recall the exact dosage of the medications but that she was on Mobic, Flexeril and Fentanyl patches and that, prior to the Fentanyl patches, she was on Norco.

Petitioner testified further that her first visit to Dr. Bathla was January 18, 2013. Petitioner testified that she saw Dr. Bathla because she was in pain. Petitioner testified she did not recall if she told Dr. Bathla that the pain medication she had been taking was not working. Petitioner testified that the prior pain medication had been given to her when she left Hawaii. At the time she saw Dr. Bathla, she had given him her prior medical records along with her then prescription medication. Petitioner testified that the entry in Dr. Bathla's records on January 18, 2013 regarding her having completed a microdiscectomy at the levels of L4-L5. L5-S1 with no relief and that the symptoms of sharp pain got worse in 2010 was an accurate statement.

The petitioner testified that following the surgeries in 2009 and 2010, there was no significant relief in her pain, and as a result, the doctors recommended that she be on narcotic pain medications. Petitioner further testified that, prior to the incident of July 22, 2014, the petitioner had been recommended for a trial of a dorsal column stimulator and that was done in 2010. Petitioner testified that she completed the use of the dorsal column stimulator on a trial basis, but, it did not provide enough relief from her pain and that the percentage of pain relief was too low-tech to go through the surgery. Petitioner testified that the trial of the dorsal column stimulator was recommended prior to the incident at the Drake Hotel. It did not give her enough relief from her pain and as a result, she was placed on narcotic medication.

Petitioner testified that when she would see Dr. Bathla, she would make every attempt to tell him the truth regarding her symptoms. On June 12, 2013, petitioner testified she started on a new medication, Mobic, because of the pain increasing. Petitioner testified that she was switched from Ibuprofen to Mobic because her body was not reacting to the Ibuprofen. Petitioner testified that, in July 2013, she was switch to Meloxicam. Petitioner testified that on June 10, 2013 she saw Dr. Bathla because of significant increase in pain and a failure of the epidural steroid injections to provide relief and that Dr. Bathla recommended a T LSO brace. Petitioner testified that, although Dr. Bathla recommended the T LSO brace, that when shown a picture of the T SLO, petitioner testified that that was not the brace that she used in that she did not identify ever having been provided a T LSO brace.

Petitioner further testified that, on September 18, 2013, that when she saw Dr. Bathla, the pain in her back was continuing, that it was radiating down into both legs. Because of the severity of the pain and the failure to get relief, Dr. Bathla recommended electromyographic study. Petitioner testified that the electromyographic study was not completed. Petitioner testified that, on September 18, 2013, when she saw Dr. Bathla, he had recommended that once the electromyographic study had been completed, that they would re-administer epidural steroid injections and would attempt to get approval for the petitioner for the T LSO brace that she would be able to wear while she did baking at work. Petitioner testified that she does not recall this brace ever having been provided for her.

Petitioner testified that, on December 5, 2013, she returned to Dr. Bathla with complaints of low back pain due to an increase work in the season that the back pain of been getting worse. Petitioner further advised Dr. Bathla, on December 5, 2013, that the cold weather made her back worse, that she was very stiff in the morning. Petitioner testified that she had arthritis.

Petitioner testified that between January 18, 2013, when she first saw Dr. Bathla, and April 18, 2014, there was never a time during any of those visits that she was asymptomatic. Petitioner testified that between January 18, 2013 and April 18, 2014, that when she was on her medication but not working, she was in less pain. Petitioner testified that those were on her days off when she could come home. Petitioner testified that there were no days where she was not in pain but the level of pain was different when she was not working. Petitioner testified that between January 18, 2013 and April 18, 2014 there were days when her pain was intolerable but she related that to her "period" which made everything worse. When she was on her medication, petitioner testified she had a dull

pain but no shooting pain and when she was on her medications, she would feel breakthroughs in pain where everything would swell up and she would experience a more striking pain. Petitioner testified that in June 2014 she was switch to Fentanyl patches. Petitioner testified she did not recall the extent of Fentanyl which was contained within each patch. Petitioner testified that in June 2014 she was switch to Fentanyl patches because of the severity of the pain which was radiating down into the left buttocks and legs. Petitioner also testified that they switched her to the Fentanyl patches because she was experiencing problems with her stomach and heartburn.

The petitioner testified that since the incident of July 22, 2014, she has had no other employers and that she is not looking for work anywhere else. Petitioner testified she lived with her brother-in-law and partner in Crown Point, Indiana.

Petitioner testified that, at the present time, she cannot sleep. In the course of day, she gets up about three in the morning, that her partner helps her to get around. Petitioner testified she could not put on her socks and first thing in the morning, her partner helps her get dressed. Her partner helps prepare her food. Petitioner testified that she is living with her family and has limited space to move around in. Petitioner testified that she cannot lie down for very long period of time and must rotate from position to position. She has a cot in the living room which is closest to the bathroom and that is where she spends her time. Petitioner testified that she does not leave unless to go to one of her doctor appointments. Petitioner testified that her partner drives her to the doctor's appointment.

The petitioner testified that at the time she slipped and fell, that she was on narcotic medication on a regular basis but she was also wearing the Fentanyl patch.

Petitioner testified regarding her job duties that if she were not moving bulk items, she would be responsible to make cookies which are obtained from freezer. The box of cookies was somewhere between 35 to 40 pounds placed on the cart and prepared from that point. Petitioner testified that she would be required to make 1000 cookies per day. The process of making cookies was to remove frozen cookies from storage, place them on the cart in trays and then into the oven. The trays were about 24 x 36". Then she would place the trays into the oven on racks, therefore, different levels one just above had high, one at eye level, one at hip level, and the other at the level.

The petitioner's initial medical care following the July 22, 2014 Incident took place at the Northwestern Memorial Healthcare facility. (Pet. Exhibit 1) On July 22, 2014, the petitioner was admitted to the emergency facility with a history of having just sustained a fall at work. The petitioner was documented and as having fallen onto the right side. (Page 2 of 30) The petitioner had complaints of back pain and right wrist pain. Prior medical history completed on July 22, 2014 gave a history of chronic back pain secondary to a lumbar surgery years previous. The petitioner was found to be wearing an opioid patch for pain. The additional history taken indicated that petitioner tripped in the kitchen striking her hand and forearm against a metal pole and landing on her right side. (Page 6 of 30) The petitioner gave a history of lumbar disc pain after a fall, she described the pain as a burning pain bilaterally on a scale of 1 to 10 being 8. The pain was present despite the fact that she was wearing an opioid patch, which she had changed every three days prior to this incident. The petitioner's significant medical history was noted as a prior lumbar surgery and chronic low back pain.

On July 22, 2014, the petitioner completed an x-ray evaluation of the lumbar spine. The findings indicated that there were present six lumbar vertebral bodies. Further, there was an age indeterminate L6 pars defect. Evidence was present of a probable laminectomy defect at the L6 level which was compatible with the reported surgical history. The vertebral bodies were of normal height and alignment. There was a moderate disc height loss at the level of L6-S1. There were some minor degenerative changes in the facet joints in the lower lumbar spine. The sacroiliac joints were within normal limits. There were no focal osseous or soft tissue abnormalities. Bone mineralization was normal. The impression of the x-rays taken on July 22, 2014 was that of a pars defect at L6 with moderate disc height loss at L6 – S1 with no acute malalignment. (Pet. Exhibit 1, page 30).

Petitioner's Exhibit 2 consisted of the medical records of the Northwestern Memorial Hospital Corporate Health Services. These records are also dated July 22, 2014 and following. On July 24, 2014, the petitioner was noted to have been seen following the emergency room visit. The history was given of an injury to the right hand and lower back. X-rays of the wrist and back were described as negative for dislocation or soft tissue injury. The treatment history consisted of the petitioner's use of Fentanyl, Norco and Mobic for a chronic low back pain. The petitioner reported pain in the right wrist of 5 on a scale of 1 to 10. The petitioner reported pain for the low back of 7 on a

scale of 1 to 10. Petitioner complained that while sitting and walking the pain was in the middle low back area which went up to the lower thoracic spine and down into both buttocks and radiated in to the posterior thigh above the knees. The petitioner was denying any paresthesia in the lower extremities. Petitioner gave a history of chronic low back pain for which she had been followed by a spine specialist and was on regular pain management with analgesic agents. She was continuing to perform harm home exercise program on a daily basis which she had learned through years of physical therapy. (Pet. Exhibit 2)

On July 24, 2014, an evaluation of the petitioner's back demonstrated a well healed midline lower lumbar scar. There was no spinous process tenderness. There was no paravertebral muscle spasm. The petitioner was diffusely tender to light touch over the lower thoracic upper lumbar spine. There was found to be limited range of motion in lateral bending and twisting due to pain. Petitioner's was diagnosed on July 24, 2014 with a right hand contusion as well as a lower back contusion with an acute on chronic low back pain. Petitioner was given work restrictions regarding her ability to return to work.

The petitioner returned to Northwestern Memorial Hospital Corporate Health on July 31, 2014. (Pet. Exhibit 2) Petitioner was found to be nine days post injury with complaints of worsening pain into the left buttocks and the posterior thigh as well as pain over the lower back. Right hand pain was in the area of the palm but mainly present at night. Regarding the lower back, the diagnosis on July 31, 2014 was that of a strain acute on chronic. There was also a description of left sciatica. Petitioner was allowed to return to work with restrictions. (Pet. Exhibit 2).

Petitioner returned to Northwestern Corporate Health on August 14, 2014 with complaints of pain in the right hand. Petitioner complained that her back continue to hurt. Petitioner complained of numbness and tingling into the bilateral thighs with pain on bowel movement in the back but no incontinence. Diagnosis remained the same as a right hand contusion with a lumbar strain acute on a chronic back condition with left sciatica. (Pet. Exhibit 2)

On January 18, 2013 the petitioner began a course of medical treatment from Dr. Bathla at the Chicago Sports and Spine Facility. (Pet.'s Exhibit 3) History given to Dr. Bathla indicates that the petitioner had started to complain about pain and difficulties with her back in 2009. Subsequent to

the completion of conservative care, the petitioner completed a surgical procedure at the level of L5-S1 in 2009, which provided no relief. Dr. Bathla, on January 18, 2013, and indicated that, following the first surgical procedure in 2009, petitioner's back pain got progressively worse. Petitioner completed a second surgical procedure in 2010. Petitioner's history indicates that the second surgery alleviated some of the pain but did not fix it. Petitioner gave history to Dr. Bathla that her doctors told her she had a congenital disc disease. Following the second surgery in 2010, the petitioner completed additional epidural injections and eventually was enrolled in a back school at the Northwest Occupational Medical Center. Subsequent to the back school, petitioner advised Dr. Bathla that she had undergone pain psychology and therapy which allowed her to be strong enough to return to work. Petitioner also told Dr. Bathla that she had a dorsal column stimulator for a two-week period of time. Petitioner advised Dr. Bathla that the dorsal column stimulator did not provide enough relief to justify having it put in permanently. Following this course of care, the petitioner then moved to Hawaii where she began seeing a general practitioner while she was working. (Pet. Exhibit 3)

On January 18, 2013, the petitioner advised Dr. Bathla that the majority of her pain was in the middle of the lumbar spine with radiation of the pain into the left buttocks. She described the pain as going down the left leg on occasion. She described a pulsating electric pain down the lateral side of the left leg from the knee and she described the electric type pain as being new as of January 18, 2013. Petitioner advised Dr. Bathla that she was unable to get rid of the pain. Petitioner further described to Dr. Bathla of minimal numbness into the back of the left leg and into the groin. Petitioner did not describe any weakness and that she had experienced bowel and bladder incontinence after her first surgery in 2009, but not after the second in 2010. As of January 18, 2013 the petitioner was taking Norco for pain and that she was taking approximately five tablets per day. Petitioner advised Dr. Bathla on January 18, 2013 that the Norco helped to take the dull pain away completely. (Pet. Exhibit 3)

Examination was completed of the petitioner January 10, 2013 and final diagnosis was post laminectomy syndrome with low back pain. Dr. Bathla began the petitioner on continuation of Norco and added 800 mg of Ibuprofen, Flexeril and Neurontin. Following evaluation of the petitioner and recommendations and prescriptions, Dr. Bathla indicated the potential need for epidural steroid injections and a dorsal column stimulator. This conversation took place according to the doctor's records on January 18, 2013. (Pet. Exhibit 3) Dr. Bathla indicates that the petitioner was uninsured

as of January 10, 2013 and would not be able to afford undergoing the stimulator trial or the implant. Dr. Bathla's records indicate that the petitioner was anticipating getting insurance, and approximately six months at that point, she would like to reconsider the procedures. Dr. Bathla recommended manual therapy with focus on soft tissue mobilization, especially scar tissue, which she may have developed from previous surgeries. Petitioner was demonstrating an interest in the procedures, but unfortunately, could not afford it. (Pet. Exhibit 3)

The petitioner returned to Dr. Bathla on February 25, 2013. Petitioner continued to complain of low back pain with left lower extremity pain. Petitioner indicates that the pain medications made the pain more tolerable. Petitioner requested a more aggressive interventional approach, but as of February 25, 2013, she had no insurance. Petitioner indicates that the medications, which she had previously been taking, did not agree with her system, however, the Norco, which she was taking, seemed to work well. Examination on February 25, 2013 indicated a post laminectomy syndrome. Petitioner's medications for Norco, Ibuprofen, Flexeril and Neurontin were renewed.

Petitioner returned to Dr. Bathla on April 5, 2013. At that time, the petitioner indicated she was getting stabbing pains into the left posterior superior iliac spine (PSIS) joint. Pain was described as intermittent in nature. Petitioner indicated that lifting or being at work made the pain worse. Petitioner also indicated that twisting to the left tend to made to make the pain worse. Petitioner indicated that the pain was relieved when she stopped what she was doing. Petitioner indicated that the combinations of medication she was taking made pain more manageable. The assessment by Dr. Bathla on April 5, 2013 was that of sacroiliac pain with post laminectomy syndrome and lower back pain. Dr. Bathla recommended a potential left sacroiliac joint injection. The petitioner agreed and the sacroiliac joint injection was completed on April 5, 2013. (Pet. Exhibit 3)

Petitioner returned to Dr. Bathla May 17, 2013. Petitioner gave a history of right sided low back pain. Petitioner's history on May 17, 2013 indicated that the low back pain was pretty painful after Mother's Day. Petitioner indicated she took three days off work. Petitioner complained that she had pain which is located in the right side of the lower back. Petitioner described less stabbing pain as of May 17, 2013. Petitioner indicated that, for the previous five days, the right low back pain had been relieved following the sacroiliac joint injection. But as of May 17, 2013, her pain was located predominantly in the lower back. Petitioner indicated that the pain was worse with twisting to either

side and that the triggering mechanism for the pain was completely random. Dr. Bathla continued petitioner's pain medications. Petitioner indicated that her medications were working well for her without any significant side effects and that she was continuing to use them on a regular basis. Dr. Bathla was concerned that the continued use of medications could cause side effects. (Pet. Exhibit 3)

On June 12, 2013, petitioner returned to Dr. Bathla. Petitioner again was complaining of chronic low back pain. Petitioner indicated that the pain was pretty much the same as previously in that it seemed to be getting worse during the "wedding season." Petitioner advised Dr. Bathla that she would be qualified for insurance as in approximately one and a half months from June 12, 2013. Dr. Bathla renewed petitioner's medications.

On July 10, 2013, petitioner again returned to Dr. Bathla with a history of low back pain. Petitioner advised Dr. Bathla that her pain was continuing to bother her. Petitioner advised Dr. Bathla that her insurance was to start in approximately one month. Petitioner indicated that she had pain across the back and down bilateral lower extremities to her thighs. Petitioner indicated that she had undergone epidural injections without any more than temporary relief in the past. Petitioner also advised Dr. Bathla that she had undergone a trial of the dorsal column stimulator in 2011 through Boston Scientific and the dorsal column stimulator did not provide much relief. Dr. Bathla discussed the potential of an additional sacroiliac joint injection. For petitioner's low back pain, Dr. Bathla's records indicate that, on July 10, 2013, he recommended the potential of TSLO Brace, to be worn during work which would relieve some of her work-related pain. (Pet. Exhibit 3)

Petitioner returned to Dr. Bathla on August 26, 2013. At that time, she continued to complain of low back pain. Petitioner indicated that the pain had been about the same for the previous months and that her period tended to make the pain in her lower back one million times worse. Petitioner stated that, otherwise, she was doing well and that the medications are continuing to work. She started that Mobic seemed to be easier on her stomach. The assessment of petitioner's condition, as of August 26, 2013, was the same sacroiliac pain post-laminectomy syndrome with lower back pain. Again, as of August 26, 2013, Dr. Bathla recommended a TSLO Brace for the petitioner. (Pet. Exhibit 3)

On September 18, 2013, the petitioner returned to Dr. Bathla. Petitioner complained of continuing low back pain with radiation bilaterally into the extremity. The petitioner presented on September 18, 2013 for an epidural steroid injection. Dr. Bathla recommended, prior to any injections, he would like to see the petitioner complete electromyographic studies to determine the origin of the pain in the lower back. On September 18, 2013, Dr. Bathla indicated his assessment was that of sacroiliac pain post-laminectomy syndrome, lower back pain. He recommended an encounter for long term or current use of other medications. Dr. Bathla continued petitioner's medications and stated that he would schedule the petitioner for an electromyographic study with the belief that the study would give insight into where the pain was coming from, and once the study was completed, he would be able to proceed with epidural steroid injection. Again, Dr. Bathla recommended the approval of a TSLO Brace. (Pet. Exhibit 3)

On October 30, 2013, the petitioner returned to Dr. Bathla. Petitioner's complaints were that of low back pain. The petitioner had not completed an electromyographic study as recommended by Dr. Bathla and that she had no insurance. Dr. Bathla renewed petitioner's medications. (Pet. Exhibit 3)

On December 5, 2013, petitioner returned to Dr. Bathla. Again, petitioner has a history of low back pain. Petitioner complained that the pain in her back had increased at work due to the seasonal work, that her back pain had been worse as of late. Petitioner advised Dr. Bathla that the cold weather seemed to make the back pain worse and then petitioner was experiencing extreme stiffness in the morning when she awakes. Examination was conducted of the petitioner and diagnosis was the same as previous examinations and Dr. Bathla refilled the petitioner's prescription for Norco, Flexeril and Meloxicam. Due to the complaints of myofascial pain in the back, Dr. Bathla's recommended that petitioner should be placed in a course of manual therapy to determine if she can get any additional relief. Dr. Bathla awaited the results of the electromyographic study which were to be completed. (Petitioner's Exhibit 3)

On January 15, 2014, petitioner returned to Dr. Bathla. Petitioner reported that her back pain had been getting progressively worse with the weather turning bad. Petitioner indicated that the cold weather been very bad for her and that her work schedule was very busy due to the holidays. Petitioner continued to complain of pain in the middle of lower back, but had no radiating of pain into

the legs, as of January 15, 2014, Petitioner did complain of stabbing pain into the left buttocks. Dr. Bathla, regarding medications, were the same. Dr. Bathla again recommended dorsal column stimulator trial. Petitioner advised Dr. Bathla that she was open to the idea of trial again for the dorsal column stimulator as the previous one had given her no relief. (Pet. Exhibit 3)

On March 7, 2014, the petitioner returned to Dr. Bathla. Petitioner continued to complain of low back pain but indicated that she had been doing well due to the fact that work has been slower. Petitioner noted that if she did not work as much that the pain would improve. Petitioner advised Dr. Bathla that when she did work, the medications worked well and reduced the pain and made her more functional. Petitioner indicated that she had tried to get some physical therapy but had issues with her current insurance program. Dr. Bathla renewed petitioner's prescription, and again, recommended manual physical therapy. (Pet. Exhibit 3)

Petitioner returned to Dr. Bathla on April 18, 2014. Petitioner indicated no change in her pain. Petitioner indicated that she had attempted to get physical therapy but the insurance she had did not cover physical therapy.

Petitioner returned to Dr. Bathla on May 16, 2014. Petitioner again gave the history of low back pain. Petitioner indicated the pain was approximately the same with no changes. Pain was present in the low back, but as of May 16, 2014, it was not radiating into her legs and the pain was localized approximately 95% in the low back with an occasional radiation into left buttocks. Petitioner indicated that she was taking 5 to 6 Norco per day which seems to provide some relief. Again, Dr. Bathla recommended a trial of the dorsal column stimulator. (Pet. Exhibit 3)

On June 16, 2014, the petitioner returned to Dr. Bathla. Petitioner was complaining that the Norco medication was working but was making her stomach upset. Petitioner was complaining of pain in the lower back with radiation of the pain into the left buttocks. Petitioner indicated that the back pain was constant but the pain was more related to movement. Petitioner indicated that the Norco was allowing her to continue to be functional. As of June 16, 2014, the petitioner was placed on transdermal Fentanyl patches to attempt to give petitioner some additional relief from pain. (Pet. Exhibit 3)

On July 9, 2014, the petitioner returned to Dr. Bathla. Petitioner indicated that the Fentanyl patches had worked well while she was at home, but there was still pain when she was at work. The petitioner indicates that when she was at home that the patch relief most for pain and she is essentially pain free petitioner described the side effects from the medication. (Pet. Exhibit 3).

On August 4, 2014 and August 6, 2014, the petitioner returned to Dr. Bathla. Petitioner was seen for chronic low back pain. Petitioner gave Dr. Bathla the history of her incident of July 22, 2014. Petitioner advised Dr. Bathla that, following the incident, she was advised that an MRI of lumbar spine would be appropriate and petitioner further advised Dr. Bathla that the pain in her lower back was getting more severe. Petitioner indicated that she could not sleep at night and that the pain was constant and radiated into the left lower extremity down to her knees. Petitioner told Dr. Bathla she felt she was being electrocuted. Petitioner also complained of pain bilaterally into her thighs and that the back pain was worse with any prolonged activity such as walking or sitting. Petitioner indicated that the back pain was better with rest and warm baths and that the medication that she had been taking previously was not assisting in relief the pain as it did prior to the accident.

Dr. Bathla completed an evaluation of the petitioner on August 6, 2014. Petitioner's medications were completed. Dr. Bathla comments that the petitioner appeared to have a significant new pain and certain neurological symptoms after her fall. Dr. Bathla recommended an increase in pain medication slightly with recommendations for the MRI to be completed and to begin a program of manual physical therapy. Petitioner indicated that the medications were continuing to work well for her without any significant side effects or adverse reactions Dr. Bathla recommended amitriptyline to assist in petitioner's sleep. (Pet. Exhibit 3)

On August 20, 2014, an MRI was completed at the MRI Lincoln imaging Center. (Pet. Exhibit 3). The impression of the MRI indicated that L5-S1 surgery had been completed with residual granulation on the left side with minimal spondylolisthesis causing a left foraminal narrowing. Secondly, the L4-L5 disc was bulging, which narrowed the foramina on the left more than on the right and there was a mild spinal stenosis. (Pet. Exhibit 3)

On September 8, 2014, the petitioner returned to Dr. Bathla. She had the history of chronic low back pain with left lower extremity pain. Petitioner was not working at that time. Petitioner

complained of pain in the lower back rating to left lower leg. Petitioner told Dr. Bathla that her muscles were spasming on the left, that she had numbness and tingling from the midcalf down. Petitioner was taking Norco medication but she was unable to identify what activities make the pain better or worse. The petitioner's medications were continued and Dr. Bathla recommended continued Fentanyl with a change from Norco to Percocet and a continuation of meloxicam. Petitioner's amitriptyline was also continued and petitioner was given a trial of Lyrica and gabapentin. Petitioner was not recommended any neuropathic medications. (Pet. Exhibit 3). On September 9, 2014 the petitioner completed a transforaminal epidural steroid injection at the in the lumbar spine. (Pet. Exhibit 3)

On September 24, 2014 the petitioner returned to Dr. Bathla. Petitioner was complaining of low back pain with radiation into the left lower extremity and also into the right buttocks. Dr. Bathla indicates that the ESI been completed which provided relief for precisely 2 to 3 days. Petitioner indicated that she was using the Fentanyl patch 25 mg and 5 to 6 Percocets per day for pain. Petitioner told Dr. Bathla that the medications were assisting her marginally and that she continued to have numbness and tingling into the left leg in the inner thigh. Petitioner described a sleeping sensation in the left leg. Petitioner indicates that any type of faint movement or activity made pain worse. Petitioner indicated that the pain was relieved with medications and rest. Petitioner told Dr. Bathla on September 24, 2014 that she was ready to see a surgeon. Dr. Bathla in turn directed to petitioner to Dr. Mok at the University of Chicago Hospital. (Pet. Exhibit 3)

On October 22, 2014, petitioner returned to Dr. Bathla. Petitioner described low back pain with left lower extremity pain. Petitioner told Dr. Bathla that the medications she was taking kept her active in that the pain medications covered up the majority of her pain. Petitioner indicated that she was scheduled to see Dr. Mok for evaluation. Petitioner further stated that when she does not use the Fentanyl patch that she feels somewhat of a withdrawal. (Pet. Exhibit 3)

On November 24, 2014, petitioner returned to Dr. Bathla. Petitioner advised Dr. Bathla that she was seen by Dr. Mok, who wanted to do some additional tests. Dr. Bathla also indicated that the petitioner had been by Dr. Zelby for an independent medical evaluation from her employer. Petitioner was complaining of lower back pain radiating to the left lower extremity. Petitioner indicated that she was taking Fentanyl, Percocet and Flexeril and had also been taking Topamax. Examination of the petitioner was completed. (Pet. Exhibit 3) As previously indicated, all of petitioner's medications

were refilled. Dr. Bathla's records indicate that the petitioner was to see a physical therapist. Dr. Bathla also recommended undergoing the dorsal column stimulator trial and petitioner indicated that she would like to wait for that procedure. (Pet. Exhibit 3)

Petitioner returned to Dr. Bathla on December 29, 2014 there were no changes in petitioner's complaints. Petitioner was complaining of pain in lower back radiating down into the legs, specially, left lower extremity just proximal to the knee. Petitioner was taking her medication. Petitioner was again advised about the potential of using a dorsal column stimulator and that manual therapy could be helpful. (Pet. Exhibit 3)

The petitioner returned to Dr. Bathla on May 27, 2015. Dr. Bathla records that the petitioner has not been seen since January 2015. Patient indicates that her pain remains the same. Petitioner indicates that she had not been on her medications, which was terrible for her. Petitioner indicates that she was having problems sleeping. Petitioner's pain was primarily located in the low back which radiated into the left extremity and pain seemed to radiate into the left calf. Petitioner returned to Dr. Bathla on August 11, 2015. Petitioner indicate that the Percocet she had been taking is not working well and that petitioner experiences pain on a level of 7 on a scale of 1 to 10 with any type of activity. Petitioner indicated that lying down made the pain in her back better or alleviated the pain. (Pet. Exhibit 3)

Petitioner returned to Dr. Bathla on September 9, 2015. Petitioner was complaining of lower back pain and that she was getting migraine headaches from her medication. The petitioner was then recommended to use Zoloft and Xanax which would relieve some of the pain. Petitioner indicated that pain is primarily into the low back with radiates into the lower extremities and hamstrings. Pain was with any activities such as lying down. Petitioner indicated that the worst activity was sitting and that bending over also made her symptomatic. Petitioner indicated that standing was better than walking, but she could only tolerate about 10 minutes of standing until she got severe stabbing pains and lower back pain. Petitioner described numbness in the lateral left leg primarily in the thigh. Petitioner indicated that the medication reduce some of her pain to a level of 6 on a scale of 1 to 10. (Pet. Exhibit 3)

Petitioner returned to see Dr. Bathla on October 7, 2015. Petitioner indicated that the Norco medication did not give her any relief and she was taking approximate 6 tablets per day. Petitioner was given a recommendation for a Fentanyl patch to be placed on the lower back to assist with any inflammatory issues.

The petitioner returned to Dr. Bathla on December 2, 2015. Petitioner indicated that she had been getting bad pain behind the knees and the calves and that the pain was present at all times. Petitioner told Dr. Bathla that the pain medication she was taking continued to work well for her without any significant side effects. Petitioner's medications were renewed. Petitioner was recommended to see a gastro- inter-neurologist regarding her complaints of stomach discomforts. (Pet. Exhibit 3)

DEPOSITION OF DR. BATHLA

The evidence deposition of Dr. Bathla was taken pursuant to agreement on a May 22, 2015. Dr. Bathla testified that he was a specialist in pain management. Dr. Bathla testified that he first saw the petitioner on January 18, 2013. (Deposition page 8) At that time, Dr. Bathla took a history from the petitioner which included her complaints, her history of two prior lumbar surgeries and the history of the pain medications that she was taking immediately prior to seeing Dr. Bathla, and that the pain medication had been prescribed for the petitioner since 2009.

Dr. Bathla testified that he had examined the petitioner on January 18, 2013 and that the examination was normal. Dr. Bathla testified that, following the examination of the petitioner, he renewed all of her pain medications that she had previously been taken and also recommended Ibuprofen, Flexeril and Neurontin. As of January 18, 2013, Dr. Bathla made a diagnosis of a post laminectomy syndrome with low back pain. (Deposition page 9) Dr. Bathla testified that he monitored the petitioner's condition throughout 2013 and 2014.

Dr. Bathla testified that he saw the petitioner in his office on August 6, 2014. (Deposition Page 10) Dr. Bathla received a history from her of having fallen at work on some food, injuring her back and developing a very severe pain in the low back and down the bilateral lower extremities. The

petitioner reported to Dr. Bathla that she also had paresthesia in the lower extremities. (Deposition page 11) She also experience numbness into her right side as well. Dr. Bathla testified that, prior to the visit of August 6, 2014, the petitioner was complaining of low back pain in left buttock with left thigh and left lower extremity pain. (Deposition page 11) The petitioner was examined on August 6, 2014 and she demonstrated soft tissue pain in the lower back with extension and rotation and that she also had a positive "slope" test and a positive straight leg raising. (Deposition page 11) Dr. Bathla stated that when he last saw the petitioner on July 7, 2014 that she had a full range of motion in the lumbar spine and positive sacroiliac joint findings on the left.

The diagnosis, as of August 6, 2014, was that of a low back pain secondary to post laminectomy syndrome. Dr. Bathla did not change petitioner's medications on August 6, 2014, but gave her some amitriptyline for sleeping. Dr. Bathla recommended an MRI of the lumbar spine (Deposition page 12) Following completion of the MRI, Dr. Bathla made a decision to refer the petitioner to Dr. Mok. Dr. Bathla testified that he continued to see the petitioner on a monthly basis following the August 6, 2014 examination.

Dr. Bathla's testified that he continue to see the petitioner through November 24, 2014. At that time, she was complaining of low back pain radiating into the left lower extremity, she had taken Topamax which gave her some relief. Physical examination of the petitioner was unchanged, all medications were refilled and the petitioner was waiting for the examination by Dr. Mok. (Deposition page 16)

Petitioner returned to Dr. Bathla on the November 29, 2014. Petitioner's complaints were relatively the same with certain exacerbations of her pain but nothing new. The petitioner reported that her medications were working well for her and it was recommended that she would be weaned off of the Fentanyl patch. Dr. Bathla testified that, as of November 29, 2014, he recommended the use of a dorsal column stimulator to the petitioner which he had used in the past and that he would defer final opinion until the petitioner had seen Dr. Mok for her final examination by him. (Deposition page 17)

Dr. Bathla testified that he had reviewed the recommendations of Dr. Mok for a fusion at the level of L5-S1. Dr. Bathla testified that he believed based on his review of the medical records and

examination of the petitioner, that there was a relationship between the petitioner's accident of July 22, 2014 and her condition of ill-being as he found it as of December 29, 2014. Dr. Bathla stated that he believed that the increase in pain, the exacerbation of the pain, and the new symptoms were directly caused by the injury of 2014. Dr. Bathla stated there was definitely an exacerbation and change the pain. (Deposition page 19) Dr. Bathla believed that the interbody fusion, which he suggested at the level of L5-S1, was a reasonable and necessary medical procedure. (Deposition page 21/22/23)

Petitioner next saw Dr. Bathla January 26, 2015. (Deposition page 24) Petitioner was complaining of pain with flexion and extension in the lumbar spine and also the sacroiliac joints bilaterally. Dr. Bathla testified that the petitioner had some weakness in the left lower extremity with a diminished sensation in the left upper thigh to light touch (Deposition page 24) Dr. Bathla testified that he had reviewed the medical reports prepared by Dr. Zelby, the respondent's independent medical evaluator, and it was his opinion that he disagreed with the conclusions of Dr. Zelby regarding the petitioner's well-being and the impact of the petitioner's accident of July 22, 2014. (Deposition page 26/27/28)

On cross-examination, Dr. Bathla testified that, between his first visit of January 18, 2013 through the July 7, 2014 examination, that the petitioner was continuously symptomatic and that her medications were continued through the period of time in an attempt to manage the petitioner's levels of pain.

Dr. Bathla testified that not seen any of the petitioner's MRI studies which were completed prior to the July 22, 2014 incident. (Deposition page 38) Dr. Bathla further testified that he was not aware as to whether or not Dr. Mok viewed any of the medical records of the petitioner from the prior surgical procedures in 2009 or 2010. (Deposition page 39) Dr. Bathla's testified that it would have been helpful to him in formulating his diagnosis and conclusions as to causation if he had seen the medical records from petitioner's surgery in 2009 and 2010 so that he might know what the final discharge summary was at that time. (Deposition page 39) Dr. Bathla testified that the petitioner was on Lyrca and Gabapentin, which were neuropathic agents, prior to the time of July 22, 2014 incident and also prior to the time he saw the petitioner in January 2013.

Dr. Bathla testified that he disagreed with the conclusion of Dr. Zelby, that the petitioner demonstrated symptom magnification, however, Dr. Bathla admitted that he did not perform any test to determine whether or not magnification was present. (Deposition page 43) Dr. Bathla testified that it would be reasonable to say that, from his first visit with the petitioner in January 2013 through the petitioner's last visit of January 2015; there was never a period of time where the petitioner was asymptomatic.

In answer to a direct question (Deposition page 47), Dr. Bathla stated as follows

Question: To the best of your knowledge, based on all the information you have, the only difference between Ms. Curran's condition, pre-injury and post-injury, was the degree of complaints that she made, which increased

Answer: She also had some weakness to the left lower extremity which I did not see before and had a lot of pain syndromes in flexion and extension of the lumbar spine

Question: Pain syndromes

Answer: Yes, she could fake it, but I don't think I don't believe she did.

DEPOSITION OF DR. ZELBY

The respondent's medical expert, Dr. Andrew Zelby, testified in a deposition completed on June 3 2015. (Resp. Exhibit 1) Dr. Zelby testified that he saw the petitioner for an independent medical examination on November 12, 2014. Dr. Zelby took a history from the petitioner. The petitioner's history was that, on July 22, 2014, she was walking around a garbage bin and slipped and fell backwards landing on her buttocks and tailbone area. Petitioner told Dr. Zelby that she tried to catch herself as she fell and fell a little more on the right and that she also injured her right wrist. Petitioner told Dr. Zelby that she had pain everywhere in the low back going into both buttocks and down into the left thigh about halfway to her knees. Petitioner then told Dr. Zelby of her immediate medical care following the fall and that diagnostic tests had been completed. Petitioner told Dr. Zelby that, at the time of his independent medical examination, she had constant pain going across the low

back with pain into the left buttocks and the very proximal posterior thigh and that the right buttock pain had been much better. The petitioner told Dr. Zelby that her symptoms were exacerbated with prolonged sitting, a lot of bending, crouching or maintaining any position for a long time. She told Dr. Zelby she got relief from heat with changes of position and lying in a supine position. Petitioner told Dr. Zelby she was able to drive and she was able to put on her shoes and socks.

The petitioner also told Dr. Zelby of pain in the left leg and low back pain since 2009. Petitioner told Dr. Zelby that she did well after her 2009 and 2010 surgery but the pain never went away completely. Petitioner told Dr. Zelby that she treated occasionally after that but that the last treatment for her back was several months prior to her work injury of July 2014. Petitioner advised Dr. Zelby that she was on medications including Norco 3 times a day for approximately the previous three years. She also told Dr. Zelby she had been taking Mobic, Flexeril, Percocet and Duragesic microgram patches.

Dr. Zelby testified that medications were as follows Mobic was a nonsteroidal anti-inflammatory for pain, Flexeril was a muscle relaxant, Fentanyl was a Norcotic analgesic used as a transdermal patch. Petitioner told Dr. Zelby that she had started the Mobic patches after the July 22, 2014 incident. (Deposition page 11)

Dr. Zelby conducted an examination of the petitioner. Petitioner demonstrated tenderness in the lumbar spine with non-physiological like touch. The non-physiological like touch response indicated to Dr. Zelby evidence of symptom magnification or amplification. (Deposition page 11) Dr. Zelby found that squatting examination was normal and the lying straight leg raising test was positive on the right in the back and positive on the left in the leg. The petitioner demonstrated normal toe and heel walking. Her gait was normal. Her posture was normal. There was no paraspinal muscle spasm. (Deposition page 12) Dr. Zelby testified that the petitioner's response to certain tests gave him the appearance that she was attempting to deceive the examiner by demonstrating weakness in the lower extremities when, in fact, no weakness was demonstrated. (Deposition page 13) Dr. Zelby based this on petitioner demonstrating normal functional strength, normal toe walking, normal heel walking, and normal squatting.

Dr. Zelby found the sensation to pinwheel evaluation in the lower extremity was diminished on

the entire left lower extremity but otherwise preserved. Vibratory examination of the lower extremities was normal as were reflexes with the exception of an absent left Achilles reflex. Dr. Zelby noted inconsistent behavioral responses which were positive for pain to superficial light touch. (Deposition page 13)

Dr. Zelby testified that the petitioner's complaint of the entire left leg was non-anatomical because there was nothing in the examination of her spine which would result in numbness of the entire left leg. (Deposition page 14) Dr. Zelby testified that measurements of the lower extremity were within 1 cm difference and that was normal.

Dr. Zelby examined the MRI studies of August 2014 which demonstrated a degenerative disease at the L5-S1 level with a mild loss of disc space. He found evidence of a prior left L5-S1 discectomy and a removal of the left inferior L5 facet. Disc spaces were otherwise normal. At the level of L3-L4, there was a minuscule disc bulge in the posterior element hyper trophy without stenosis. At the L4-L5 level, there was a broad-based disc bulge and a posterior element per trophy with a modest canal and minimal bilateral moral stenosis a little more prominent on the left. At the L5-S1 level, there were postoperative changes but no evidence of recurrent disc herniation. The MRI result revealed no acute or posttraumatic abnormalities. (Deposition page 15/16) Dr. Zelby testified that, based upon the MRI study which was completed August 20, 2014; there was no evidence of acute or posttraumatic abnormalities. In short, Dr. Dr. Zelby indicated "in short it means that there is no evidence that Ms. Curran did anything to alter structurally or functionally or biomechanically whatever pre-existing condition she had in her spine. She didn't accelerate her condition she didn't alter her condition there is no herniated disc there's no annular tears there's no fractures." (Deposition page 16)

Dr. Zelby testified that the findings in the MRI, which was completed August 2014, demonstrated no evidence of findings of recent origin. (Deposition page 17) Dr. Zelby testified that potentially the findings indicated in the MRI of August 2014 could require some type of surgical intervention. Dr. Zelby testified that the MRI did have a slight slip of the L5-S1 that appeared to be possibly due to too much removal of the left inferior L5 facet, which would have happened at the time of the surgery in 2009 or 2010, and that was causing a relative instability. (Deposition page 17) Dr. Zelby's suggested the appropriate procedure to correct that proved pre-injury surgical defect would be an L5-S1 fusion. (Deposition page 17) Dr. Zelby went on to testify that there was nothing in the

August 20, 2014 MRI that any fusion procedure would be related to the slip and fall which occurred on July 22, 2014. (Deposition page 18) Dr. Zelby testified that the petitioner's condition was clearly long-standing symptomatic and that there was no evidence medically to suggest that the condition was aggravated, accelerated or altered in any matter. (Deposition page 18)

Dr. Zelby further testified that he had reviewed the records of Dr. Bathla. (Deposition page 19) Dr. Zelby specifically noted the medical history given to Dr. Bathla by the petitioner and referenced in his testimony Dr. Bathla;s note of August 6, 2014, post July 22, 2014 accident. Dr. Zelby noted that Dr. Bathla made no new diagnosis of petitioner's condition and refilled all prior medications with the addition of amitriptyline, which was given for assistance to petitioner's sleep difficulties, and that a new MRI was ordered. (Deposition page 22) Dr. Zelby noted that, in September 2000 and September 9, 2014, Dr. Bathla performed an epidural steroid injection, which provided no significant relief, and that petitioner was switched from Norco to Percocet. (Deposition page 22) Dr. Zelby went on to testify that he did not believe that the epidural steroid injection, which was administered to the level of L5-S1, on September 9, 2014, was appropriate. Dr. Zelby believed that the petitioner had already given the history that epidural steroid injections had not helped from previous attempts. (Deposition page 23)

In reviewing the records of Dr. Bathla, from June 12, 2013 through October 22, 2014, Dr. Zelby testified that it was conceivable in the context of the fall that she had sustained a soft tissue bruise or strain, but there was no evidence to indicate any more than that in that her condition was otherwise unchanged. (Deposition page 24) Dr. Zelby testified that he did not believe that the petitioner was symptom-free. Dr. Zelby indicated that the petitioner had symptoms for more than three years. The petitioner was on narcotic medication for three years. Dr. Zelby believed that the pain was not going to go away because of the injury but also in this case based upon the evidence condition was no worse because of the injury. (Deposition page 25)

In answer to a specific question, Dr. Zelby testified as follows:

Question: and what objective evidence would you go back to explain to the Arbitrator why you believed that it (the condition) was no worse

Answer: because there is nothing to indicate that the MRI showed any acute findings. The symptoms were essentially the same, and by October, she said things were okay which is similar to her baseline which was not so okay. So it's a long-standing condition with no evidence that she aggravated or accelerated or did anything to change it. (Deposition page 25)

Dr. Zelby testified that his final opinion was that the petitioner had sustained a mild lumbosacral. Dr. Zelby testified that the petitioner had a mild lumbosacral spondylosis with the history of a prior discectomy. Dr. Zelby testified that the review of the petitioner's medical records, when compared to her history given to him, Dr. Zelby demonstrated that her history was factually inaccurate. Dr. Zelby testified that the medical records revealed that the petitioner was symptomatic and attached essentially taking the same amounts of narcotic medication both before and after the injury. (Deposition page 27) Dr. Zelby testified that the petitioner did not need any additional diagnostic studies as a result of the incident of July 22, 2014. (Deposition page 28) Dr. Zelby did not believe that the petitioner should continue to use the medications which were described to him, in fact, he recommended that the petitioner should be weaned off all of the narcotic medications over a period of 3 to 4 months. (Deposition page 28) Dr. Zelby testified that, as of October 22, 2014, the petitioner had returned to her base line levels of pain, and therefore, could return to work. Dr. Zelby testified that petitioner had worked with this pain until July 2014. Dr. Zelby testified there was no medical evidence to suggest that she would not be able to return to those same activities, in particular when she even went back to Dr. Bathla in October 2014 she said she was feeling okay. Dr. Zelby went on to testify that it did not mean that the symptoms were going to be gone but that, as of October 2014, the petitioner was back to her previous baseline. (Deposition page 29)

Dr. Zelby testified that, subsequent to his examination, he received diagnostic studies, which were dated February 1, 2015, and a CT scan of the lumbar spine, also dated February 12, 2015. (Deposition page 30) Dr. Zelby testified that the CT scan of the lumbar spine showed no evidence of a fracture. The study demonstrated epidural calcification at the level of L3 – L4. There was a slight disc bulge at the level of L4–L5 and mild bilateral facet and ligamentous hypertrophy with mild canal stenosis. At the level of L5-S1 there were post-operative changes including a left partial vasectomy and hemi laminotomy. At the level of L5-S1, there was also moderate disc space narrowing with right facet arthroscopy and left on co-vertebral hypertrophy with moderate left foraminal stenosis and mild right foraminal stenosis. The vertebral column alignment was within normal limits. (Deposition page

29/30) Dr. Zelby testified that his review of the CT scan dated February 2015 demonstrated no evidence of any acute trauma or recent pathologies. (Deposition page 31) Dr. Zelby further testified that he had reviewed the recommendations and reports of Dr. Mok. Dr. Zelby testified that he did not agree with the conclusions and opinions of Dr. Mok because they were based on improper and erroneous information. Dr. Mok had been provided information by the petitioner telling Dr. Mok that she was asymptomatic prior to the fall at work. Dr. Zelby testified that this was obviously an inaccurate history of the back complaints. (Deposition page 31/32)

Dr. Zelby's testified that, regarding Dr. Mok's recommendation for a stabilization fusion at the level of L5-S1, that it is possible that Ms. Curran had significant enough instability at that level to require stabilization in the form of an L5-S1 fusion because of the prior surgery. (Deposition page 33) Dr. Zelby went on to testify that the MRI and CT scan studies demonstrated no evidence of instability or malalignment, although Dr. Mok had made that conclusion in his report, and Dr. Zelby could not reconcile the difference between the MRI/CT studies and Dr. Mok's conclusion. (Deposition page 33) Dr. Zelby went on to state that "but it was clear that the need for any such treatment (L5-S1 fusion) is related to ongoing manifestations of the pre-existing and already symptomatic degenerative conditions. The continued complaints and the need for surgery are not related to any work activity or work injury and should be treated as such." (Deposition page 33)

FINDINGS OF FACT AND CONCLUSIONS

In support of the Arbitrator's decision pertaining to (F) whether or not petitioner's present condition of ill-being and surgical necessity is related to the accident of July 22, 2014, the Arbitrator finds as follows:

The Arbitrator notes that, having reviewed the medical evidence in this case, both Dr. Mok and Dr. Zelby, the respondent's expert, are of the opinion that the petitioner could be a candidate for a stabilization fusion in the lumbar spine at the level of L5-S1. The key question is whether or not this procedure is necessitated by the incident of July 22, 2014 or is a natural progressive result of petitioner's condition for which she had received surgery in 2009 in 2010.

The Arbitrator has reviewed carefully the testimony of the petitioner in reference to her job duties, and particularly in reference to her complaints of pain and discomfort, which were elicited from her both at the time of Arbitration and as elicited from her by her treating physicians and the examination which was conducted by Dr. Zelby.

The petitioner and her testimony admits that, between 2009 and 2014, when she slipped and fell at the respondent's place of business, that she had been in constant pain in varying degrees in her lumbar spine and lower extremities. The petitioner further testified that, from 2009 through 2014, in an attempt to relieve the pain, the petitioner had taken prescribed narcotic medication which in varying degrees provided some relief from her complaints of pain and discomfort. The petitioner clearly testified that the surgeries, which were performed in 2009 and 2010, did not alleviate her pain. The petitioner further testified, and is consistently reflected in her medical records, that she had also completed epidural steroid injections physical therapy and a trial of a dorsal column stimulator. All of this was done prior to the incident of July 22, 2014.

Petitioner testified that postoperatively in 2010 through 2013, petitioner testified that, between the date of her last surgery in 2011 through the date she first saw Dr. Bathla on January 18, 2013, that she was in pain and had been taking various forms of medication to ease the pain. The petitioner testified that the medical records reflect that the reason that she sought treatment from Dr. Bathla on January 18, 2013 was for management of her pain and for supplementation of the narcotic medication which she had previously been taking. The petitioner clearly stated, not only on her in her testimony before the Arbitrator, but also in the medical records of Dr. Bathla, that she had attempted and that she had completed a trial implantation of a dorsal column stimulator but the simulator did not provide sufficient relief, and therefore, contrary to the recommendations of the treating surgeon, she did not have a permanent implantation of this device.

The petitioner began seeing her pain specialist, Dr. Bathla, on January 18, 2013. The Arbitrator notes that, between January 18, 2013 and August 6, 2014, the petitioner had been seen by Dr. Bathla 17 times. The Arbitrator further notes that the petitioner, during this interim period, was never symptom-free. At all the visits, petitioner referred to a significant amount of pain which she was experiencing in various degrees in the lower portion of her back and to varying degrees into her lower extremities. The Arbitrator further notes that at each visit to Dr. Bathla between January 18, 2013 and

August 6, 2014 Dr. Bathla continued to prescribe narcotic medication in an attempt to alleviate the petitioner's pain. The Arbitrator further notes that, due to ongoing intensities of pain and the petitioner's continuing complaints that Dr. Bathla, similar to the surgeon who had performed the procedure in 2011, recommended a trial of a dorsal column stimulator.

Dr. Bathla also recommended and completed an epidural steroid injection and finally recommended the use of a TLSO stabilization brace for the petitioner's lower back. The Arbitrator is aware that the petitioner, on cross-examination, testified that she was not aware that Dr. Bathla had recommended a TLSO brace but that she did, in fact, use a brace different from the TLSO brace which had been recommended by Dr. Bathla.

The Arbitrator further notes that due to the increase in pain that the petitioner was also given Fentanyl patches immediately prior to her incident of July 22, 2014. The Arbitrator notes that, between January 18, 2013 through July 9, 2014, just prior to the July 22, 2014 incident, the only variance regarding the petitioner symptomatology regarding her back and lower extremities was the degree to which the pain was affecting the petitioner's lifestyle. The Arbitrator does note that subjectively the petitioner testified that through the use of the various narcotic medications that she was able to continue working.

The Arbitrator notes that the petitioner, following the July 22, 2014 incident, continued to see Dr. Bathla. The petitioner alleged, subsequent to July 22, 2014, that the narcotic medication which she had been using to provide enough relief to continue working was no longer having the effect it had, and thus, she could not continue working. The Arbitrator notes that Dr. Bathla acknowledges the petitioner subjective complaints of pain and discomfort and the Arbitrator also notes that, immediately prior to July 22, 2014, that Dr. Bathla had recommended the dorsal column stimulator and Fentanyl patches.

The Arbitrator further notes that Dr. Bathla's records contained in petitioner's Exhibit 3 demonstrate consistent lack of any objective findings relative to petitioner's complaints of pain and the Arbitrator notes that the recommendations for chronic medication were based upon the petitioner's subjective complaints.

The Arbitrator also notes the records of Dr. Mok (Pet. Exhibit 4), dated October 28, 2014. Dr. Mok indicates that the petitioner gave a history of having slipped on a surface while at work with her feet going out from under her into the air and she fell directly upon her back. The Arbitrator notes that this history, as indicated in Dr. Mok's records, is inconsistent with the petitioner's testimony and also inconsistent with the mechanism of the injury as reflected in other medical records.

The Arbitrator also notes that Dr. Mok states in his October 28, 2014 records that the petitioner had been seen by a couple of spine surgeons at the Northwestern Memorial Hospital emergency room. A review of the records of the Northwestern Memorial Hospital emergency room (Pet. Exhibit 1) do not indicate that the petitioner was ever seen by a spine surgeon between 2011 and the time she saw Dr. Mok for the first time on October 28, 2014. Significantly, the Arbitrator also notes that Dr. Mok's records are absent of any reference in the petitioner's history as to her continuing use of medications between 2009 and July 22, 2014. The Arbitrator further notes that there is no mention that the petitioner was complaining of constant pain and discomfort between 2009 through July 22, 2014. There is no mention that the petitioner was recommended, prior to July 22, 2014, for a trial of a dorsal column stimulator and there is no mention that the petitioner had been taking Fentanyl as recently as one week prior to the July 22, 2014 incident. Additionally, Dr. Mok does not mention that the petitioner had attempted to use a dorsal column stimulator to relieve her pain in 2011 and found that the pain was not affected by the dorsal column stimulator, and therefore, it was not used. Dr. Mok further fails to note the petitioner's 17 visits made to Dr. Bathla between January 18, 2013 and July 22, 2014 wherein the petitioner complained of constant pain, was given multiple narcotic medications, was recommended for a TLSO brace, and was recommended to complete a second attempt at a dorsal column stimulator trial to which the petitioner had, in fact, suggested that she would be willing to do if she had appropriate insurance coverage.

The Arbitrator, having observed that Dr. Mok's records do not contain any of this information, finds that Dr. Mok's opinion that the petitioner's surgical necessity and complaints are related to the July 22, 2014 incident are based upon false premise or lack of sufficient information to accurately make that recommendation.

The Arbitrator also notes that Dr. Mok recommended and there was completed a CT scan of the spine on February 12, 2015. Based upon the CT scan (Pet. Exhibit 4), Dr. Mok recommended a

fusion stabilization process at the level of L5-S1. Dr. Mok's recommendation for the fusion to be completed is based upon his statement that there is likely been a disruption of some of the scar tissue at the level of L5-S1 which was causing spinal instability at that level. The Arbitrator notes that Dr. Mok did not review any of the prior studies for the surgical procedures that were done in 2009 and 2010 and there is no indication that he evaluated any MRIs which were done under the direction of Dr. Bathla. Dr. Mok had seen a prior MRI study which he felt was of such poor quality that it was non-diagnostic. This failure to have a comparative study to determine what pathology may have been present prior to the fall versus pathology which was found subsequent to the fall, again, affects the doctor's credibility for his opinion that the petitioner's condition of ill-being in surgical necessities were caused by the incident of July 22, 2014.

The Arbitrator finds the opinion of Dr. Mok to be unpersuasive. Clearly, the petitioner had been symptomatic from 2009 through 2014. During this time, and immediately prior to the July 22, 2014 incident, the petitioner was taking narcotic pain relievers. Petitioner's statements that the narcotics were no longer effective are self-serving and unsupported.

Dr. Zelby, in his testimony, stated that there was no medical objective sign of a traumatic injury to the spine which would have indicated anything other than a temporary aggravation of prior problems which returned to baseline in October 2014. Dr. Zelby's conclusion that, if the L5-S1 fusion is appropriate, it is to address the potential instability created by the surgery in 2009 and 2010. Petitioner's constant use of narcotic medications for 5 years supports Dr. Zelby's positions. The Arbitrator finds the opinion of Dr. Zelby to be more credible and persuasive than Dr. Mok or Dr. Bathla.

The Arbitrator finds that there is no casual connection between the petitioner's accident of July 22, 2014 and the present condition of ill-being. The petitioner has failed to prove by a preponderance of the evidence that her inability to work and need for surgery are supported by objective medical or factual evidence. Accordingly, compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ashley Preston,

Petitioner,

vs. NO: 14 WC 26915

17IWCC0391

Shop 'N Save,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 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.

17IWCC0391

The party commencing 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: JUN 27 2017
TJT:yl
o 6/20/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRESTON, ASHLEY
Employee/Petitioner

Case# **14WC026915**

SHOP 'N SAVE
Employer/Respondent

17IWCC0391

On 3/22/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
LESLIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

1256 HOLTKAMP LIESE SCHULTZ & ET AL
KENNETH ALEXANDER
217 N 10TH ST SUITE 400
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ASHLEY PRESTON,
Employee/Petitioner

v.

SHOP 'N SAVE
Employer/Respondent

Case # **14** WC **26915**

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 **January 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 _____

17IWCC0391

FINDINGS

On **July 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 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 a work accident.

In the year preceding the injury, Petitioner earned **$5,830.54**; the average weekly wage was **$291.53**.

On the date of accident, Petitioner was **19** years of age, ***single*** with **1** dependent child.

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

Respondent ***has*** 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 **$N/A** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$0**.

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

ORDER

Accident

The Arbitrator finds that the Petitioner failed to prove she sustained accidental injuries on July 25, 2014 that arose out of and in the course of her employment with Respondent.

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

March 16, 2016
Date

ICArbDec p. 2

MAR 22 2016

STATEMENT OF FACTS

The Petitioner was employed by Respondent as a deli worker. She testified that on July 25, 2014, she was at work in a cooler lifting approximate 50 pound boxes of chicken from floor level and injured her low back. As to reporting it to the Respondent that day, the Petitioner testified: "I tried to, but supposedly, they told me there were no on duty managers, and they would not listen to me."

On cross examination, Petitioner testified that about halfway through lifting 8 to 10 boxes she bent over, was lifting and felt something pull in her back, so she stopped. She said the pain was sharp and stabbing, and she felt like she could barely move.

She awoke the next day in severe pain. She testified she went to tell the store manager about her injury: "I was trying to tell him, and he would not listen to me. He said to go ahead and come into work, and it would be okay. I said, No, I'm in a lot of pain. I cannot work."

The Petitioner then sought treatment that day (July 26, 2014) at Anderson Hospital. An intake form noted a registration complaint of abdominal pain. The emergency room (ER) report from Anderson Hospital that day notes Petitioner had a 7 to 10 day history of sharp, stabbing left lower abdominal pain, noting she had been evaluated by her gynecologist that day and underwent pelvic exam and ultrasound along with blood work. No specific diagnosis was indicated beyond abdominal pain, Naproxen was prescribed, and she was advised to follow up with her gynecologist. A separate note indicated she could return to work in three days. Nothing in the records from Anderson Hospital reflected complaints of low back or leg pain. (Px2).

On cross examination, Petitioner was asked about why the Anderson Hospital ER report did not reflect a history of a work related injury, and she responded that she reported the injury there, as well as low back and left lower abdominal pain: "I did tell them, but they didn't listen to me, though. They just kept insisting it was a cyst because of the pain and where the location was. But I tried telling them it was a sharp stabbing pain, and it was constant, and that my cysts are dull, and it goes on and off, and this was not going away. And they said because of me having a cyst and being treated for it, it is just a cyst acting up."

The records of Maryville Women's Center (Px1) indicate that on July 21, 2014, the Petitioner appeared for an IUD check, and that: "She states the symptoms are acute and are of new onset", noting pain with intercourse. The gynecologist, Dr. Sanford, indicated that an ultrasound noted the IUD was in the lower uterine segment and that the device might need to be replaced. The July 23, 2014 ultrasound report noted bilateral ovarian cysts along with a left adnexal cyst. Petitioner returned to Dr. Sanford on July 30, 2014. The report appears to note that this was in follow up to an ER visit for low abdominal/back pain. Petitioner indicated her symptoms were acute and unchanged. Petitioner "admits to chronic back injury and states that her main concern were the ovarian cysts that were found on (ultrasound)". The diagnosis was chronic back pain, and Petitioner was reassured with regard to both the cysts and the IUD placement. The report noted the Petitioner was 5 feet tall and weighed 252 pounds, and that she had gained 50 pounds in the last 18 months. She was counseled about weight loss and how increased weight can strain the low back. (Px1). The Petitioner denied reporting chronic back pain to Dr. Sanford, and denied ever having prior back pain.

On July 28, 2014, Petitioner sought treatment with chiropractor Dr. Eavenson at Multi-Care Specialists at her attorney's recommendation. The report of the doctor indicates that the Petitioner reported injuring her low back at work on July 25th while lifting eight to ten approximately 50 pound boxes. Petitioner indicated she had requested a break from her supervisor, but that this was denied, and her pain intensified through the evening. The Petitioner also noted that she went to the Anderson Hospital ER the next day, and Dr. Eavenson reported:

"They have the patient complaining of abdominal pain for 7 to 10 days. She had been evaluated that same day by her gynecologist and had a pelvic ultrasound and blood work done as well. According to the patient the exam revealed an ovarian cyst." Petitioner reported improved pelvic pain but complained of continued low back pain with pain and numbness in the left leg. She denied any prior injury. X-rays were unremarkable. The diagnosis was a lumbar disc protrusion and left lumbar radiculitis with an apparent ovarian cyst. Lumbar MRI and physical therapy were prescribed, and she was held off work until further notice. She was to follow up with her gynecologist regarding the cysts. (Px3).

July 29, 2014 lumbar MRI was essentially normal at all levels other than L5/S1, which noted a 2 to 3 mm retrolisthesis with mild central disc bulge and mild facet arthropathy. There was no spinal canal or foraminal stenosis at any level. (Px4).

Petitioner continued to treat with Dr. Eavenson through December 1, 2014. with chiropractic manipulation, physical therapy, electrical stimulation, ultrasound and heat/cold packs. There was no significant improvement, but rather waxing and waning symptoms. On September 15, 2014 Petitioner reported tripping over her son's toy with increased right sided low back pain. On September 29, 2014 she was referred to Dr. Gornet. (Px3).

On October 6, 2014, the Petitioner was examined by Dr. Hurford at the request of the Respondent (see Rx1).

Petitioner saw orthopedic surgeon Dr. Gornet on October 8, 2014. She reported bilateral low back pain, particularly in the left buttock, hip and thigh to the knee. She had intermittent left leg tingling but no frank numbness. She indicated this current problem began on July 25th while lifting about eight 50 pound boxes from the floor to a shelf at work, when she felt a pull in her back. The report also states: "She stated that she tried to report this to the manager. There were no official managers there. The patient felt the substitute manager did recognize this issue. She went in the next day to again try and report this injury, but she states she was not given a formal documentation for this. Out of frustration, she went to the emergency room. There was some concern in the emergency room that she had some cramping or abdominal pain also and they were concerned about a cyst. She states that they were essentially focused on this during the emergency room visit. The next day she went to Dr. Eavenson to begin treatment for her back problems." (Px5). Petitioner indicated constant symptoms, worse with bending or lifting. She had been placed on light duty but was not actually working. Neurological examination was within normal limits, except for positive left straight leg raise testing, and the Petitioner was noted to be morbidly obese. Dr. Gornet stated that x-rays showed no significant bony or degenerative changes, but subtle suggestion of an L5/S1 pars fracture and strong suggestion of an annular tear at that level. He opined that she sustained a causally related, by history of July 25, 2014 injury, L5/S1 annular tear and prescribed epidural injections, weight loss and light duty restrictions.

On October 13, 2014, Dr. Sanford noted Petitioner reported a herniated lumbar disc, that she was to begin injections and physical therapy, and that she had a December appointment to see a surgeon.

The initially scheduled epidural injection of October 22, 2014 was not performed, with Petitioner reporting she was unable to get transportation to the facility. (Px3). Petitioner received a left L5/S1 epidural on November 10, 2014. (Px6). On November 19th, Dr. Eavenson noted Petitioner no longer had leg pain and just had some back soreness. She did not want any additional injections. On December 1, 2014, Dr. Gornet noted slow improvement, relaxed her work restrictions and indicated she could move from formal therapy to a home exercise program. At the last visit of February 5, 2015, Petitioner reported minimal symptoms to Dr. Gornet, and he released her back to full duty work at maximum medical improvement. (Px5).

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:

First, the Arbitrator finds that the Petitioner's testimony regarding the reporting of an injury at work was not particularly credible. The Arbitrator finds it unlikely that two attempts at reporting a work injury, on July 25 and 26, 2014, failed and that the Respondent's managers would have essentially ignored the reporting of a work related injury, and per the history given to Dr. Eavenson, would not allow her to take a break after reporting the alleged injury. While there is the possibility that these facts are accurate, the Arbitrator believes the greater weight of the evidence supports that the Petitioner did not report a work related injury on either of these dates.

The Arbitrator notes that while Dr. Gornet's records indicate Petitioner's statements that the Anderson Hospital ER staff were focused on cysts at her July 26, 2014 visit, none of the records from the ER in Petitioner's Exhibit 2 reference abdominal cysts, or even any concern regarding such cysts.

The Petitioner herself testified as follows: "It was a sharp, stabbing pain, and it was constant. And usually, with my cysts, it's dull, and it goes off and on, so I knew it was not a cyst, but that is how they did treat me, was for a cyst, and I knew it was not a cyst, and I was in a lot of pain. I have known the pain for cysts. I've had them for a while, and it's never like that." In the Arbitrator's view, given that the ER report notes nothing whatsoever about cysts, and the Petitioner testified that she knew her pain on July 26, 2014 was of a different quality than pain she had due to cysts, it is difficult to believe that she reported a work related low back injury at the ER on July 26, 2014. Plus, no testing whatsoever was done for the low back at the ER, not even lumbar x-rays. On balance, it appears more likely than not that Petitioner's complaints on July 26, 2014 were abdominal complaints, not low back complaints. She testified that she reported both low back and left lower abdominal pain to the ER, but did not testify that the accident caused the abdominal pain.

The July 30, 2014 report of Dr. Sanford noted Petitioner's statement that she had a history of "chronic", as opposed to acute, low back pain, as well as that she had gained fifty pounds in the 18 months prior to the visit. One of the doctor's recommendations was weight loss, and Petitioner was counseled on how the weight gain can impact the lumbar spine.

The history noted in the initial July 28, 2014 report of Dr. Eavenson gives the Arbitrator pause regarding the issue of accident, but based on the above findings, the Arbitrator finds that the greater weight of the evidence supports the finding that Petitioner failed to prove she sustained accidental injury on July 25, 2014 which arose out of and in the course of her employment. The Arbitrator does not believe it is more likely than not that the Respondent refused to accept the Petitioner's reporting of a work accident, that the Anderson Hospital ER noted nothing whatsoever about a work injury despite Petitioner's testimony that she reported the injury and indicated that it caused severe back pain, and that her gynecologist somehow documented chronic back pain when the Petitioner never reported it. It appears more likely that she had ongoing chronic low back pain as well as abdominal problems due to cysts, and that it is unlikely that an acute injury occurred on July 25, 2014.

Given this finding, all other issues are moot.

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

KEITH MOODY,

Petitioner,

17IWCC0418

vs.

NO: 14 WC 29244

HOBBY LOBBY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by both parties herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, reasonableness and necessity of medical expenses, prospective medical, and penalties and attorney's fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 Arbitrator awarded Petitioner temporary total disability benefits for 22-1/7 weeks, for the period beginning October 26, 2014 through March 29, 2015.

Petitioner testified that immediately following the accident he also lost time from work prior to Respondent providing him a light-duty position within his restrictions. Petitioner testified he went to Advocate Sherman Outpatient Center after work on the date of accident. He was given multiple restrictions including lifting restrictions. Petitioner testified he could not drive with the medication he was prescribed. Petitioner returned to Advocate Sherman

17IWCC0418

Outpatient Center on July 17, 2014 and he was prescribed additional medications. (T, pp. 11-14) The records from Advocate Sherman Outpatient Center confirm that Petitioner was assigned work restrictions at his visits on July 5, 7, 10,14, 17, 2014. (Px1)

Petitioner also began treating with chiropractor Dr. Daniel Summerkamp, at Summerkamp Spine Center. On July 15, 2014, Dr. Summerkamp assigned restrictions of no lifting, no twisting, no bending, no stooping and referred Petitioner for an MRI. Petitioner testified he was off work for approximately three weeks after the accident before Respondent provided light-duty work. Petitioner testified he returned to work the next work shift after July 23, 2014. Respondent initially provided him sitting work. (T, pp. 14-16)

The Commission, therefore, modifies the Arbitrator's Decision to reflect the Petitioner's entitlement to temporary total disability benefits for the additional 2-3/7 weeks immediately following the accident from July 7, 2014 through July 23, 2014.

Petitioner testified he was then provided light duty work until the beginning of October, 2014, either the 3rd or the 4th although paid through mid-October. In November he received another payment. (T, pp. 30, 37-38).

Respondent's exhibit #5 reflects temporary total disability payments issued to Petitioner for the periods of lost time between July 7, 2014 through July 20, 2014 and between October 26, 2014 through December 6, 2014, and a temporary total disability payment issued to Petitioner's attorney on January 22, 2015, a total of $8,828.92 in temporary total disability benefits paid and for which Respondent shall receive credit.

The Commission finds the Petitioner is entitled to temporary total disability benefits for 24-4/7 weeks, for the period beginning July 7, 2014 through July 23, 2014 plus for the period beginning October 26, 2014 through March 29, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed July 18, 2016 is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $683.33 per week for a period of 24-4/7 weeks, from July 7, 2014 through July 23, 2014 and from October 26, 2014 through March 29, 2015, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act. The Respondent shall have credit for the amount of $8,828.92 previously paid to the Petitioner. This award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills for Petitioner's treatment related to his lumbar spine itemized in Petitioner's exhibit

#5 and additionally the reasonable and related costs, and attendant costs, for the L5 through S3 ablation procedures as recommend by Dr. Noveseletsky, in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $29,900.00. 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: JUN 29 2017
KWL/bsd
O-05/16/17
42

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I agree with the majority's decision to affirm and adopt the arbitrator's decision with a modification to the temporary total disability benefit, except that I would also award penalties pursuant to section 19(l) of the Act.

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

The section 19(l) penalty is in the nature of a late fee. *Mechanical Devices v. Industrial Commission*, 344 Ill. App. 3d 752, 763 (2003). Assessment of the penalty is mandatory "if the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan*, 183 Ill. 2d at 515. In determining whether an employer has "good and just cause" in failing to pay or delaying payment of benefits, the standard is reasonableness. *McMahan*, 183 Ill. 2d at 515.

Respondent's basis for delaying or declining to pay temporary total disability payments was presumably the report of Dr. Soriano, who examined Petitioner on Respondent's behalf on October 28, 2014. Dr. Soriano opined that Petitioner reached maximum medical improvement on October 14, 2014, and was able to return to full work. He further opined that there was no causal relationship between Petitioner's continued complaints and his workplace injury. The majority correctly discounts these opinions as inconsistent with the evidence. So, too, did Respondent. Through Petitioner's testimony, the record establishes that Respondent told him in early October 2014 that he could not return to work "without a full bill of health," that he did not receive that clearance from his physicians, and that he did not return to Respondent's employ. Thus, Respondent deemed Petitioner unfit for work despite Dr. Soriano's opinion. Consistent with that view, and inconsistent with Dr. Soriano's view that no benefits were due after October 14, Respondent paid Petitioner temporary total disability benefits for all of November 2014 and parts of the next two months. For that reason, I would conclude that Respondent did not reasonably rely on Dr. Soriano's report for delaying or denying benefits. I would conclude instead that Respondent paid benefits, then unilaterally delayed or terminated them without good and just cause.

Respondent does not dispute that payments were delayed or that, at the statutory rate of $30 per day of delay, the delays in this case would bring its penalty to the $10,000 maximum. I would award section 19(l) penalties in that amount.

Thomas J. Tyrrell

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

17IWCC0418

MODDY, KEITH M
Employee/Petitioner

Case# **14WC029244**

HOBBY LOBBY
Employer/Respondent

On 7/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0247 HANNIGAN & BOTHA LTD
RICHARD D HANNIGAN
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

1120 BRADY CONNOLLY & MASUDA PC
JOHN O'GRADY
10 S LASALLE ST SUITE 900
CHICAGO, IL 60603

☐	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

17IWCC0418

KEITH M. MOODY
Employee/Petitioner

Case #14 WC 29244

V.

HOBBY LOBBY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on May 26 and June 27, 2006. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☒ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On July 5, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $53,300.00; the average weekly wage was $1,025.00.
- At the time of injury, the petitioner was 29 years of age, single with two children under 18.
- The parties agreed that the respondent paid $8,828.92 in temporary total disability benefits.
- The parties agreed that the petitioner was off of work without any pay from October 26, 2014, through March 29, 2015.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $683.33/week for 22-1/7 weeks, from October 26, 2014, through March 29, 2015, which is the period of temporary total disability for which compensation is payable. The respondent has an off-set for the amount of $8,828.92 previously paid to the petitioner.
- The medical care rendered the petitioner for his lumbar spine was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- The petitioner's request for penalties and fees is denied.
- The petitioner is awarded the reasonable cost for the L5 through S3 ablation procedures recommended by Dr. Novoseletsky.
- 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

July 11, 2016

Date

JUL 18 2016

FINDINGS OF FACTS:

The petitioner, an assistant store manager, was struck on his back by a door on July 5, 2014. He sought care for mild back pain that night at Advocate Sherman Outpatient Center. X-rays were negative for fractures. He was treated with medication and activity restrictions for a back contusion. The petitioner reported no improvement at multiple follow-ups at Advocate through August 21st. He started chiropractic care for lower back pain with Dr. Daniel Summerkamp at Summerkamp Spine & Joint Center on July 15th and followed up numerous times through August 20th. A pelvic MRI on August 18th revealed a transitional vertebra at the lumbosacral junction, disc desiccation and a posterior central bulge at the lumbar/transitional vertebrae and small bilateral hip effusions.

Pursuant to a referral from Advocate, the petitioner started care with Dr. Chhadia at Suburban Orthropaedics on November 21st for lower back pain with radiation into his left buttocks, numbness and tingling and occasional radiating pain in the back of his left thigh. The doctor noted positive tenderness in the petitioner's paraspinal muscles and spinous process and a positive straight leg sign and opined that the MRI showed a small central/left disc protrusion at L4-5. He was given restrictions of no lifting and light duty. He reported moderate to severe lumbar symptoms to Dr. Chhadia on December 19th, January 16, 2015, and February 20, 2015. At his last follow-up with Dr. Chhadia on June 3, 2015, the petitioner reported little change in his symptoms, a near constant ache with intermittent sharp pain through his lower lumbar spine around the top of his buttocks, no lower extremity pain, numbness or tingling but intermittent left leg weakness/giving out.

The petitioner saw Dr. Novoseletsky at Suburban Orthopedics on August 7, 2015, and reported primarily varying left-sided lower back pain with radiation down the left leg with stiffness and with numbness and tingling that radiates down to his knee. On August 19, 2015, Dr. Novoseletsky gave the petitioner a left-sided sacroiliac joint injection which provided him great relief. The petitioner reported numbness and tingling in his lower back with radiation into his bilateral buttocks. On February 23, 2016, Dr. Novoseletsky gave the petitioner right-sided sacral lateral branch blocks at S1 thru S3. The petitioner reported a 75% pain relief for four hours. On March 14, 2016, Dr. Novoseletsky recommended left L5 thru S3 sacral lateral branch radiofrequencies.

At the request of the respondent, Dr. Morris Soriano evaluated the petitioner on October 28, 2014. The doctor opined that the petitioner sustained a resolved mild soft tissue contusion of his left iliac crest and buttock and that his pre-existing mild degenerative L4-5 disc disease was not worsened by the work injury. On March 30, 2015, the petitioner began a door-to-door salesperson position with Comcast. The petitioner is able to perform his job duties, which requires mostly walking and standing.

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

The medical care rendered the petitioner for his lumbar spine was reasonable and necessary and is awarded.

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 his current condition of ill-being with his lumbar spine is causally related to the work injury. The petitioner has consistently sought medical care for unrelenting lumbar spine

pain since his work injury. The opinions of Dr. Soriano are not consistent with the evidence and are not given any probative weight.

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

The respondent shall pay the petitioner temporary total disability benefits of $683.33/week for 22-1/7 weeks, from October 26, 2014, through March 29, 2015, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner proved that he is entitled to reasonable and necessary medical care to relieve the effects of the work injury to his lumbosacral spine. Dr. Novoseletsky recommended L5 through S3 radiofrequency ablation procedures as the next step to relieve the petitioner's back pain. The petitioner is entitled to receive the reasonable cost for the L5 through S3 ablation procedures recommended by Dr. Novoseletsky.

FINDING REGARDING PENALTIES AND FEES:

The petitioner failed to prove that he is entitled to §19(l) and §19(k) penalties and fees. There was a genuine dispute regarding the issue of medical care and causation of his condition of ill-being. The respondent's delay in the payment of temporary total disability and medical benefits was not vexatious and unreasonable. The petitioner's request for penalties and fees is denied.

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

Jim Armstrong,

Petitioner,

vs. NO: 14WC 34029

NMMC Inc.,

17IWCC0363

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 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.

17IWCC0363

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: JUN 16 2017
MJB/bm
o-4/25/17
052

Michael J. Brennan

Kevin W. Lamborn

DISSENT

I respectfully dissent from the finding that Petitioner failed to establish that his lumbar and cervical back conditions are causally related to his workplace injury.
Dr. Siemionow found a relationship between the exacerbation of petitioner's cervical condition and the April 12, 2014, workplace accident based on some combination of two theories: (1) the neck injury coincided with the April 2014 injury but was masked by pain from that injury; and (2) the neck injury was caused by Petitioner's October 15, 2014, right-shoulder surgery. To refute Dr. Siemionow's opinion and find no causal connection, the majority relies on what it views as inconsistencies in Petitioner's injury-reporting timeline. The majority observes that Petitioner reported neck pain following a September 4, 2014, examination by Dr. Lee, and again two weeks before a December 16, 2014, treatment visit. Thus, the majority concludes, Petitioner's neck pain predated his October 15, 2014, shoulder surgery and could not have been caused by it. This approach overlooks what Dr. Siemionow concluded was "the most likely scenario for the neck injuries": that Petitioner's neck injury occurred at the same time as his right shoulder injury. As Dr. Siemionow explained, "the shoulder pain was so intense that it could have masked his right upper extremity radiculopathy. You get the shoulder taken care of or the shoulder settles down and this thing becomes more apparent, more prevalent. I think either [the shoulder injury] or the surgery could have caused it. *** [S]houlder injuries and neck injuries go hand in hand ***." The medical evidence, including the evidence the majority recounts, supports this theory.

Further, the record contains no persuasive evidence to discredit that theory. Dr. Gleason found no causal connection based on the notion that Petitioner's complaints did not arise until after surgery. That observation is counterfactual, but if believed it would actually support Petitioner's theory that his cervical condition was caused by his April 2014 accident or the related surgery. With Dr. Gleason's opinion set aside for those reasons, there is nothing in the record to refute Dr. Siemionow's causation opinion.

As for Petitioner's lumbar condition, again Dr. Gleason's causation opinion—that there could be no causal relationship because the lumbar condition did not arise until after the shoulder surgery, in March 2015—misses the point. Petitioner's theory is that the physical therapy he underwent to recover from his shoulder surgery triggered his lumbar symptoms. Contrary to the majority's view, that theory is well-supported by the record. There is no evidence that Petitioner suffered any lumbar symptoms at any relevant time, until he began physical therapy for his shoulder issues. Then, on two occasions, in February 23 and March 2, 2015, physical therapy treatment notes, Petitioner documented lumbar problems that occurred during physical therapy sessions. (The majority overlooks this evidence when it says that the physical therapy records "only mention in passing when petitioner was discharged from physical therapy on March 27, 2015," that he suffered a lumbar incident during a therapy session.) The remainder of the record provides additional support for Petitioner's theory. A March 30, 2015, treatment note states that Petitioner reported the mechanism of his injury—carrying 10-pound weights during therapy—to Dr. Siemionow, and Petitioner described the mechanism similarly in his testimony. Dr. Siemionow opined in his deposition that Petitioner's carrying those weights could have caused a lumbar herniation.

In my view, the above evidence inexorably dictates a finding that Petitioner's cervical and lumbar conditions are causally related to his April 2014 injury. I would, therefore, modify the arbitrator's decision and find that the Petitioner's cervical and lumbar conditions are related to his workplace accident. I would award prospective medical treatment for those conditions; award temporary total disability from July 23, 2014, through February 8, 2016; and remand the case back to the arbitrator.

Thomas J. Tyrrell

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

ARMSTRONG, JIM
Employee/Petitioner

Case# 14WC034029

NMMC INC
Employer/Respondent

17IWCC0363

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1357 RATHBUN CSERVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

1337 KNELL LAW LLC
CHARLES KNELL
504 FAYETTE ST
PEORIA, IL 61603

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)

Jim Armstrong
Employee/Petitioner

v.

NMMC, Inc.
Employer/Respondent

Case # 14 WC 34029

17IWCC0363

An *Application for Adjustment 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 **February 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0363

FINDINGS

On the date of accident **April 12, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$38,993.24**; the average weekly wage was **$749.87**.

On the date of accident, Petitioner was **46** 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 **$38,759.04** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$38,759.04**.

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

ORDER

AWARD FOR ANY BENEFITS WAS MADE IN 14 WC 34415.

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

05/25/2016
Date

IC ArbDec19(b) p.2

MAY 26 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jim Armstrong	)	
Petitioner,	)	
vs.	)	**No. 14 WC 34029**
NMMC	)	**17IWCC0363**
Respondent.	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on February 8, 2016 in New Lenox under §19b/§8a of the Act. The parties agree that on April 12, 2014 Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner was injured in a work accident that arose out of and in the course of his employment with Respondent on April 10, 2014 and that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $38,993.24, and that his average weekly wage was $749.87.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether the medical services provided were reasonable, necessary and causally related to the work accident.
3. Whether petitioner entitled to any prospective medical care.
4. The amount of temporary benefits due petitioner.

FINDING OF FACTS

Petitioner testified he last worked for respondent in August, 2014. Respondent is a trucking company that hauls rail containers. Petitioner had been working for respondent since 2010; driving an eighteen-wheeler/semi-truck. Petitioner reported to respondent's yard for his assignments from Dan, the owner, or Wendy, the office manager. He would pick up and unload containers in the Chicagoland area.

Petitioner's job involved no touch freight. The physical part of petitioner's job required him to ensure the four locking pins that hold down the container were locked in place. To do this, the petitioner had to use a crow bar and sledge hammer to lock the pins. The crowbar and sledge hammer were used also to unstick the pins.

On April 10, 2014, petitioner was injured while working for respondent. The injury occurred when petitioner was trying to unhook the trailer and had to loosen a stuck pin on the 5th wheel that was jammed. Petitioner bent over and was stretching out to the right side trying to dislodge the pin. He was not using any tools. Eventually the pin came loose, causing petitioner

to jerk bac. Petitioner felt pain in his right shoulder that was intense for about a day. He reported the injury to Wendy via cell phone and finished the day at about 5 o'clock. He estimated the injury occurred about midday.

Petitioner worked the following day and the day after. On April 12, 2014, while working, petitioner aggravated his right shoulder condition when doing the same thing; disconnecting the trailer.

Petitioner did not seek medical treatment immediately as he thought it was just a pulled muscle. Petitioner took Aleve and Tylenol. He continued working the summer of 2014. The pain was getting worse. Petitioner testified he got to the point where he couldn't raise his hand to eat.

Petitioner testified that on July 7, 2014, while driving he hit a rough road. He testified the steering wheel jerked and aggravated his shoulder. He notified Wendy of the occurrence.

Petitioner testified he never had shoulder symptoms before April 10, 2014.

Petitioner testified that after the July 7, 2014 incident he sought treatment from his family doctor, Dr. Kuhlman, with Adventist in Bolingbrook. Petitioner testified he reported the April 10, 2014 incident to Dr. Kuhlman and had complaints of pain, weakness, numbness and tingling in his right hand and arm. Dr. Kuhlman prescribed medication and therapy. Dr. Kuhlman kept petitioner off work. On August 21, 2014, Dr. Kuhlman ordered an MRI and then referred petitioner to orthopedic surgeon, Dr. Lee with Midwest Bone and Joint.

Petitioner testified he told Dr. Lee of his shoulder pain, neck stiffness and numbness and tingling into his shoulders. Petitioner testified he noticed numbness and tingling bilaterally in his shoulders before he saw Dr. Lee. Dr. Lee recommended surgery for a torn rotator cuff. Dr. Lee also ordered testing for his neck, which was not done. Petitioner worked two days in August, 2014 while in physical therapy, but has not worked since then.

Petitioner testified he underwent surgery by Dr. Joy with Integrity Orthopedics. Petitioner testified he changed to Dr. Joy as he was not comfortable with Dr. Lee. Petitioner first saw Dr. Joy on September 19, 2014. Petitioner provided Dr. Joy details of the accident and of his symptoms of numbness and tingling in his arms and right hand. Dr. Joy did the surgery on October 16, 2014. The shoulder symptoms got better, but the numbness and tingling into the fingers continued. Petitioner noticed the neck pain increased after the shoulder surgery. Because the numbness and tingling continued, petitioner was referred to Dr. Siemionow by Dr. Joy.

Petitioner first saw Dr. Siemionow on January 15, 2015. He advised Dr. Siemionow of the accident and of his symptoms. He was still in therapy for his arm when he saw Dr. Siemionow. Petitioner testified that while doing physical therapy, walking with 10-pound weights, he felt pain in his lower back and dropped the weights. He made the therapist aware of the problem. Petitioner continued physical therapy for a while until his neck and back got worse at which time therapy was stopped in order to address the neck and back issues.

Petitioner underwent testing for his neck and back which was ordered by Dr. Siemionow. Dr. Siemionow advised petitioner he had herniated discs in the neck and lower back. Petitioner understood Dr. Siemionow wanted to remove the herniated discs in the neck. Petitioner continued to see Dr. Joy. He obtained an injection in his lower back as ordered by Dr. Siemionow. He also had shots in his cervical spine.

Petitioner previously had cervical surgery in 1996, which was a fusion done by Dr. Andrew Zelby. Petitioner also had lumbar surgery in 1994 which was done by Dr. Jack Casini. After physical therapy, post neck and back surgery, petitioner was released to return to work without restrictions. Petitioner testified that after recovering from the neck and lower back surgeries he did not have problems with his neck or back until his April, 2014 accidents.

Petitioner testified he had been ordered off work by Dr. Siemionow for his neck and back. He continues to see Dr. Joy, whom he last saw for his shoulder on February 1, 2016. Dr. Joy also kept petitioner off work. The last time he saw Dr. Siemionow was in December, 2015; Dr. Siemionow continued to recommend cervical surgery and physical therapy for the lower back.

Petitioner admitted that on December 16, 2014 he saw Dr. Kuhlman and reported that two weeks before he felt sudden pain encircling his neck and radiating down the spine and into his buttocks, but these symptoms resolved without treatment. Petitioner denied knowing what triggered the pain and radiating pain in his neck and down his spine. Petitioner claimed it was not pain that he was having presently, but rather tingling.

Petitioner was examined by Dr. Gleason for an independent medical exam. Petitioner described the accident and his symptoms to Dr. Gleason. The exam took 30 minutes at the most. He returned to Dr. Gleason again on October 20, 2015 for another exam. The October 20, 2015 exam was rather short. Petitioner testified that on October 20, 2015, he provided details to Dr. Gleason of the back pain; the physical therapy incident; and the incident involving the pain on April 10, 2014.

Petitioner testified he could not recall the last time he was at the Pain and Spine Center, but it would have been for his lower back injection. He would return to the Pain and Spine Center if Dr. Siemionow would send him back.

On cross examination petitioner agreed he was primarily a driver, but needed to work with the 5th wheel to unpin it. Petitioner was required to get in and out of the cab by using both arms. Petitioner could not confirm or deny that his neck or back was injured on April 10, 2014. Petitioner did not have any complaints of pain in his neck or lower back after the April 12, 2014 accident.

On July 7, 2014, petitioner testified that the steering wheel jerked which caused re-injury to his right shoulder. Petitioner could not say whether he injured his neck at that time. Petitioner testified he did not hurt his lower back when the steering wheel jerked.

Petitioner testified that his low back surgery in 1994 and the cervical fusion in 1996 was the result of a fall that occurred at work. Petitioner returned to work in 1998 as a truck driver after recovering from both surgeries.

Petitioner opened his own business in 1998, which was a power washing business. Petitioner shut down the business in 2008. Thereafter, in 2009 or 2010, petitioner began working for respondent.

Petitioner claimed he had no problems with his lower back from April 10, 2014 until early March, 2015. At that time, while doing physical therapy and lifting 10-pound weights in each hand, that he started having problems with his lower back. Petitioner testified that he reported the incident to Dr. Siemionow.

Petitioner continued to work until the end of July or early August, 2014. Petitioner confirmed he first saw Dr. Joy on September 19, 2014 for his shoulder. Petitioner confirmed Dr. Joy examined petitioner's cervical area on that day. Dr. Joy then scheduled surgery for his right shoulder, which was done on October 15, 2014. Petitioner testified that between September 19, 2014 until his shoulder surgery, he discussed his cervical complaints. Petitioner first saw Dr. Siemionow on December 16, 2014. Dr. Siemionow ordered an MRI and an EMG for petitioner's cervical area.

Petitioner did not have an EMG for his lower back, but did have an MRI. Petitioner denied having any problems with a pulled muscle from between April 10, 2014 until March, 2015. Petitioner testified he went for physical therapy for his back after he was released for his surgery in 1994 the 1990s. Petitioner testified he was just walking along with the 10-pound weights in each hand below his waist when he began having back pain.

Petitioner denied missing any time from work due to cervical or low back pain from 2009 or 2010 until after April, 2014.

According to the records of Dr. Geoffrey Kuhlman of Bolingbrook Family Medicine, petitioner was first seen by Dr. Kuhlman, after his claimed work accidents, on July 22, 2014. According to the records, petitioner complained of moderate to severe shoulder pain of three-month duration. It occurred when petitioner was pulling a pin on a truck. (PX.3)

According to Dr. Kuhlman's July 22, 2014 records, petitioner had decreased mobility, popping, weakness, but no numbness or tingling in the arms. The ultrasound of that day showed a partial articular surface tearing of the supraspinatus and partial infraspinatus tearing. Petitioner had active pain free range of motion of the cervical spine. Diagnosis was incomplete rotator cuff tear. Physical therapy was ordered. (PX.3).

Petitioner returned to Dr. Kuhlman on August 6, 2014. Petitioner continued to complain of pain and weakness in his right shoulder. He reported his pain improved with the first week of physical therapy, but returned when he returned to work. Dr. Kuhlman ordered more physical therapy and placed petitioner on work restrictions. (PX.3)

Petitioner returned to Dr. Kuhlman on August 21, 2014 with constant and worsening pain in his right shoulder, which had been aggravated by stabilizing physical therapy the previous week. Petitioner's symptoms included popping, tingling and weakness in both arms. He reported to Dr. Kuhlman that he had problem eating with the right hand the night before and could not brush his teeth with that hand either. An MRI of the right shoulder was ordered and petitioner was referred to orthopedic surgeon, Dr. John Lee. Physical therapy was continued. (PX.3)

The August 29, 2014 MRI of the right shoulder showed a full-thickness tear of the subscapularis tendon and partial thickness tear of the supraspinatus tendon, as well dislocation of long head of the biceps tendon. (PX.3) (PX.12)

According to the records of Dr. John Lee, of Midwest Bone and Joint Specialists, petitioner first presented to his office on September 4, 2014, with right shoulder pain that was aching and sharp. Petitioner related that the injury occurred on April 10, 2014 when he was disconnecting a tractor trailer at work, injury his shoulder. He denied numbness popping, spasms, swelling, or tingling in his arms and legs. Dr. Lee reported active and pain free cervical range of motion. Dr. Lee diagnosed rotator cuff tear. Surgery was recommended. (PX.4)

Petitioner again saw Dr. Lee on September 15, 2014. Petitioner reported neck stiffness since his last visit. Petitioner reported the night before he had numbness and tingling sensation in both shoulders. Dr. Lee recommended C spine series due to reported numbness and tingling. Surgery was awaiting insurance approval. (PX.4)

According to the records of Dr. Edward Joy, of Integrity Orthopedics, petitioner was first seen there on September 19, 2014 with right shoulder pain due to the work injury. Petitioner's cervical spine evaluation was normal. Spurling's maneuver was negative. (PX.2)

On October 4, 2014, petitioner was scheduled for shoulder surgery on October 16, 2014 by Dr. Joy (RX.8, p.4).

On October 7, 2014 petitioner had a pre-op visit with Dr. Joy (RX.8, pp.5-6).

Petitioner returned to Dr. Kuhlman on October 8, 2014 for medical clearance for surgery by Dr. Joy of Integrity. According to Dr. Kuhlman's records of that date, petitioner reported neck pain and stiffness and crepitus since Dr. Lee performed a Spurling's maneuver the month before. Because of this, petitioner left Dr. Lee for treatment by Dr. Joy. (PX.3)

Petitioner underwent right shoulder surgery by Dr. Edward Joy on October 15, 2014 which was reported as arthroscopic limited acromioplasty and open subpectoral biceps tenodesis for a right shoulder long head of the biceps tendon medial dislocation with full-thickness upper border subscapularis and superior rotator cuff tear (PX.12).

Petitioner returned to Dr. Joy on October 20, 2014, post October 16, 2014 (sic) right shoulder cuff repair. Petitioner reported he had intermittent numbness and tingling in his fingers.

His cervical spine examination was normal. He followed up with Dr. Joy on October 27, 2014. (PX.2)

Petitioner was seen by Dr. Joy on November 10, 2014. Petitioner's complaints included continued pain in his shoulder and a small rash on his stomach. (RX.8, pp.11-13)

According to the ATI records, petitioner was initially evaluated at ATI physical therapy on November 17, 2014. Petitioner's primary complaint at the initial evaluation was: "My shoulder is not bad, it's my forearm and hand discomfort, occasional neck, soreness, seems to getting worse." "After that other doctor pushed on my neck it's been different." (PX.6)

Petitioner received physical therapy at ATI from November 17, 2014 through March 27, 2015. There is no mention of any specific incident involving petitioner's lower back contained in the ATI physical therapy records. (PX.6)

The only mention of any lower back problems that occurred during physical therapy was at the time of discharge on March 27, 2015. At that time, the physical therapist wrote: "Pt. reports intermittent cervical complaints & although did not report a low back injury during therapy he states he experienced significant LBP after a recent session of therapy. Therefore, due to multiple recent spinal complaints and limited ability to progress PT, we will hold therapy at this time." (PX.6)

According to Dr. Joy's records of November 24, 2014, petitioner returned for follow up to his right shoulder surgery and had complaints of pain with numbness and tingling in his neck and forearm on the right side. Petitioner's cervical spine examination by Dr. Joy was reported as normal. Petitioner's visit of December 1, 2014 with Dr. Joy was the same as the previous visit. (PX. 12)

According to the records of Dr. Joy of December 8, 2014, the petitioner's examination remained the same, however, Dr. Joy added cervical radiculopathy (brachial neuritis or radiculitis [not otherwise specified]. Dr. Joy ordered a cervical MRI. (PX.12)

Respondent introduced the medical records of Dr. Kuhlman from December 16, 2014. According to the records, petitioner was seen by Dr. Kuhlman for elbow pain with a duration of two months. The pain reportedly radiated to the radial wrist and thenar area. Petitioner reported the pain was present since waking from rotator cuff surgery. The right wrist was flexed for two weeks after surgery as shoulder was in a sling. The diagnosis was injury to radial nerve at the forearm arising from positioning of his arm during shoulder surgery. (RX.9)

Dr. Kuhlman's records of December 16, 2014 also include a history related by petitioner was that he felt sudden pain encircling his neck and radiating down the spine into his buttocks which occurred two weeks before the visit. The symptoms resolved without treatment. Dr. Kuhlman believed the neck complaints were unrelated to his right forearm complaints and his neck and torso symptoms were non-specific. (RX.9)

Petitioner saw Dr. Joy on January 5, 2015 with the same complaints he had previously on December 8, 2014. (PX.12)

On January 13, 2015, petitioner first saw Dr. Siemionow, with Illinois Spine & Scoliosis Center as a referral from Dr. Joy. Dr. Siemionow recommended a cervical CT scan and an MRI of the cervical spine. (PX. 8)

The cervical spine MRI report of January 27, 2015, indicated petitioner had a posterior disc osteophyte complex at the C5-C6 level (PX.8).

Petitioner returned to Dr. Joy on February 9, 2015. Dr. Joy reported the chief complaint was follow up for right shoulder surgery and Dr. Siemionow for cervical radiculopathy evaluation. (PX.12)

The EMG of February 16, 2015 showed a chronic right C6 radiculopathy (PX.8).

The records of Dr. Udit Patel of Pain and Spine Institute reflect petitioner was first evaluated there on February 16, 2015 as a referral from Dr. Siemionow due to neck pain. Petitioner relates that he was doing well after surgery in 1996 until he awoke from shoulder surgery. Dr. Patel recommended a right C5-C6 TFESI. The injection was carried out by Dr. Patel on February 25, 2015. (PX.11).

On March 4, 2015, Dr. Siemionow reported the MRI showed a C5-C6 herniated disc and C4-C5 spinal stenosis. Surgery was discussed. (PX.8).

On March 9, 2015, Dr. Patel's records reflect petitioner noted some pain relief in the right arm from the injection (PX.11).

The records of Dr. Joy from March 9, 2015 incidate petitioner advised Dr. Joy he had seen Dr. Siemionow and spine surgery was scheduled. (PX.12)

On March 30, 2015 petitioner reported to Dr. Siemionow that he started having new low back pain after starting physical therapy for right shoulder rotator cuff. Petitioner reported it happened after he was carrying two 10-pound weights. Dr. Siemionow recommended an MRI of lower back. (PX.8)

Petitioner returned to Dr. Siemionow on April 8, 2015 treatment for cervical and lumbar spine. The diagnosis was C4-5 spinal stenosis, C5-C6 disc herniation, cervical radiculopathy and low back pain. (PX.8)

On April 20, 2015, petitioner followed up with Dr. Joy and reported he had not been to physical therapy for a few weeks awaiting insurance approval. He also reported he is taking pain medication daily for his back and neck pain. He felt his shoulder was improving but still weak. (PX.12)

Petitioner returned to Dr. Siemionow on April 29, 2015. Dr. Siemionow again recommended a lumbar MRI and prescribed Fentanyl patches. (PX.8).

On May 18, 2015, petitioner reported to Dr. Joy that physical therapy was not yet authorized and Dr. Siemionow was recommending C4-6 fusion. (PX.12)

On May 27, 2015, petitioner was seen by Dr. Siemionow's PA. Petitioner's condition remained the same. (PX.8)

Petitioner returned to Dr. Joy on June 15, 2015 as follow up of his right shoulder surgery. Petitioner's condition remained the same. (PX.12)

June 17, 2015 petitioner returned to Dr. Siemionow. Dr. Siemionow's records indicated petitioner feels he really exacerbated the neck pain and right upper extremity numbness, tingling and pain when he went for physical therapy and rehabilitation for his shoulder. Petitioner also reiterated that the low back pain started after carrying 10-pound weights while in physical therapy. Dr. Siemionow epidural steroid injection at the L4-L5 level. The MRI obtained on June 9, 2015 reportedly demonstrated a large left paracentral disc herniation at the L4-L5 level. (PX.8)

Petitioner followed up with Dr. Joy on July 20, 2015; August 17, 2015; September 14, 2015; October 12, 2015; November 9, 2015; December 7, 2015; January 4, 2016; February 1, 2016. His condition remained the same; he was kept off work by Dr. Joy. (PX.12)

On July 22, 2015 Dr. Siemionow reported petitioner now has complaints in the left lateral arm and left anterolateral forearm and continued to recommend the cervical fusion. On August 19, 2015 Dr. Siemionow noted petitioner's neck pain was resolving, but it waxed and waned. Dr. Siemionow continued to recommend a cervical fusion and an injection of the L4-L5 disc (PX.8)

The records from Dr. Patel reflect petitioner returned on August 25, 2015 for lower back pain. Petitioner related the low back pain to carrying 10-pound weights in physical therapy. Dr. Patel recommended an epidural injection to the left L4 [nerve]. The injection was carried out by Dr. Patel on September 2, 2015. (PX.11).

On September 16, 2015, Dr. Siemionow reported petitioner received some relief in the lower back. Dr. Siemionow continued to recommend a cervical fusion, and also injection at L4-L5. (PX.8)

Dr. Krzysztof Siemionow testified in behalf of the petitioner via deposition on September 16, 2015 (PX. 7). Dr. Siemionow is a board certified orthopedic surgeon (PX.7, pp.4-5).

Dr. Siemionow first examined petitioner at the referral of Dr. Joy on January 13, 2015 (PX.7, p.6). Petitioner related to Dr. Siemionow that shortly after having his right shoulder rotator cuff repair on October 16, 2015 (sic) he developed radicular symptoms and neck pain (PX.7, p.7). Dr. Siemionow examination was negative for objection findings, with the exception

that the right deltoid which was a touch weak and there was a decreased right bicep reflex (PX.7, p.7).

Dr. Siemionow testified that after reviewing the EMG, CT scan and MRI diagnosed the condition as prior surgery at C6-C7 with a herniated disc at C5-C6 (PX.7, p.11). Dr. Siemionow does not recall if he provided an off-work slip at the time of his first visit, but believed petitioner was off work due to his shoulder surgery at that time; for sure Dr. Siemionow gave a note of disability at the time of his second visit (PX.7, pp.10-11). Dr. Siemionow surmised petitioner's cervical problem could be related to the original shoulder injury as it may have been masked by the shoulder injury. Alternative, Dr. Siemionow thought the neck problems wat the result of position during the right shoulder surgery (PX.7, pp.11-13).

Dr. Siemionow testified that on March 4, 2015 noted petitioner had spinal stenosis at C4-C5. He recommended a cervical fusion from C4-C6 (PX.7, p.14). Dr. Siemionow testified that on March 3, 2015 (sic) petitioner returned with a new complaint of low back pain which petitioner related the onset to carrying 10-pound weights in physical therapy (PX.7, p.14). On June 17, 2015, the lumbar MRI confirmed the presence of the left paracentral disc herniation at L4-5 with compression of the L5 nerve root (PX.7, p.18).

Dr. Siemionow authored a letter dated June 23, 2015 in which he rendered an opinion as to the cause of the low back pain and neck pain (PX.7, p.19). Dr. Siemionow opined that petitioner's low back pain was the result of walking with 10-pound weights that caused the low back herniated disc (PX.7, p.19). Dr. Siemionow admitted he did not have the physical records from ATI, only the description of the incident as related by the petitioner, when rendering his opinion in the letter (PX.7, pp. 19-20). Dr. Siemionow reiterated that he felt the neck injury originated at the time the shoulder was injured and masked by the shoulder problem, or was the result of the position of the neck during the shoulder surgery (PX.7, 20).

On July 17, 2015, Dr. Siemionow reviewed petitioner's MRIs and again recommended cervical fusion from C4-C6, as well as injection to the lumbar spine (PX.7, p.23). Dr. Siemionow testified petitioner had the epidural injection on the morning of the deposition (PX.7, pp.24-25).

On cross examination Dr. Siemionow testified that it was impossible to tell at the time of his deposition as to whether the neck was originally injured at the time the shoulder was injured or if it occurred at the time of the shoulder surgery (PX.7, p.30). Dr. Siemionow agreed that the CT scan of the petitioner's cervical spine of January 29, 2015 showed no evidence of an acute injury, only degenerative process (PX.7, pp.36-37). Dr. Siemionow also agreed the MRI of January 27, 2015 also showed only degenerative issues (PX.7, p.37). Dr. Siemionow testified that the EMG showed a mild chronic right C6 radiculopathy; chronic meaning more than six months (PX.7, pp.38-39).

Dr. Siemionow agreed, that if the physical therapy notes do not support the history petitioner gave of carrying 10-pound weights, his opinion may be put into question (PX.7, p.45). Dr. Siemionow admitted he had not reviewed the operative report and only made the assumption that the positon of the petitioner could have caused the neck problem (PX.7, p.46-47).

Respondent introduced the reports of Dr. Thomas F. Gleason of Illinois Bone and Joint who examined petitioner on March 31, 2015 and October 20, 2015 pursuant to §12 of the Act. (RX. 5 & RX.6).

According to Dr. Gleason's report of March 31, 2015, petitioner related a work accident of April 10, 2014 wherein he injured his right shoulder. Petitioner stated that he awoke from his surgery on October 16, 2014 with excruciating right forearm pain that radiated into his hand and he subsequently developed neck pain. After performing an examination and reviewing the medical records, diagnostic and film studies, Dr. Gleason concluded the right shoulder rotator cuff injury and repair was related to the work accident of April 10, 2014. With regard to the right shoulder injury, Dr. Gleason believe petitioner was restricted to heavy lifting and excessive overhead use. Dr. Gleason did not believe the need for the cervical discectomy and fusion was related to the work accident of April 10, 2014. (RX.5)

Petitioner returned to Dr. Gleason for another evaluation on October 20, 2015. Petitioner related to Dr. Gleason that since his last evaluation, at the end of February or the beginning of March, 2015, he began having increased neck and back pain while in physical therapy. Dr. Gleason did not believe the cervical or lumbar condition was related to the work injury. Dr. Gleason further opined that petitioner could return to work from his work-related injury and only restricted due to the unrelated cervical and lumbar conditions. (RX.6)

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

The evidence supports a finding that petitioner's right shoulder torn rotator cuff that necessitated arthroscopic surgery on October 15, 2014 was caused by the work accident of April 10, 2014 and aggravated by the April 12, 2014 accident.

The Arbitrator finds the evidence does not support a finding of causal connection of petitioner's cervical or lumbar condition to the work accidents. The Arbitrator looked at the inconsistence histories by the petitioner as to the origination of both condition in making this determination. Although petitioner's doctor, Dr. Siemionow, testified there was a causal connection between the neck and the low back condition, and the work accidents in April, 2014, Dr. Siemionow relied on the information provided by the petitioner when rendering this opinion. The stories provided by petitioner to Dr. Siemionow as to when the problems began, do not jive with the histories contained in petitioner's medical records.

Specifically, before his shoulder surgery, petitioner indicated he was having problems with his neck that originated at the time of his examination by Dr. Lee on September 4, 2014, which was the reason he changed his shoulder treatment to Dr. Joy. (See PX. 3, Dr. Kuhlman's entry of October 8, 2014.)

Furthermore, the records of ATI physical therapy from November 17, 2014 recorded a history of "My shoulder is not bad, it's my forearm and had discomfort, occasional neck soreness, seems to be getting worse." "After that other doctor pushed on my neck it's been different." (PX.6) This statement by petitioner to ATI buttress the fact petitioner's neck problems likely originated at the time of his first exam with Dr. Lee in September, 2014.

An additional history which causes suspicion as to the origin of petitioner's neck problems is contained in Dr. Kuhlman's record the December 16, 2014 visit. At that visit, the petitioner related he had elbow pain with a duration of two months that radiated to the radial wrist and thenar area which had been present since he awoke from the rotator cuff surgery. Dr. Kuhlman diagnosis was injury to radial nerve at the forearm arising from the positioning of his arm during the shoulder surgery. (RX.9)

Also, at the December 16, 2014 visit with Dr. Kuhlman, petitioner provided a history of sudden pain encircling his neck and radiating down his spine into his buttocks that occurred two weeks before the visit. Dr. Kuhlman believed the neck complaints were unrelated to his right forearm complaints and his neck and torso symptoms were non-specific. (RX.9)

Petitioner testified he did not know what triggered the pain for which he sought treatment from Dr. Kuhlman on December 16, 2014. It was not until after this unidentified sudden pain that Dr. Joy added cervical radiculopathy as a diagnosis. (See PX.12, Dr. Joy's record of December 8, 2014 visit.)

The EMG of February 16, 2015 showed a chronic right C6 radiculopathy; chronic being six months or more according to Dr. Siemionow's testimony (PX.8, PX.7, pp.37-38). Furthermore, Dr. Siemionow agreed that the cervical CT scan and MRI showed no acute injury, only degenerative issues (PX.7, pp.36-37). Petitioner had previously had a cervical fusion at the C6-C7 level in 1996.

The treating records do not record any cervical radicular symptoms until after the exam by Dr. Lee in September, 2014, but before the October 15, 2014 surgery.

For the aforementioned reasons, the Arbitrator agrees with the conclusions of Dr. Thomas Gleason that petitioner' cervical condition was not related to work accidents of April 10, 2014 or April 12, 2014.

As for petitioner's lumbar spine condition, the Arbitrator finds the evidence does not support petitioner's claim that the lumbar spine condition was caused by the work accident; specifically resulting from physical therapy for his right shoulder injury as claimed.

The petitioner testified to a specific incident in physical therapy which was that he was carrying 10 pound weights in each hand at the end of February or the beginning of March, 2015. Even if the medical records backed up petitioner's testimony, this act in and of itself does not appear to be so onerous as to cause what has been described as a large left paracentral disc herniation at the L4-L5 level. However, the physical therapy records only mention in passing when petitioner was discharged from physical therapy on March 27, 2015 that although he did not report a low back injury during therapy he stated he experienced significant [low back pain] after a recent session of therapy.

Petitioner was seen by Dr. Siemionow on March 4, 2015, Dr. Patel on March 9, 2015 and Dr. Joy on March 9, 2015. There is no mention of any lower back problems whatsoever, even though petitioner testified the incident occurred in early March, 2015. The first history of the 10-pound weight carrying incident during physical therapy provided to any physician was to Dr. Siemionow on March 30, 2015.

Dr. Siemionow agreed that his opinion as to causal connection of the low back injury would be called into question if the physical therapy records do not contain the history by petitioner that it occurred when carrying the 10-pound weights in therapy. (PX.7, p. 45)

Petitioner also reported to Dr. Gleason at the time of his October 20, 2015, that in late February or the beginning of March, 2015 he developed neck and low back pain (PX.5).

However, the Arbitrator notes petitioner was examined for the first time by Dr. Thomas Gleason on March 31, 2015. Petitioner's complaints and Dr. Gleason's' findings were limited to neck and right shoulder. There was no mention by petitioner of the low back problem even though the exam occurred within the month after the purported physical therapy incident. (RX.5)

For the foregoing reasons, the Arbitrator finds petitioner failed to prove that the lumbar condition, described by Dr. Siemionow as a large herniated disc at the L4-L5 level, was caused directly or indirectly by the work accidents of April 10, 2014 or April 12, 2014.

The Arbitrator further finds petitioner had reached maximum medical improvement for his work-related injury to his right shoulder as of Dr. Thomas Gleason's examination on October 20, 2015. The Arbitrator also finds petitioner was capable of returning to work as of October 20, 2015 due to his right shoulder injury and that any further disability was due to the petitioner's unrelated neck and lower back problems.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator, having determined petitioner's neck and low back problems are not related to the April 10, 2014 or the April 12, 2014 accident, denies any medical bills incurred for treatment of petitioner's neck or lower back. Furthermore, the Arbitrator, having determined petitioner had reached maximum medical improvement of his right shoulder injury as of October 20, 2015, denies any treatment related to the right shoulder after October 20, 2015.

K. In support of the Arbitrator's decision with regard to prospective medical care, the Arbitrator finds the following:

For the reasons already stated, the Arbitrator denies any prospective treatment to petitioner.

L. In support of the Arbitrator's decision with regard to temporary benefits, the Arbitrator finds the following:

Award for temporary total disability was made in case number 14 WC 34415.

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

Jim Armstrong,

Petitioner,

vs.

NO: 14WC 34035

17IWCC0364

NMMC Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses and causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 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.

17IWCC0364

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: JUN 16 2017
MJB/bm
o-4/25/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

ARMSTRONG, JIM
Employee/Petitioner

Case# **14WC034035**

NMMC INC
Employer/Respondent

17IWCC0364

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1357 RATHBUN CSERVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

1337 KNELL LAW LLC
CHARLES KNELL
504 FAYETTE ST
PEORIA, IL 61603

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 # 14 WC 34035

Jim Armstrong
Employee/Petitioner

v.

NMMC, Inc.
Employer/Respondent

17IWCC0364

An *Application for Adjustment 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 **February 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. X Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. X Is Petitioner entitled to any prospective medical care?
L. X What temporary benefits are in dispute?
☐ TPD ☐ Maintenance X TTD
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

17IWCC0364

FINDINGS

On the date of accident **July 7, 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 **$38,993.24**; the average weekly wage was **$749.87**.

On the date of accident, Petitioner was **46** years of age, **married** with **0** dependent children.

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

Respondent shall be given a credit of **$38,759.04** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$38,759.04**.

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

ORDER

Denial of Benefits

Petitioner failed to prove that he sustained accidental injuries, to any part of his body, including but not limited his right shoulder, his neck or his lower back to as the result of the July 7, 2014 claimed work accident.

Credits

Respondent is given credit for payments made in case 14 WC 34415.

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) p.2

05/25/2016
Date

MAY 26 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jim Armstrong	)	
Petitioner,	)	
vs.	)	**No. 14 WC 34025**
NMMC	)	**17IWCC0364**
Respondent.	)	
	)	

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on February 8, 2016 in New Lenox under §19b/§8a of the Act. The parties agree that on July 7, 2014 Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They further agree that in the year preceding the injuries, the Petitioner earned $38,993.24, and that his average weekly wage was $749.87.

At issue in this hearing is as follows:

1. Whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent?
2. Was timely notice of the accident given to Respondent?
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether the medical services provided were reasonable, necessary and causally related to the work accident.
5. Whether petitioner is entitled to any prospective medical care.
6. The amount of temporary benefits due petitioner.

FINDING OF FACTS

Petitioner testified he last worked for respondent in August, 2014. Respondent is a trucking company that hauls rail containers. Petitioner had been working for respondent since 2010; driving an eighteen-wheeler/semi-truck. Petitioner reported to respondent's yard for his assignments from Dan, the owner, or Wendy, the office manager. He would pick up and unload containers in the Chicagoland area.

Petitioner's job involved no touch freight. The physical part of petitioner's job required him to ensure the four locking pins that hold down the container were locked in place. To do this, the petitioner had to use a crow bar and sledge hammer to lock the pins. The crowbar and sledge hammer were used also to unstick the pins.

On April 10, 2014, petitioner was injured while working for respondent. The injury occurred when petitioner was trying to unhook the trailer and had to loosen a stuck pin on the 5th wheel that was jammed. Petitioner bent over and was stretching out to the right side trying to

dislodge the pin. He was not using any tools. Eventually the pin came loose, causing petitioner to jerk bac. Petitioner felt pain in his right shoulder that was intense for about a day. He reported the injury to Wendy via cell phone and finished the day at about 5 o'clock. He estimated the injury occurred about midday.

Petitioner worked the following day and the day after. On April 12, 2014, while working, petitioner aggravated his right shoulder condition when doing the same thing; disconnecting the trailer.

Petitioner did not seek medical treatment immediately as he thought it was just a pulled muscle. Petitioner took Aleve and Tylenol. He continued working the summer of 2014. The pain was getting worse. Petitioner testified he got to the point where he couldn't raise his hand to eat.

Petitioner testified that on July 7, 2014, while driving he hit a rough road. He testified the steering wheel jerked and aggravated his shoulder. He notified Wendy of the occurrence.

Petitioner testified he never had shoulder symptoms before April 10, 2014.

Petitioner testified that after the July 7, 2014 incident he sought treatment from his family doctor, Dr. Kuhlman, with Adventist in Bolingbrook. Petitioner testified he reported the April 10, 2014 incident to Dr. Kuhlman and had complaints of pain, weakness, numbness and tingling in his right hand and arm. Dr. Kuhlman prescribed medication and therapy. Dr. Kuhlman kept petitioner off work. On August 21, 2014, Dr. Kuhlman ordered an MRI and then referred petitioner to orthopedic surgeon, Dr. Lee with Midwest Bone and Joint.

Petitioner testified he told Dr. Lee of his shoulder pain, neck stiffness and numbness and tingling into his shoulders. Petitioner testified he noticed numbness and tingling bilaterally in his shoulders before he saw Dr. Lee. Dr. Lee recommended surgery for a torn rotator cuff. Dr. Lee also ordered testing for his neck, which was not done. Petitioner worked two days in August, 2014 while in physical therapy, but has not worked since then.

Petitioner testified he underwent surgery by Dr. Joy with Integrity Orthopedics. Petitioner testified he changed to Dr. Joy as he was not comfortable with Dr. Lee. Petitioner first saw Dr. Joy on September 19, 2014. Petitioner provided Dr. Joy details of the accident and of his symptoms of numbness and tingling in his arms and right hand. Dr. Joy did the surgery on October 16, 2014. The shoulder symptoms got better, but the numbness and tingling into the fingers continued. Petitioner noticed the neck pain increased after the shoulder surgery. Because the numbness and tingling continued, petitioner was referred to Dr. Siemionow by Dr. Joy.

Petitioner first saw Dr. Siemionow on January 15, 2015. He advised Dr. Siemionow of the accident and of his symptoms. He was still in therapy for his arm when he saw Dr. Siemionow. Petitioner testified that while doing physical therapy, walking with 10-pound weights, he felt pain in his lower back and dropped the weights. He made the therapist aware of the problem. Petitioner continued physical therapy for a while until his neck and back got worse at which time therapy was stopped in order to address the neck and back issues.

Petitioner underwent testing for his neck and back which was ordered by Dr. Siemionow. Dr. Siemionow advised petitioner he had herniated discs in the neck and lower back. Petitioner understood Dr. Siemionow wanted to remove the herniated discs in the neck. Petitioner continued to see Dr. Joy. He obtained an injection in his lower back as ordered by Dr. Siemionow. He also had shots in his cervical spine.

Petitioner previously had cervical surgery in 1996, which was a fusion done by Dr. Andrew Zelby. Petitioner also had lumbar surgery in 1994 which was done by Dr. Jack Casini. After physical therapy, post neck and back surgery, petitioner was released to return to work without restrictions. Petitioner testified that after recovering from the neck and lower back surgeries he did not have problems with his neck or back until his April, 2014 accidents.

Petitioner testified he had been ordered off work by Dr. Siemionow for his neck and back. He continues to see Dr. Joy, whom he last saw for his shoulder on February 1, 2016. Dr. Joy also kept petitioner off work. The last time he saw Dr. Siemionow was in December, 2015; Dr. Siemionow continued to recommend cervical surgery and physical therapy for the lower back.

Petitioner admitted that on December 16, 2014 he saw Dr. Kuhlman and reported that two weeks before he felt sudden pain encircling his neck and radiating down the spine and into his buttocks, but these symptoms resolved without treatment. Petitioner denied knowing what triggered the pain and radiating pain in his neck and down his spine. Petitioner claimed it was not pain that he was having presently, but rather tingling.

Petitioner was examined by Dr. Gleason for an independent medical exam. Petitioner described the accident and his symptoms to Dr. Gleason. The exam took 30 minutes at the most. He returned to Dr. Gleason again on October 20, 2015 for another exam. The October 20, 2015 exam was rather short. Petitioner testified that on October 20, 2015, he provided details to Dr. Gleason of the back pain; the physical therapy incident; and the incident involving the pain on April 10, 2014.

Petitioner testified he could not recall the last time he was at the Pain and Spine Center, but it would have been for his lower back injection. He would return to the Pain and Spine Center if Dr. Siemionow would send him back.

On cross examination petitioner agreed he was primarily a driver, but needed to work with the 5th wheel to unpin it. Petitioner was required to get in and out of the cab by using both arms. Petitioner could not confirm or deny that his neck or back was injured on April 10, 2014. Petitioner did not have any complaints of pain in his neck or lower back after the April 12, 2014 accident.

On July 7, 2014, petitioner testified that the steering wheel jerked which caused re-injury to his right shoulder. Petitioner could not say whether he injured his neck at that time. Petitioner testified he did not hurt his lower back when the steering wheel jerked.

Petitioner testified that his low back surgery in 1994 and the cervical fusion in 1996 was the result of a fall that occurred at work. Petitioner returned to work in 1998 as a truck driver after recovering from both surgeries.

Petitioner opened his own business in 1998, which was a power washing business. Petitioner shut down the business in 2008. Thereafter, in 2009 or 2010, petitioner began working for respondent.

Petitioner claimed he had no problems with his lower back from April 10, 2014 until early March, 2015. At that time, while doing physical therapy and lifting 10-pound weights in each hand, that he started having problems with his lower back. Petitioner testified that he reported the incident to Dr. Siemionow.

Petitioner continued to work until the end of July or early August, 2014. Petitioner confirmed he first saw Dr. Joy on September 19, 2014 for his shoulder. Petitioner confirmed Dr. Joy examined petitioner's cervical area on that day. Dr. Joy then scheduled surgery for his right shoulder, which was done on October 15, 2014. Petitioner testified that between September 19, 2014 until his shoulder surgery, he discussed his cervical complaints. Petitioner first saw Dr. Siemionow on December 16, 2014. Dr. Siemionow ordered an MRI and an EMG for petitioner's cervical area.

Petitioner did not have an EMG for his lower back, but did have an MRI. Petitioner denied having any problems with a pulled muscle from between April 10, 2014 until March, 2015. Petitioner testified he went for physical therapy for his back after he was released for his surgery in 1994 the 1990s. Petitioner testified he was just walking along with the 10-pound weights in each hand below his waist when he began having back pain.

Petitioner denied missing any time from work due to cervical or low back pain from 2009 or 2010 until after April, 2014.

According to the records of Dr. Geoffrey Kuhlman of Bolingbrook Family Medicine, petitioner was first seen by Dr. Kuhlman, after his claimed work accidents, on July 22, 2014. According to the records, petitioner complained of moderate to severe shoulder pain of three-month duration. It occurred when petitioner was pulling a pin on a truck. (PX.3)

According to Dr. Kuhlman's July 22, 2014 records, petitioner had decreased mobility, popping, weakness, but no numbness or tingling in the arms. The ultrasound of that day showed a partial articular surface tearing of the supraspinatus and partial infraspinatus tearing. Petitioner had active pain free range of motion of the cervical spine. Diagnosis was incomplete rotator cuff tear. Physical therapy was ordered. (PX.3).

Petitioner returned to Dr. Kuhlman on August 6, 2014. Petitioner continued to complain of pain and weakness in his right shoulder. He reported his pain improved with the first week of physical therapy, but returned when he returned to work. Dr. Kuhlman ordered more physical therapy and placed petitioner on work restrictions. (PX.3)

Petitioner returned to Dr. Kuhlman on August 21, 2014 with constant and worsening pain in his right shoulder, which had been aggravated by stabilizing physical therapy the previous week. Petitioner's symptoms included popping, tingling and weakness in both arms. He reported to Dr. Kuhlman that he had problem eating with the right hand the night before and could not brush his teeth with that hand either. An MRI of the right shoulder was ordered and petitioner was referred to orthopedic surgeon, Dr. John Lee. Physical therapy was continued. (PX.3)

The August 29, 2014 MRI of the right shoulder showed a full-thickness tear of the subscapularis tendon and partial thickness tear of the supraspinatus tendon, as well dislocation of long head of the biceps tendon. (PX.3) (PX.12)

According to the records of Dr. John Lee, of Midwest Bone and Joint Specialists, petitioner first presented to his office on September 4, 2014, with right shoulder pain that was aching and sharp. Petitioner related that the injury occurred on April 10, 2014 when he was disconnecting a tractor trailer at work, injury his shoulder. He denied numbness popping, spasms, swelling, or tingling in his arms and legs. Dr. Lee reported active and pain free cervical range of motion. Dr. Lee diagnosed rotator cuff tear. Surgery was recommended. (PX.4)

Petitioner again saw Dr. Lee on September 15, 2014. Petitioner reported neck stiffness since his last visit. Petitioner reported the night before he had numbness and tingling sensation in both shoulders. Dr. Lee recommended C spine series due to reported numbness and tingling. Surgery was awaiting insurance approval. (PX.4)

According to the records of Dr. Edward Joy, of Integrity Orthopedics, petitioner was first seen there on September 19, 2014 with right shoulder pain due to the work injury. Petitioner's cervical spine evaluation was normal. Spurling's maneuver was negative. (PX.2)

On October 4, 2014, petitioner was scheduled for shoulder surgery on October 16, 2014 by Dr. Joy (RX.8, p.4).

On October 7, 2014 petitioner had a pre-op visit with Dr. Joy (RX.8, pp.5-6).

Petitioner returned to Dr. Kuhlman on October 8, 2014 for medical clearance for surgery by Dr. Joy of Integrity. According to Dr. Kuhlman's records of that date, petitioner reported neck pain and stiffness and crepitus since Dr. Lee performed a Spurling's maneuver the month before. Because of this, petitioner left Dr. Lee for treatment by Dr. Joy. (PX.3)

Petitioner underwent right shoulder surgery by Dr. Edward Joy on October 15, 2014 which was reported as arthroscopic limited acromioplasty and open subpectoral biceps tenodesis for a right shoulder long head of the biceps tendon medial dislocation with full-thickness upper border subscapularis and superior rotator cuff tear (PX.12).

Petitioner returned to Dr. Joy on October 20, 2014, post October 16, 2014 (sic) right shoulder cuff repair. Petitioner reported he had intermittent numbness and tingling in his fingers.

His cervical spine examination was normal. He followed up with Dr. Joy on October 27, 2014. (PX.2)

Petitioner was seen by Dr. Joy on November 10, 2014. Petitioner's complaints included continued pain in his shoulder and a small rash on his stomach. (RX.8, pp.11-13)

According to the ATI records, petitioner was initially evaluated at ATI physical therapy on November 17, 2014. Petitioner's primary complaint at the initial evaluation was: "My shoulder is not bad, it's my forearm and hand discomfort, occasional neck, soreness, seems to getting worse." "After that other doctor pushed on my neck it's been different." (PX.6)

Petitioner received physical therapy at ATI from November 17, 2014 through March 27, 2015. There is no mention of any specific incident involving petitioner's lower back contained in the ATI physical therapy records. (PX.6)

The only mention of any lower back problems that occurred during physical therapy was at the time of discharge on March 27, 2015. At that time, the physical therapist wrote: "Pt. reports intermittent cervical complaints & although did not report a low back injury during therapy he states he experienced significant LBP after a recent session of therapy. Therefore, due to multiple recent spinal complaints and limited ability to progress PT, we will hold therapy at this time." (PX.6)

According to Dr. Joy's records of November 24, 2014, petitioner returned for follow up to his right shoulder surgery and had complaints of pain with numbness and tingling in his neck and forearm on the right side. Petitioner's cervical spine examination by Dr. Joy was reported as normal. Petitioner's visit of December 1, 2014 with Dr. Joy was the same as the previous visit. (PX. 12)

According to the records of Dr. Joy of December 8, 2014, the petitioner's examination remained the same, however, Dr. Joy added cervical radiculopathy (brachial neuritis or radiculitis [not otherwise specified]. Dr. Joy ordered a cervical MRI. (PX.12)

Respondent introduced the medical records of Dr. Kuhlman from December 16, 2014. According to the records, petitioner was seen by Dr. Kuhlman for elbow pain with a duration of two months. The pain reportedly radiated to the radial wrist and thenar area. Petitioner reported the pain was present since waking from rotator cuff surgery. The right wrist was flexed for two weeks after surgery as shoulder was in a sling. The diagnosis was injury to radial nerve at the forearm arising from positioning of his arm during shoulder surgery. (RX.9)

Dr. Kuhlman's records of December 16, 2014 also include a history related by petitioner was that he felt sudden pain encircling his neck and radiating down the spine into his buttocks which occurred two weeks before the visit. The symptoms resolved without treatment. Dr. Kuhlman believed the neck complaints were unrelated to his right forearm complaints and his neck and torso symptoms were non-specific. (RX.9)

Petitioner saw Dr. Joy on January 5, 2015 with the same complaints he had previously on December 8, 2014. (PX.12)

On January 13, 2015, petitioner first saw Dr. Siemionow, with Illinois Spine & Scoliosis Center as a referral from Dr. Joy. Dr. Siemionow recommended a cervical CT scan and an MRI of the cervical spine. (PX. 8)

The cervical spine MRI report of January 27, 2015, indicated petitioner had a posterior disc osteophyte complex at the C5-C6 level (PX.8).

Petitioner returned to Dr. Joy on February 9, 2015. Dr. Joy reported the chief complaint was follow up for right shoulder surgery and Dr. Siemionow for cervical radiculopathy evaluation. (PX.12)

The EMG of February 16, 2015 showed a chronic right C6 radiculopathy (PX.8).

The records of Dr. Udit Patel of Pain and Spine Institute reflect petitioner was first evaluated there on February 16, 2015 as a referral from Dr. Siemionow due to neck pain. Petitioner relates that he was doing well after surgery in 1996 until he awoke from shoulder surgery. Dr. Patel recommended a right C5-C6 TFESI. The injection was carried out by Dr. Patel on February 25, 2015. (PX.11).

On March 4, 2015, Dr. Siemionow reported the MRI showed a C5-C6 herniated disc and C4-C5 spinal stenosis. Surgery was discussed. (PX.8).

On March 9, 2015, Dr. Patel's records reflect petitioner noted some pain relief in the right arm from the injection (PX.11).

The records of Dr. Joy from March 9, 2015 indicate petitioner advised Dr. Joy he had seen Dr. Siemionow and spine surgery was scheduled. (PX.12)

On March 30, 2015 petitioner reported to Dr. Siemionow that he started having new low back pain after starting physical therapy for right shoulder rotator cuff. Petitioner reported it happened after he was carrying two 10-pound weights. Dr. Siemionow recommended an MRI of lower back. (PX.8)

Petitioner returned to Dr. Siemionow on April 8, 2015 treatment for cervical and lumbar spine. The diagnosis was C4-5 spinal stenosis, C5-C6 disc herniation, cervical radiculopathy and low back pain. (PX.8)

On April 20, 2015, petitioner followed up with Dr. Joy and reported he had not been to physical therapy for a few weeks awaiting insurance approval. He also reported he is taking pain medication daily for his back and neck pain. He felt his shoulder was improving but still weak. (PX.12)

Petitioner returned to Dr. Siemionow on April 29, 2015. Dr. Siemionow again recommended a lumbar MRI and prescribed Fentanyl patches. (PX.8).

On May 18, 2015, petitioner reported to Dr. Joy that physical therapy was not yet authorized and Dr. Siemionow was recommending C4-6 fusion. (PX.12)

On May 27, 2015, petitioner was seen by Dr. Siemionow's PA. Petitioner's condition remained the same. (PX.8)

Petitioner returned to Dr. Joy on June 15, 2015 as follow up of his right shoulder surgery. Petitioner's condition remained the same. (PX.12)

June 17, 2015 petitioner returned to Dr. Siemionow. Dr. Siemionow's records indicated petitioner feels he really exacerbated the neck pain and right upper extremity numbness, tingling and pain when he went for physical therapy and rehabilitation for his shoulder. Petitioner also reiterated that the low back pain started after carrying 10-pound weights while in physical therapy. Dr. Siemionow epidural steroid injection at the L4-L5 level. The MRI obtained on June 9, 2015 reportedly demonstrated a large left paracentral disc herniation at the L4-L5 level. (PX.8)

Petitioner followed up with Dr. Joy on July 20, 2015; August 17, 2015; September 14, 2015; October 12, 2015; November 9, 2015; December 7, 2015; January 4, 2016; February 1, 2016. His condition remained the same; he was kept off work by Dr. Joy. (PX.12)

On July 22, 2015 Dr. Siemionow reported petitioner now has complaints in the left lateral arm and left anterolateral forearm and continued to recommend the cervical fusion. On August 19, 2015 Dr. Siemionow noted petitioner's neck pain was resolving, but it waxed and waned. Dr. Siemionow continued to recommend a cervical fusion and an injection of the L4-L5 disc (PX.8)

The records from Dr. Patel reflect petitioner returned on August 25, 2015 for lower back pain. Petitioner related the low back pain to carrying 10-pound weights in physical therapy. Dr. Patel recommended an epidural injection to the left L4 [nerve]. The injection was carried out by Dr. Patel on September 2, 2015. (PX.11).

On September 16, 2015, Dr. Siemionow reported petitioner received some relief in the lower back. Dr. Siemionow continued to recommend a cervical fusion, and also injection at L4-L5. (PX.8)

Dr. Krzysztof Siemionow testified in behalf of the petitioner via deposition on September 16, 2015 (PX. 7). Dr. Siemionow is a board certified orthopedic surgeon (PX.7, pp.4-5).

Dr. Siemionow first examined petitioner at the referral of Dr. Joy on January 13, 2015 (PX.7, p.6). Petitioner related to Dr. Siemionow that shortly after having his right shoulder rotator cuff repair on October 16, 2015 (sic) he developed radicular symptoms and neck pain (PX.7, p.7). Dr. Siemionow examination was negative for objection findings, with the exception

that the right deltoid which was a touch weak and there was a decreased right bicep reflex (PX.7, p.7).

Dr. Siemionow testified that after reviewing the EMG, CT scan and MRI diagnosed the condition as prior surgery at C6-C7 with a herniated disc at C5-C6 (PX.7, p.11). Dr. Siemionow does not recall if he provided an off-work slip at the time of his first visit, but believed petitioner was off work due to his shoulder surgery at that time; for sure Dr. Siemionow gave a note of disability at the time of his second visit (PX.7, pp.10-11). Dr. Siemionow surmised petitioner's cervical problem could be related to the original shoulder injury as it may have been masked by the shoulder injury. Alternative, Dr. Siemionow thought the neck problems wat the result of position during the right shoulder surgery (PX.7, pp.11-13).

Dr. Siemionow testified that on March 4, 2015 noted petitioner had spinal stenosis at C4-C5. He recommended a cervical fusion from C4-C6 (PX.7, p.14). Dr. Siemionow testified that on March 3, 2015 (sic) petitioner returned with a new complaint of low back pain which petitioner related the onset to carrying 10-pound weights in physical therapy (PX.7, p.14). On June 17, 2015, the lumbar MRI confirmed the presence of the left paracentral disc herniation at L4-5 with compression of the L5 nerve root (PX.7, p.18).

Dr. Siemionow authored a letter dated June 23, 2015 in which he rendered an opinion as to the cause of the low back pain and neck pain (PX.7, p.19). Dr. Siemionow opined that petitioner's low back pain was the result of walking with 10-pound weights that caused the low back herniated disc (PX.7, p.19). Dr. Siemionow admitted he did not have the physical records from ATI, only the description of the incident as related by the petitioner, when rendering his opinion in the letter (PX.7, pp. 19-20). Dr. Siemionow reiterated that he felt the neck injury originated at the time the shoulder was injured and masked by the shoulder problem, or was the result of the position of the neck during the shoulder surgery (PX.7, 20).

On July 17, 2015, Dr. Siemionow reviewed petitioner's MRIs and again recommended cervical fusion from C4-C6, as well as injection to the lumbar spine (PX.7, p.23). Dr. Siemionow testified petitioner had the epidural injection on the morning of the deposition (PX.7, pp.24-25).

On cross examination Dr. Siemionow testified that it was impossible to tell at the time of his deposition as to whether the neck was originally injured at the time the shoulder was injured or if it occurred at the time of the shoulder surgery (PX.7, p.30). Dr. Siemionow agreed that the CT scan of the petitioner's cervical spine of January 29, 2015 showed no evidence of an acute injury, only degenerative process (PX.7, pp.36-37). Dr. Siemionow also agreed the MRI of January 27, 2015 also showed only degenerative issues (PX.7, p.37). Dr. Siemionow testified that the EMG showed a mild chronic right C6 radiculopathy; chronic meaning more than six months (PX.7, pp.38-39).

Dr. Siemionow agreed, that if the physical therapy notes do not support the history petitioner gave of carrying 10-pound weights, his opinion may be put into question (PX.7, p.45). Dr. Siemionow admitted he had not reviewed the operative report and only made the assumption that the positon of the petitioner could have caused the neck problem (PX.7, p.46-47).

Respondent introduced the reports of Dr. Thomas F. Gleason of Illinois Bone and Joint who examined petitioner on March 31, 2015 and October 20, 2015 pursuant to §12 of the Act. (RX. 5 & RX.6).

According to Dr. Gleason's report of March 31, 2015, petitioner related a work accident of April 10, 2014 wherein he injured his right shoulder. Petitioner stated that he awoke from his surgery on October 16, 2014 with excruciating right forearm pain that radiated into his hand and he subsequently developed neck pain. After performing an examination and reviewing the medical records, diagnostic and film studies, Dr. Gleason concluded the right shoulder rotator cuff injury and repair was related to the work accident of April 10, 2014. With regard to the right shoulder injury, Dr. Gleason believe petitioner was restricted to heavy lifting and excessive overhead use. Dr. Gleason did not believe the need for the cervical discectomy and fusion was related to the work accident of April 10, 2014. (RX.5)

Petitioner returned to Dr. Gleason for another evaluation on October 20, 2015. Petitioner related to Dr. Gleason that since his last evaluation, at the end of February or the beginning of March, 2015, he began having increased neck and back pain while in physical therapy. Dr. Gleason did not believe the cervical or lumbar condition was related to the work injury. Dr. Gleason further opined that petitioner could return to work from his work-related injury and only restricted due to the unrelated cervical and lumbar conditions. (RX.6)

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusion of Law.

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

Petitioner testified without rebuttal that on July 7, 2014, he hit a rough road while driving for respondent, which caused the steering wheel to jerk aggravating his right shoulder condition. Petitioner notified Wendy of the occurrence immediately.

Based upon the unrebutted testimony of petitioner, the Arbitrator finds that petitioner sustained accidental injuries to his right arm which arose out of and in the course of his employment with respondent on July 7, 2014.

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

The Arbitrator finds petitioner's unrebutted testimony that he reported the accident immediately to Wendy supports the conclusion petitioner gave timely notice of the accident of July 7, 2014.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

The Arbitrator finds that the medical histories and opinions of the treating and examining physicians, as well as petitioner's testimony, fail to support that any of petitioner's claimed

condition of ill-being was caused by the claimed work accident of July 7, 2014 as the records of these medical providers are void of any history of this claimed accident.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

For the aforementioned reasons, the Arbitrator denies petitioner's claim for medical treatment.

K. In support of the Arbitrator's decision with regard to prospective medical care, the Arbitrator finds the following:

For the aforementioned reasons, the Arbitrator denies the costs of any prospective medical care for this accident.

L. In support of the Arbitrator's decision with regard to temporary benefits, the Arbitrator finds the following:

For the aforementioned reasons, the Arbitrator denies temporary total disability for this accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jim Armstrong,

Petitioner,

vs.

NO: 14WC 34415

17IWCC0365

NMMC Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent, herein and notice given to all parties, the Commission, after considering the issues of medical expenses and causal connection, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 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.

17IWCC0365

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 16 2017
MJB/bm
o-4/25/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

ARMSTRONG, JIM
Employee/Petitioner

Case# **14WC034415**

NMMC INC
Employer/Respondent

17IWCC0365

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1357 RATHBUN CSERVENYAK & KOZOL
LUIS J MAGANA
3260 EXECUTIVE DR
JOLIET, IL 60431

1337 KNELL LAW LLC
CHARLES KNELL
504 FAYETTE ST
PEORIA, IL 61603

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)

Jim Armstrong
Employee/Petitioner
v.
NMMC, Inc.
Employer/Respondent

Case # 14 WC 34415

17IWCC0365

An *Application for Adjustment 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 **February 8, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0365

On the date of accident **April 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$38,993.24**; the average weekly wage was **$749.87**.

On the date of accident, Petitioner was **46** 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 **$38,759.04** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$38,759.04**.

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

ORDER

Medical benefits

Petitioner's claim for medical benefits for treatment of his neck and lower back are denied. Petitioner is awarded payment of outstanding medical bills, if any, for treatment of his right shoulder up to October 20, 2015 pursuant to §8 and §8.2 of the Act.

Petitioner is denied any further medical treatment for his neck or lower back as he failed to prove there was a causal connection between these conditions and his work accidents. Further treatment to his right shoulder is denied as he reached maximum medical improvement as of October 20, 2015.

Temporary Total Disability

Petitioner is awarded temporary total disability from July 23, 2014 through October 20, 2015, which is 65 weeks at the rate of $499.91 per week.

Credits

Respondent is given credit for the sum of $38,759.04

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

05/25/2016
Date

IC ArbDec19(b) p.2

MAY 26 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jim Armstrong	)	
Petitioner,	)	
vs.	)	**No. 14 WC 34415**
NMMC	)	
Respondent.	)	
	)	

17IWCC0365

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing on February 8, 2016 in New Lenox under §19b/§8a of the Act. The parties agree that on April 10, 2014 Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner was injured in a work accident that arose out of and in the course of his employment with Respondent on April 10, 2014 and that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $38,993.24, and that his average weekly wage was $749.87.

At issue in this hearing is as follows:

1. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
2. Whether the medical services provided were reasonable, necessary and causally related to the work accident.
3. Whether petitioner entitled to any prospective medical care.
4. The amount of temporary benefits due petitioner.

FINDING OF FACTS

Petitioner testified he last worked for respondent in August, 2014. Respondent is a trucking company that hauls rail containers. Petitioner had been working for respondent since 2010; driving an eighteen-wheeler/semi-truck. Petitioner reported to respondent's yard for his assignments from Dan, the owner, or Wendy, the office manager. He would pick up and unload containers in the Chicagoland area.

Petitioner's job involved no touch freight. The physical part of petitioner's job required him to ensure the four locking pins that hold down the container were locked in place. To do this, the petitioner had to use a crow bar and sledge hammer to lock the pins. The crowbar and sledge hammer were used also to unstick the pins.

On April 10, 2014, petitioner was injured while working for respondent. The injury occurred when petitioner was trying to unhook the trailer and had to loosen a stuck pin on the 5th wheel that was jammed. Petitioner bent over and was stretching out to the right side trying to

dislodge the pin. He was not using any tools. Eventually the pin came loose, causing petitioner to jerk bac. Petitioner felt pain in his right shoulder that was intense for about a day. He reported the injury to Wendy via cell phone and finished the day at about 5 o'clock. He estimated the injury occurred about midday.

Petitioner worked the following day and the day after. On April 12, 2014, while working, petitioner aggravated his right shoulder condition when doing the same thing; disconnecting the trailer.

Petitioner did not seek medical treatment immediately as he thought it was just a pulled muscle. Petitioner took Aleve and Tylenol. He continued working the summer of 2014. The pain was getting worse. Petitioner testified he got to the point where he couldn't raise his hand to eat.

Petitioner testified that on July 7, 2014, while driving he hit a rough road. He testified the steering wheel jerked and aggravated his shoulder. He notified Wendy of the occurrence.

Petitioner testified he never had shoulder symptoms before April 10, 2014.

Petitioner testified that after the July 7, 2014 incident he sought treatment from his family doctor, Dr. Kuhlman, with Adventist in Bolingbrook. Petitioner testified he reported the April 10, 2014 incident to Dr. Kuhlman and had complaints of pain, weakness, numbness and tingling in his right hand and arm. Dr. Kuhlman prescribed medication and therapy. Dr. Kuhlman kept petitioner off work. On August 21, 2014, Dr. Kuhlman ordered an MRI and then referred petitioner to orthopedic surgeon, Dr. Lee with Midwest Bone and Joint.

Petitioner testified he told Dr. Lee of his shoulder pain, neck stiffness and numbness and tingling into his shoulders. Petitioner testified he noticed numbness and tingling bilaterally in his shoulders before he saw Dr. Lee. Dr. Lee recommended surgery for a torn rotator cuff. Dr. Lee also ordered testing for his neck, which was not done. Petitioner worked two days in August, 2014 while in physical therapy, but has not worked since then.

Petitioner testified he underwent surgery by Dr. Joy with Integrity Orthopedics. Petitioner testified he changed to Dr. Joy as he was not comfortable with Dr. Lee. Petitioner first saw Dr. Joy on September 19, 2014. Petitioner provided Dr. Joy details of the accident and of his symptoms of numbness and tingling in his arms and right hand. Dr. Joy did the surgery on October 16, 2014. The shoulder symptoms got better, but the numbness and tingling into the fingers continued. Petitioner noticed the neck pain increased after the shoulder surgery. Because the numbness and tingling continued, petitioner was referred to Dr. Siemionow by Dr. Joy.

Petitioner first saw Dr. Siemionow on January 15, 2015. He advised Dr. Siemionow of the accident and of his symptoms. He was still in therapy for his arm when he saw Dr. Siemionow. Petitioner testified that while doing physical therapy, walking with 10-pound weights, he felt pain in his lower back and dropped the weights. He made the therapist aware of the problem. Petitioner continued physical therapy for a while until his neck and back got worse at which time therapy was stopped in order to address the neck and back issues.

Petitioner underwent testing for his neck and back which was ordered by Dr. Siemionow. Dr. Siemionow advised petitioner he had herniated discs in the neck and lower back. Petitioner understood Dr. Siemionow wanted to remove the herniated discs in the neck. Petitioner continued to see Dr. Joy. He obtained an injection in his lower back as ordered by Dr. Siemionow. He also had shots in his cervical spine.

Petitioner previously had cervical surgery in 1996, which was a fusion done by Dr. Andrew Zelby. Petitioner also had lumbar surgery in 1994 which was done by Dr. Jack Casini. After physical therapy, post neck and back surgery, petitioner was released to return to work without restrictions. Petitioner testified that after recovering from the neck and lower back surgeries he did not have problems with his neck or back until his April, 2014 accidents.

Petitioner testified he had been ordered off work by Dr. Siemionow for his neck and back. He continues to see Dr. Joy, whom he last saw for his shoulder on February 1, 2016. Dr. Joy also kept petitioner off work. The last time he saw Dr. Siemionow was in December, 2015; Dr. Siemionow continued to recommend cervical surgery and physical therapy for the lower back.

Petitioner admitted that on December 16, 2014 he saw Dr. Kuhlman and reported that two weeks before he felt sudden pain encircling his neck and radiating down the spine and into his buttocks, but these symptoms resolved without treatment. Petitioner denied knowing what triggered the pain and radiating pain in his neck and down his spine. Petitioner claimed it was not pain that he was having presently, but rather tingling.

Petitioner was examined by Dr. Gleason for an independent medical exam. Petitioner described the accident and his symptoms to Dr. Gleason. The exam took 30 minutes at the most. He returned to Dr. Gleason again on October 20, 2015 for another exam. The October 20, 2015 exam was rather short. Petitioner testified that on October 20, 2015, he provided details to Dr. Gleason of the back pain; the physical therapy incident; and the incident involving the pain on April 10, 2014.

Petitioner testified he could not recall the last time he was at the Pain and Spine Center, but it would have been for his lower back injection. He would return to the Pain and Spine Center if Dr. Siemionow would send him back.

On cross examination petitioner agreed he was primarily a driver, but needed to work with the 5th wheel to unpin it. Petitioner was required to get in and out of the cab by using both arms. Petitioner could not confirm or deny that his neck or back was injured on April 10, 2014. Petitioner did not have any complaints of pain in his neck or lower back after the April 12, 2014 accident.

On July 7, 2014, petitioner testified that the steering wheel jerked which caused re-injury to his right shoulder. Petitioner could not say whether he injured his neck at that time. Petitioner testified he did not hurt his lower back when the steering wheel jerked.

Petitioner testified that his low back surgery in 1994 and the cervical fusion in 1996 was the result of a fall that occurred at work. Petitioner returned to work in 1998 as a truck driver after recovering from both surgeries.

Petitioner opened his own business in 1998, which was a power washing business. Petitioner shut down the business in 2008. Thereafter, in 2009 or 2010, petitioner began working for respondent.

Petitioner claimed he had no problems with his lower back from April 10, 2014 until early March, 2015. At that time, while doing physical therapy and lifting 10-pound weights in each hand, that he started having problems with his lower back. Petitioner testified that he reported the incident to Dr. Siemionow.

Petitioner continued to work until the end of July or early August, 2014. Petitioner confirmed he first saw Dr. Joy on September 19, 2014 for his shoulder. Petitioner confirmed Dr. Joy examined petitioner's cervical area on that day. Dr. Joy then scheduled surgery for his right shoulder, which was done on October 15, 2014. Petitioner testified that between September 19, 2014 until his shoulder surgery, he discussed his cervical complaints. Petitioner first saw Dr. Siemionow on December 16, 2014. Dr. Siemionow ordered an MRI and an EMG for petitioner's cervical area.

Petitioner did not have an EMG for his lower back, but did have an MRI. Petitioner denied having any problems with a pulled muscle from between April 10, 2014 until March, 2015. Petitioner testified he went for physical therapy for his back after he was released for his surgery in 1994 the 1990s. Petitioner testified he was just walking along with the 10-pound weights in each hand below his waist when he began having back pain.

Petitioner denied missing any time from work due to cervical or low back pain from 2009 or 2010 until after April, 2014.

According to the records of Dr. Geoffrey Kuhlman of Bolingbrook Family Medicine, petitioner was first seen by Dr. Kuhlman, after his claimed work accidents, on July 22, 2014. According to the records, petitioner complained of moderate to severe shoulder pain of three-month duration. It occurred when petitioner was pulling a pin on a truck. (PX.3)

According to Dr. Kuhlman's July 22, 2014 records, petitioner had decreased mobility, popping, weakness, but no numbness or tingling in the arms. The ultrasound of that day showed a partial articular surface tearing of the supraspinatus and partial infraspinatus tearing. Petitioner had active pain free range of motion of the cervical spine. Diagnosis was incomplete rotator cuff tear. Physical therapy was ordered. (PX.3).

Petitioner returned to Dr. Kuhlman on August 6, 2014. Petitioner continued to complain of pain and weakness in his right shoulder. He reported his pain improved with the first week of physical therapy, but returned when he returned to work. Dr. Kuhlman ordered more physical therapy and placed petitioner on work restrictions. (PX.3)

Petitioner returned to Dr. Kuhlman on August 21, 2014 with constant and worsening pain in his right shoulder, which had been aggravated by stabilizing physical therapy the previous week. Petitioner's symptoms included popping, tingling and weakness in both arms. He reported to Dr. Kuhlman that he had problem eating with the right hand the night before and could not brush his teeth with that hand either. An MRI of the right shoulder was ordered and petitioner was referred to orthopedic surgeon, Dr. John Lee. Physical therapy was continued. (PX.3)

The August 29, 2014 MRI of the right shoulder showed a full-thickness tear of the subscapularis tendon and partial thickness tear of the supraspinatus tendon, as well dislocation of long head of the biceps tendon. (PX.3) (PX.12)

According to the records of Dr. John Lee, of Midwest Bone and Joint Specialists, petitioner first presented to his office on September 4, 2014, with right shoulder pain that was aching and sharp. Petitioner related that the injury occurred on April 10, 2014 when he was disconnecting a tractor trailer at work, injury his shoulder. He denied numbness popping, spasms, swelling, or tingling in his arms and legs. Dr. Lee reported active and pain free cervical range of motion. Dr. Lee diagnosed rotator cuff tear. Surgery was recommended. (PX.4)

Petitioner again saw Dr. Lee on September 15, 2014. Petitioner reported neck stiffness since his last visit. Petitioner reported the night before he had numbness and tingling sensation in both shoulders. Dr. Lee recommended C spine series due to reported numbness and tingling. Surgery was awaiting insurance approval. (PX.4)

According to the records of Dr. Edward Joy, of Integrity Orthopedics, petitioner was first seen there on September 19, 2014 with right shoulder pain due to the work injury. Petitioner's cervical spine evaluation was normal. Spurling's maneuver was negative. (PX.2)

On October 4, 2014, petitioner was scheduled for shoulder surgery on October 16, 2014 by Dr. Joy (RX.8, p.4).

On October 7, 2014 petitioner had a pre-op visit with Dr. Joy (RX.8, pp.5-6).

Petitioner returned to Dr. Kuhlman on October 8, 2014 for medical clearance for surgery by Dr. Joy of Integrity. According to Dr. Kuhlman's records of that date, petitioner reported neck pain and stiffness and crepitus since Dr. Lee performed a Spurling's maneuver the month before. Because of this, petitioner left Dr. Lee for treatment by Dr. Joy. (PX.3)

Petitioner underwent right shoulder surgery by Dr. Edward Joy on October 15, 2014 which was reported as arthroscopic limited acromioplasty and open subpectoral biceps tenodesis for a right shoulder long head of the biceps tendon medial dislocation with full-thickness upper border subscapularis and superior rotator cuff tear (PX.12).

Petitioner returned to Dr. Joy on October 20, 2014, post October 16, 2014 (sic) right shoulder cuff repair. Petitioner reported he had intermittent numbness and tingling in his fingers.

His cervical spine examination was normal. He followed up with Dr. Joy on October 27, 2014. (PX.2)

Petitioner was seen by Dr. Joy on November 10, 2014. Petitioner's complaints included continued pain in his shoulder and a small rash on his stomach. (RX.8, pp.11-13)

According to the ATI records, petitioner was initially evaluated at ATI physical therapy on November 17, 2014. Petitioner's primary complaint at the initial evaluation was: "My shoulder is not bad, it's my forearm and hand discomfort, occasional neck, soreness, seems to getting worse." "After that other doctor pushed on my neck it's been different." (PX.6)

Petitioner received physical therapy at ATI from November 17, 2014 through March 27, 2015. There is no mention of any specific incident involving petitioner's lower back contained in the ATI physical therapy records. (PX.6)

The only mention of any lower back problems that occurred during physical therapy was at the time of discharge on March 27, 2015. At that time, the physical therapist wrote: "Pt. reports intermittent cervical complaints & although did not report a low back injury during therapy he states he experienced significant LBP after a recent session of therapy. Therefore, due to multiple recent spinal complaints and limited ability to progress PT, we will hold therapy at this time." (PX.6)

According to Dr. Joy's records of November 24, 2014, petitioner returned for follow up to his right shoulder surgery and had complaints of pain with numbness and tingling in his neck and forearm on the right side. Petitioner's cervical spine examination by Dr. Joy was reported as normal. Petitioner's visit of December 1, 2014 with Dr. Joy was the same as the previous visit. (PX. 12)

According to the records of Dr. Joy of December 8, 2014, the petitioner's examination remained the same, however, Dr. Joy added cervical radiculopathy (brachial neuritis or radiculitis [not otherwise specified]. Dr. Joy ordered a cervical MRI. (PX.12)

Respondent introduced the medical records of Dr. Kuhlman from December 16, 2014. According to the records, petitioner was seen by Dr. Kuhlman for elbow pain with a duration of two months. The pain reportedly radiated to the radial wrist and thenar area. Petitioner reported the pain was present since waking from rotator cuff surgery. The right wrist was flexed for two weeks after surgery as shoulder was in a sling. The diagnosis was injury to radial nerve at the forearm arising from positioning of his arm during shoulder surgery. (RX.9)

Dr. Kuhlman's records of December 16, 2014 also include a history related by petitioner was that he felt sudden pain encircling his neck and radiating down the spine into his buttocks which occurred two weeks before the visit. The symptoms resolved without treatment. Dr. Kuhlman believed the neck complaints were unrelated to his right forearm complaints and his neck and torso symptoms were non-specific. (RX.9)

Petitioner saw Dr. Joy on January 5, 2015 with the same complaints he had previously on December 8, 2014. (PX.12)

On January 13, 2015, petitioner first saw Dr. Siemionow, with Illinois Spine & Scoliosis Center as a referral from Dr. Joy. Dr. Siemionow recommended a cervical CT scan and an MRI of the cervical spine. (PX. 8)

The cervical spine MRI report of January 27, 2015, indicated petitioner had a posterior disc osteophyte complex at the C5-C6 level (PX.8).

Petitioner returned to Dr. Joy on February 9, 2015. Dr. Joy reported the chief complaint was follow up for right shoulder surgery and Dr. Siemionow for cervical radiculopathy evaluation. (PX.12)

The EMG of February 16, 2015 showed a chronic right C6 radiculopathy (PX.8).

The records of Dr. Udit Patel of Pain and Spine Institute reflect petitioner was first evaluated there on February 16, 2015 as a referral from Dr. Siemionow due to neck pain. Petitioner relates that he was doing well after surgery in 1996 until he awoke from shoulder surgery. Dr. Patel recommended a right C5-C6 TFESI. The injection was carried out by Dr. Patel on February 25, 2015. (PX.11).

On March 4, 2015, Dr. Siemionow reported the MRI showed a C5-C6 herniated disc and C4-C5 spinal stenosis. Surgery was discussed. (PX.8).

On March 9, 2015, Dr. Patel's records reflect petitioner noted some pain relief in the right arm from the injection (PX.11).

The records of Dr. Joy from March 9, 2015 indicate petitioner advised Dr. Joy he had seen Dr. Siemionow and spine surgery was scheduled. (PX.12)

On March 30, 2015 petitioner reported to Dr. Siemionow that he started having new low back pain after starting physical therapy for right shoulder rotator cuff. Petitioner reported it happened after he was carrying two 10-pound weights. Dr. Siemionow recommended an MRI of lower back. (PX.8)

Petitioner returned to Dr. Siemionow on April 8, 2015 treatment for cervical and lumbar spine. The diagnosis was C4-5 spinal stenosis, C5-C6 disc herniation, cervical radiculopathy and low back pain. (PX.8)

On April 20, 2015, petitioner followed up with Dr. Joy and reported he had not been to physical therapy for a few weeks awaiting insurance approval. He also reported he is taking pain medication daily for his back and neck pain. He felt his shoulder was improving but still weak. (PX.12)

Petitioner returned to Dr. Siemionow on April 29, 2015. Dr. Siemionow again recommended a lumbar MRI and prescribed Fentanyl patches. (PX.8).

On May 18, 2015, petitioner reported to Dr. Joy that physical therapy was not yet authorized and Dr. Siemionow was recommending C4-6 fusion. (PX.12)

On May 27, 2015, petitioner was seen by Dr. Siemionow's PA. Petitioner's condition remained the same. (PX.8)

Petitioner returned to Dr. Joy on June 15, 2015 as follow up of his right shoulder surgery. Petitioner's condition remained the same. (PX.12)

June 17, 2015 petitioner returned to Dr. Siemionow. Dr. Siemionow's records indicated petitioner feels he really exacerbated the neck pain and right upper extremity numbness, tingling and pain when he went for physical therapy and rehabilitation for his shoulder. Petitioner also reiterated that the low back pain started after carrying 10-pound weights while in physical therapy. Dr. Siemionow epidural steroid injection at the L4-L5 level. The MRI obtained on June 9, 2015 reportedly demonstrated a large left paracentral disc herniation at the L4-L5 level. (PX.8)

Petitioner followed up with Dr. Joy on July 20, 2015; August 17, 2015; September 14, 2015; October 12, 2015; November 9, 2015; December 7, 2015; January 4, 2016; February 1, 2016. His condition remained the same; he was kept off work by Dr. Joy. (PX.12)

On July 22, 2015 Dr. Siemionow reported petitioner now has complaints in the left lateral arm and left anterolateral forearm and continued to recommend the cervical fusion. On August 19, 2015 Dr. Siemionow noted petitioner's neck pain was resolving, but it waxed and waned. Dr. Siemionow continued to recommend a cervical fusion and an injection of the L4-L5 disc (PX.8)

The records from Dr. Patel reflect petitioner returned on August 25, 2015 for lower back pain. Petitioner related the low back pain to carrying 10-pound weights in physical therapy. Dr. Patel recommended an epidural injection to the left L4 [nerve]. The injection was carried out by Dr. Patel on September 2, 2015. (PX.11).

On September 16, 2015, Dr. Siemionow reported petitioner received some relief in the lower back. Dr. Siemionow continued to recommend a cervical fusion, and also injection at L4-L5. (PX.8)

Dr. Krzysztof Siemionow testified in behalf of the petitioner via deposition on September 16, 2015 (PX. 7). Dr. Siemionow is a board certified orthopedic surgeon (PX.7, pp.4-5).

Dr. Siemionow first examined petitioner at the referral of Dr. Joy on January 13, 2015 (PX.7, p.6). Petitioner related to Dr. Siemionow that shortly after having his right shoulder rotator cuff repair on October 16, 2015 (sic) he developed radicular symptoms and neck pain (PX.7, p.7). Dr. Siemionow examination was negative for objection findings, with the exception

that the right deltoid which was a touch weak and there was a decreased right bicep reflex (PX.7, p.7).

Dr. Siemionow testified that after reviewing the EMG, CT scan and MRI diagnosed the condition as prior surgery at C6-C7 with a herniated disc at C5-C6 (PX.7, p.11). Dr. Siemionow does not recall if he provided an off-work slip at the time of his first visit, but believed petitioner was off work due to his shoulder surgery at that time; for sure Dr. Siemionow gave a note of disability at the time of his second visit (PX.7, pp.10-11). Dr. Siemionow surmised petitioner's cervical problem could be related to the original shoulder injury as it may have been masked by the shoulder injury. Alternative, Dr. Siemionow thought the neck problems wat the result of position during the right shoulder surgery (PX.7, pp.11-13).

Dr. Siemionow testified that on March 4, 2015 noted petitioner had spinal stenosis at C4-C5. He recommended a cervical fusion from C4-C6 (PX.7, p.14). Dr. Siemionow testified that on March 3, 2015 (sic) petitioner returned with a new complaint of low back pain which petitioner related the onset to carrying 10-pound weights in physical therapy (PX.7, p.14). On June 17, 2015, the lumbar MRI confirmed the presence of the left paracentral disc herniation at L4-5 with compression of the L5 nerve root (PX.7, p.18).

Dr. Siemionow authored a letter dated June 23, 2015 in which he rendered an opinion as to the cause of the low back pain and neck pain (PX.7, p.19). Dr. Siemionow opined that petitioner's low back pain was the result of walking with 10-pound weights that caused the low back herniated disc (PX.7, p.19). Dr. Siemionow admitted he did not have the physical records from ATI, only the description of the incident as related by the petitioner, when rendering his opinion in the letter (PX.7, pp. 19-20). Dr. Siemionow reiterated that he felt the neck injury originated at the time the shoulder was injured and masked by the shoulder problem, or was the result of the position of the neck during the shoulder surgery (PX.7, 20).

On July 17, 2015, Dr. Siemionow reviewed petitioner's MRIs and again recommended cervical fusion from C4-C6, as well as injection to the lumbar spine (PX.7, p.23). Dr. Siemionow testified petitioner had the epidural injection on the morning of the deposition (PX.7, pp.24-25).

On cross examination Dr. Siemionow testified that it was impossible to tell at the time of his deposition as to whether the neck was originally injured at the time the shoulder was injured or if it occurred at the time of the shoulder surgery (PX.7, p.30). Dr. Siemionow agreed that the CT scan of the petitioner's cervical spine of January 29, 2015 showed no evidence of an acute injury, only degenerative process (PX.7, pp.36-37). Dr. Siemionow also agreed the MRI of January 27, 2015 also showed only degenerative issues (PX.7, p.37). Dr. Siemionow testified that the EMG showed a mild chronic right C6 radiculopathy; chronic meaning more than six months (PX.7, pp.38-39).

Dr. Siemionow agreed, that if the physical therapy notes do not support the history petitioner gave of carrying 10-pound weights, his opinion may be put into question (PX.7, p.45). Dr. Siemionow admitted he had not reviewed the operative report and only made the assumption that the positon of the petitioner could have caused the neck problem (PX.7, p.46-47).

Respondent introduced the reports of Dr. Thomas F. Gleason of Illinois Bone and Joint who examined petitioner on March 31, 2015 and October 20, 2015 pursuant to §12 of the Act. (RX. 5 & RX.6).

According to Dr. Gleason's report of March 31, 2015, petitioner related a work accident of April 10, 2014 wherein he injured his right shoulder. Petitioner stated that he awoke from his surgery on October 16, 2014 with excruciating right forearm pain that radiated into his hand and he subsequently developed neck pain. After performing an examination and reviewing the medical records, diagnostic and film studies, Dr. Gleason concluded the right shoulder rotator cuff injury and repair was related to the work accident of April 10, 2014. With regard to the right shoulder injury, Dr. Gleason believe petitioner was restricted to heavy lifting and excessive overhead use. Dr. Gleason did not believe the need for the cervical discectomy and fusion was related to the work accident of April 10, 2014. (RX.5)

Petitioner returned to Dr. Gleason for another evaluation on October 20, 2015. Petitioner related to Dr. Gleason that since his last evaluation, at the end of February or the beginning of March, 2015, he began having increased neck and back pain while in physical therapy. Dr. Gleason did not believe the cervical or lumbar condition was related to the work injury. Dr. Gleason further opined that petitioner could return to work from his work-related injury and only restricted due to the unrelated cervical and lumbar conditions. (RX.6)

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

The evidence supports a finding that petitioner's right shoulder torn rotator cuff that necessitated arthroscopic surgery on October 15, 2014 was caused by the work accident of April 10, 2014 and aggravated by the April 12, 2014 accident.

The Arbitrator finds the evidence does not support a finding of causal connection of petitioner's cervical or lumbar condition to the work accidents. The Arbitrator looked at the inconsistence histories by the petitioner as to the origination of both condition in making this determination. Although petitioner's doctor, Dr. Siemionow, testified there was a causal connection between the neck and the low back condition, and the work accidents of April, 2014, Dr. Siemionow relied on the information provided by the petitioner when rendering this opinion. The stories provided by petitioner to Dr. Siemionow as to when the problems began, do not jive with the histories contained in petitioner's medical records.

Specifically, before his shoulder surgery, petitioner indicated he was having problems with his neck that originated at the time of his examination by Dr. Lee on September 4, 2014, which was the reason he changed his shoulder treatment to Dr. Joy. (See PX. 3, Dr. Kuhlman's entry of October 8, 2014.)

Furthermore, the records of ATI physical therapy from November 17, 2014 recorded a history of "My shoulder is not bad, it's my forearm and had discomfort, occasional neck soreness, seems to be getting worse." "After that other doctor pushed on my neck it's been different." (PX.6) This statement by petitioner to ATI buttress the fact petitioner's neck problems likely originated at the time of his first exam with Dr. Lee in September, 2014.

An additional history which causes suspicion as to the origin of petitioner's neck problems is contained in Dr. Kuhlman's record the December 16, 2014 visit. At that visit, the petitioner related he had elbow pain with a duration of two months that radiated to the radial wrist and thenar area which had been present since he awoke from the rotator cuff surgery. Dr. Kuhlman diagnosis was injury to radial nerve at the forearm arising from the positioning of his arm during the shoulder surgery. (RX.9)

Also, at the December 16, 2014 visit with Dr. Kuhlman, petitioner provided a history of sudden pain encircling his neck and radiating down his spine into his buttocks that occurred two weeks before the visit. Dr. Kuhlman believed the neck complaints were unrelated to his right forearm complaints and his neck and torso symptoms were non-specific. (RX.9)

Petitioner testified he did not know what triggered the pain for which he sought treatment from Dr. Kuhlman on December 16, 2014. It was not until after this unidentified sudden pain that Dr. Joy added cervical radiculopathy as a diagnosis. (See PX.12, Dr. Joy's record of December 8, 2014 visit.)

The EMG of February 16, 2015 showed a chronic right C6 radiculopathy; chronic being six months or more according to Dr. Siemionow's testimony (PX.8, PX.7, pp.37-38). Furthermore, Dr. Siemionow agreed that the cervical CT scan and MRI showed no acute injury, only degenerative issues (PX.7, pp.36-37). Petitioner had previously had a cervical fusion at the C6-C7 level in 1996.

The treating records do not record any cervical radicular symptoms until after the exam by Dr. Lee in September, 2014, but before the October 15, 2014 surgery.

For the aforementioned reasons, the Arbitrator agrees with the conclusions of Dr. Thomas Gleason that petitioner' cervical condition was not related to work accidents of April 10, 2014 or April 12, 2014.

As for petitioner's lumbar spine condition, the Arbitrator finds the evidence does not support petitioner's claim that the lumbar spine condition was caused by the work accident; specifically resulting from physical therapy for his right shoulder injury as claimed.

The petitioner testified to a specific incident in physical therapy which was that he was carrying 10 pound weights in each hand at the end of February or the beginning of March, 2015. Even if the medical records backed up petitioner's testimony, this act in and of itself does not appear to be so onerous as to cause what has been described as a large left paracentral disc herniation at the L4-L5 level. However, the physical therapy records only mention in passing when petitioner was discharged from physical therapy on March 27, 2015 that although he did not report a low back injury during therapy he stated he experienced significant [low back pain] after a recent session of therapy.

Petitioner was seen by Dr. Siemionow on March 4, 2015, Dr. Patel on March 9, 2015 and Dr. Joy on March 9, 2015. There is no mention of any lower back problems whatsoever, even though petitioner testified the incident occurred in early March, 2015. The first history of the 10-pound weight carrying incident during physical therapy provided to any physician was to Dr. Siemionow on March 30, 2015.

Dr. Siemionow agreed that his opinion as to causal connection of the low back injury would be called into question if the physical therapy records do not contain the history by petitioner that it occurred when carrying the 10-pound weights in therapy. (PX.7, p. 45)

Petitioner also reported to Dr. Gleason at the time of his October 20, 2015, that in late February or the beginning of March, 2015 he developed neck and low back pain (PX.5).

However, the Arbitrator notes petitioner was examined for the first time by Dr. Thomas Gleason on March 31, 2015. Petitioner's complaints and Dr. Gleason's' findings were limited to neck and right shoulder. There was no mention by petitioner of the low back problem even though the exam occurred within the month after the purported physical therapy incident. (RX.5)

For the foregoing reasons, the Arbitrator finds petitioner failed to prove that the lumbar condition, described by Dr. Siemionow as a large herniated disc at the L4-L5 level, was caused directly or indirectly by the work accidents of April 10, 2014 or April 12, 2014.

The Arbitrator further finds petitioner had reached maximum medical improvement for his work-related injury to his right shoulder as of Dr. Thomas Gleason's examination on October 20, 2015. The Arbitrator also finds that petitioner was capable of returning to work as of October 20, 2015 due to his right shoulder injury and that any further disability was due to the petitioner's unrelated neck and lower back problems.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator, having determined petitioner's neck and low back problems are not related to the April 10, 2014 accident, denies any medical bills incurred for treatment of petitioner's neck or lower back. Furthermore, the Arbitrator, having determined petitioner had reached maximum medical improvement of his right shoulder injury as of October 20, 2015, denies any treatment related to the right shoulder after October 20, 2015.

K. In support of the Arbitrator's decision with regard to prospective medical care, the Arbitrator finds the following:

For the reasons already stated, the Arbitrator denies any prospective treatment to petitioner.

L. In support of the Arbitrator's decision with regard to temporary benefits, the Arbitrator finds the following:

For the aforementioned reasons, the Arbitrator finds petitioner's period of temporary total disability was from July 23, 2014 through October 20, 2015 and awards 65 weeks @ $499.31 per week.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL SCOTT,

Petitioner,

vs.

NO: 14 WC 38865

COUNTY MATERIALS,

17IWCC0414

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 notice, causation, and medical expenses, and being advised of the facts and law, reverses the Decision of the Arbitrator on the issue of notice but attaches the Decision of the Arbitrator for the Findings of Fact with the modifications noted below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill. Dec. 794 (1980).

The Commission finds that Petitioner provided adequate notice of his injury to Josh Finckbone on July 16, 2014. Petitioner testified that, on that date while "pulling and tugging" to install a header, he told Mr. Finckbone that it felt like he had been "kicked in the nuts." Petitioner testified that Mr. Finckbone asked if he was okay. Petitioner told him, "Just give me a few minutes" and he rested until he could continue working. (T.16). Petitioner testified that, although they are all laborers, Mr. Finckbone was a "crew chief," which is like a supervisor, who "runs the bed" and that Petitioner had to do what Mr. Finckbone told him to do. Petitioner testified that Joe Travis, the foreman, was "over" Mr. Finckbone but Mr. Finckbone was the only supervisor that was onsite at the time he was injured. (T.18). On cross-examination, Petitioner testified that Mr. Finckbone earned more money than he did and it was Mr. Finckbone's responsibility to make sure everything gets done right. (T.45).

The Commission notes that Mr. Finckbone was not called as a witness by Respondent to dispute that Petitioner reported an injury on July 16, 2014. Joe Travis testified on behalf of Respondent. He testified that Mr. Finckbone is not a supervisor or a member of management but,

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rather, a "team leader, a lead man" who directs the crew. Mr. Travis testified that he was the supervisor of both Mr. Finckbone and Petitioner. (T.55). On cross-examination, Mr. Travis admitted that the hierarchy goes from him down to Mr. Finckbone and that Petitioner was under Mr. Finckbone. Although Mr. Travis testified that both Petitioner and Mr. Finckbone are laborers, he also testified that it is "not negotiable" for Petitioner to refuse Mr. Finckbone's direction and that Petitioner could not direct Mr. Finckbone on the job site. (T.60-62).

We find that, under the circumstances of this case, Mr. Finckbone was Petitioner's supervisor on the date of accident. He was the "crew leader" and the only supervisor on the job site at the time. We find Petitioner's unrebutted testimony credible that Mr. Finckbone had notice of Petitioner's injury when it occurred. Therefore, Petitioner gave adequate notice under §6(c).

On the issue of causation, both Petitioner's treating physician, Dr. Murfin, and Respondent's §12 examiner, Dr. Bennett, agreed that Petitioner's left inguinal hernia was causally related to the work accident and that surgery is required. Regarding the right side, Petitioner had a previous right-side hernia in 1986, which was surgically repaired. (T.28, Px1 at 8). Dr. Murfin diagnosed a recurrent right inguinal hernia. However, the extent of his testimony on the issue of causation was that it was "possible" that Petitioner ruptured both sides at the same time but that this was just an "educated guess" and "I don't know what the genesis of the right inguinal hernia is." (Px1 at 11). Dr. Bennett testified that Petitioner does not even have a right inguinal hernia and "most likely had a strain," which would require only conservative care. (Rx1 at 12-13). However, Dr. Bennett could not state within a reasonable degree of medical and surgical certainty what the cause of that strain was. (Id. at 14). Based on the above, we find that Petitioner's left-side inguinal hernia is causally related to this work injury but that Petitioner failed to prove causation for any right-side hernia or condition of ill-being.

On the Request for Hearing form, Petitioner claimed the following medical bills:

Dr. Murfin	$90.00
Salem Township Hosp.	$3,738.00

We find that these expenses are supported by medical bills and records in evidence and award $3,828.00 under §8(a) of the Act subject to the fee schedule in §8.2 of the Act. We also award prospective medical treatment, including surgery and post-operative care, for the left inguinal hernia.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,828.00 for medical expenses under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay for prospective medical treatment, including surgery and post-operative care, for the left inguinal hernia.

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.

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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 $4,000.00. 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: JUN 28 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 6/7/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

SCOTT, PAUL
Employee/Petitioner

Case# **14WC038865**

COUNTY MATERIALS
Employer/Respondent

17IWCC0414

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:

4562 WALTON TELKEN FOSTER LLC
RONALD J FOSTER
241 N MAIN ST
EDWARDSVILLE, IL 62025

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0414

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)

PAUL SCOTT
Employee/Petitioner

v.

COUNTY MATERIALS
Employer/Respondent

Case # 14 WC 38865

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 **Mt. Vernon**, on **March 4, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **July 16, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$28,662.40**; the average weekly wage was **$551.20**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **3** dependent children.

ORDER

As explained in the Arbitration Decision, Petitioner failed to provide timely notice of the alleged accident to Respondent within the 45 days required by Section 6(c) of the Act. Benefits 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.

Signature of Arbitrator

June 5, 2016
Date

ICArbDec19(b)

JUN 7 - 2016

17IWCC0414

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

PAUL SCOTT
Employee/Petitioner

v.

Case #: 14 WC 38865

COUNTY MATERIALS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On his date of accident, Petitioner was 47 years old, single, with three dependent children. He was employed by County Materials as a laborer and his duties included pouring concrete, getting a seal, finishing, and the like. Petitioner is currently employed by Claiborne Heating, Air Conditioning and Refrigeration in Port Sumner, New Mexico, where he resides. Petitioner testified that on July 16, 2014, he was putting in a header, which he described as being like a shoe box without the ends. He estimated the header weighed 300-350 pounds, and had to be brought over by a fork lift. He was working with his crew leader, Josh Finckbone, and a co-worker, Jacob Heser. His crew leader brought the header over and as he lowered it down on the fork truck Petitioner was attempting to work it into the specific slot it had to go into. He described it as a tight fit, which required him to pull and tug to try and force it down into the slot. During this process he felt like someone kicked him in the groin. His crew leader asked if he was ok, and he responded that he felt he had been kicked in the testicles. He took a couple minutes to recover in the bed of the truck, and ultimately resumed his duties.

Petitioner described Josh Finckbone as the crew chief, and said he was "like a supervisor". The foreman over Josh was Joe, and then above Joe was the plant manager. He testified Josh ran the bed and if he told you to do something, you had to do it. Petitioner testified that Joe Travis, Respondent's representative who testified at trial, was not at the job site on the day the accident occurred. The only supervisor Petitioner had on site at the time he was injured was Josh Finckbone. He testified Josh was on the fork truck trying to help put the header in, and as he lowered the header, Petitioner attempted to work it into the slot when he was injured. Petitioner testified that Josh saw what occurred and was aware he had been hurt. The co-worker, Jacob Heser, was busy doing something else at the time and did not see the accident occur. Petitioner told Jacob what had happened, and let him know that if he had been down there helping with the header, Petitioner would not have gotten hurt.

After resting for a couple of minutes, Petitioner resumed working and the pain subsided. Later in the day he saw a lump on the left side when he went to urinate. He reported to work the next day, but did not report the incident to anyone. Petitioner testified that the first time he made a written report about the accident was September 22, 2014. Prior to that time, he only mentioned the incident to his co-workers in casual conversation. Between the date of accident and the date of the written report, Petitioner testified he had groin pain off and on. He described it as pressure and throbbing, like a headache, and testified that the lump would go in and out. He thought it would go away, but it continued to progress. He testified he did not go to his foreman prior to September 22, 2014, as he did not think of it as "a legitimate injury", since there was nothing obvious like a cut or abrasion or bruise.

Petitioner testified the pain kept getting worse and was not going away, and he believed there might be something wrong, so he reported the accident to John Clark. Mr. Clark was the plant manager and oversaw everything. Petitioner indicated to Mr. Clark that there might be something wrong and he needed to have it checked out. He testified his pain at that time was 6/10, and was getting bad enough that it needed to be looked at. Petitioner denied having any pain in his groin area prior to the accident on July 16, 2014, but admitted he had a right side hernia repair in 1986. He reported to Mr. Clark the details of the accident, consistent with his testimony. When he reported the accident he was given a verbal reprimand for not reporting the accident and injury as soon as it happened.

After he reported the accident, Tim Wright, one of the foremen, took him to see Dr. Gupta at Care First Medical Center in Mt. Vernon. Dr. Gupta examined him and referred him to a surgeon, Dr. Harad. Petitioner was unsure if Dr. Gupta actually made a diagnosis. He saw Dr. Harad on October 8, 2014, and reported pain in both his left and right side, as well as the bulge on the left side. He was diagnosed with a bilateral hernia. He reported that he felt a "fullness" in his right scrotum, like what the doctor feels when you cough. The Arbitrator notes this description during Petitioner's testimony was difficult to follow or understand. Dr. Harad recommended a hernia repair.

Petitioner had a CT scan done at Salem Hospital. He testified it did not reveal anything because he was laying down, and it was his understanding from the doctors that you can't get a CT scan laying down and have to do something standing up. He testified he continued to have pain on both sides of the groin, but that it was mostly on the right, as that's "how it emanates". Petitioner's testimony when describing this was very difficult to understand, as he described the pain as "emanating", and "in line with each other", and "more behind", and then "more centered". He testified that he thought the pain was affiliated with the left, but that the doctors let him know that he had bilateral hernias.

Petitioner testified he was seen by Dr. Bennett for an IME on October 21, 2014, and cooperated with the examination. His understanding was that Dr. Bennett said there was nothing wrong on the right side, and that he had a hernia on the left side. He testified Dr. Bennett "seemed to be inclined that (the left-sided hernia) was definitely work related".

Petitioner testified he chose to see his own doctor, Dr. Murfin in Centralia, on November 10, 2014. Dr. Murfin also diagnosed bilateral hernia and also recommended surgery. To date, Petitioner has not had the surgery but testified he would like to.

Petitioner testified his current condition was "kind of like you have a headache". When the left hernia comes out he is able to put it back in the hole. The right side continues to emanate pain. He testified it happens while lying down, sitting, working, or walking. He is able to cope and manage because of the location of the pain, but the right side definitely emanates pain.

Petitioner testified he has had no other injuries in the groin area subsequent to the accident on July 16, 2104. He switched jobs because he went to school for heating and air conditioning and refrigeration prior to working in concrete. There were no concrete jobs available and he found this job in New Mexico, in his career field.

On cross-examination, Petitioner testified that the previous right hernia repair in 1986 was due to being kicked at a younger age, and that it was in a different area on the right than currently. Petitioner acknowledged that he told Dr. Bennett he lifted weights, and explained that he worked on a Nautilus machine to tone up. He was in the middle of losing weight at that time, was toning up, and regularly worked out. He testified he was not really lifting weights, but rather was doing light stuff on a variety of machines to tone and lose weight, rather than to build muscle and create weight. He explained that there is a seat, where your knees are bent and you lift light weights. He confirmed he was doing some bike riding exercises and some sit up or crunch-type exercises. Petitioner acknowledged that he told Dr. Bennett he was coaching soccer in the summer of 2014 for his kids' teams. He admitted that when he coached he would get out on the field and demonstrate plays and how to kick the ball, but denied scrimmaging with the kids or running up and down the field with them. He testified the kids were around the age of eight and that he tried to keep them in order, more than work out with them.

Petitioner confirmed that Josh Finckbone was the lead worker when he, Josh, and a third co-worker were working on the headers. Josh was the crew leader over the bed. Petitioner described his job as a laborer and he worked on the railroad bed. He considered Josh to be his supervisor, as he was a crew leader. He understood that Josh made more money and had more responsibility, to make sure everything got done right.

Petitioner acknowledged he was written up for not telling anyone other than Josh about his injury until September 22, 2014. His understanding was that it was because he had not actually made a formal written documentation of the incident. He reported the accident to John Clark because he was starting to hurt and thought there was something really wrong. He went to John instead of Josh because John runs it all, it would ultimately go to him, and he was the one who was going to make decisions. Petitioner acknowledged that the Employee Incident Report stated he failed to report an apparent incident in a timely manner to his supervisor, and he testified he took that to mean that he failed to fill out paperwork or an actual accident report, and that was why he was written up.

Petitioner testified his understanding of how to report an accident or injury on the job was to tell somebody, tell his supervisor, which is what he did. He testified he did not really know he

had a substantial injury at the time, as it was common to hit your elbow or bend your finger the wrong way on the job. He testified if he felt he had a legitimate injury, he would have gone to Joe or John and let them know.

On re-direct examination, Petitioner testified that when he was toning with Nautilus it was light weights only, and that the machine is set up to kind of protect you from strain on your body. He explained that since he was losing weight at that time he did not lift any heavy weights and that, due to his low intake of food, the diet would not have allowed him to lift heavy weights and build muscle. He confirmed that he never felt the same thing working on Nautilus that he felt at work on July 16, 2014. He confirmed that prior to that day he had never noticed or seen a bulge on his left side.

Petitioner acknowledged he did not seek treatment or report the accident until September 22, 2014, and did so at that time because the condition was getting worse. He believed he gave plenty of notice about the accident because he told his immediate supervisor at that time. When Petitioner was written up for late reporting, he wrote on the report that he was not sure he had a real problem, that he was confused, that he did not want to add to work comp problems, and that he had felt it was no different than bumping your elbow or jamming your finger.

Mr. Joe Travis testified on behalf of Respondent. He is a supervisor for County Material and was present in the room when Petitioner testified. Mr. Travis testified that Josh Finckbone was not a supervisor or member of management, but rather was a team leader or lead man. He directs the crew on what direction they need to take any time they are not sure what the next step is in a procedure. Mr. Travis testified that he himself was the supervisor of Josh Finckbone and Petitioner on July 16, 2014. He testified that work injuries were supposed to be reported to your immediate supervisor, but that "supervisor" did not include or refer to the crew chief or lead man. Mr. Travis testified that Respondent had three supervisors at this location at the time of Petitioner's accident.

Mr. Travis testified that he received a phone call from John Clark, his operations manager, that Petitioner was in the office to report an accident. He went to Mr. Clark's office and filled out an accident report with Petitioner. Mr. Clark also completed an incident report, due to Petitioner not reporting the work accident on time. Mr. Travis testified that Petitioner telling Mr. Finckbone about the accident, or Mr. Finckbone being present at the time of the accident, did not meet the company policy for reporting an accident to the employer.

On cross-examination, Mr. Travis confirmed that Mr. Finckbone, as team leader, directed the crew, including Petitioner. Mr. Travis was next in command above him. When he was not at the job site, Mr. Finckbone did not take full responsibility for the job, but rather helped give direction to the men. He was not a member of management and did not have supervisory responsibility, but the crew was expected to give Mr. Finckbone respect and let him give direction. Petitioner and Mr. Finckbone were both laborers, but Petitioner would not have been able to direct him on the job site. Mr. Travis agreed that there was not always an injury with an accident, and that employees are supposed to report any and all accidents, even when there is no injury, and to complete an accident report. Mr. Travis acknowledged that at the time of the accident he believed Petitioner to be trustworthy, honest, and a hard worker.

On September 22, 2014, Petitioner completed a First Report of Accident or Injury in his own hand, listing the date of accident as July 16, 2014. He stated he had been prying and twisting, trying to put a header in the railroad bed, when he had discomfort in his lower left abdominal area. He reported he was working with Josh Finckbone at the time, and that Josh witnessed the incident. On September 23, 2014, an Employee Incident Report was completed, which listed the "nature of misconduct" to be failure to report an accident in a timely manner. It listed the date of infraction as September 22, 2014. It was noted Petitioner failed to report an apparent injury or accident in a timely manner to his supervisor for an injury that occurred in July 2014 and which was finally reported the day prior. In the Supervisor Comments section it was noted the infraction was due to not reporting in a timely manner, and instructed Petitioner to read and refer to Policies and Procedures Manual Section 1000.65. This was categorized as a verbal warning, rather than a written warning, unpaid suspension, or termination. On that report, Petitioner handwrote comments, indicating that at the time he was not sure if there was any real problem and that he did not want to add to any work comp problems at work. He stated he felt it was no different than bumping your elbow or jamming a finger. He further commented, "Am I a man with a stewardship and responsibility or a child who crys about everything? My work ethics speak for itself!" (sic) He signed and dated the statement on September 23, 2014. RX2.

Following the accident, Petitioner first sought treatment on September 22, 2014. At that time he was seen by Dr. Veena Gupta at Care First Medical Center with chief complaint of possible work related hernia in lower abdomen. He gave a history of discomfort in the bilateral groin area which started on the left side. He related it happened at work while bending and he felt a pull. He not seek medical help but felt it was getting worse. He complained of inguinal pain on both the right and left sides, and rated his pain at 2/10. Upon examination, review of systems was normal with the exception of abdominal pain. The abdomen was soft and non-tender, with no masses. It was noted Petitioner had no increase in urinary frequency. Exam of the penis, scrotum, and testes was normal. It was noted that the cough test was negative and he had no signs of a hernia. There is a notation that prescriptions were sent to a pharmacy electronically, but there is no indication what those prescriptions were. Dr. Gupta's assessment was injury of the groin, rule out inguinal hernia, and recommended Petitioner see a general surgeon. Dr. Gupta noted that Petitioner requested a second opinion and stated he would get one with a surgeon. Petitioner was allowed to work with no restrictions. PX2.

Later that same day, September 22, 2014, Petitioner presented to Salem Township Hospital Emergency Room around 6:00 p.m. and was examined by NP Harris-Deaton. It was noted that the reason for the visit was that several days ago Petitioner felt something give in his lower groin and now had a large mass swelling that would come and go. He stated that the pain was minimal, that he had a hernia repair done in the past, and that this felt like it did when the hernia on the right ruptured. The genitourinary exam revealed the inguinal canal was tender on the left. A hernia was present only with straining, was reducible, and was tender. It was noted Petitioner had an abdominal mass and abdominal pain, and that there was lower abdominal swelling. The Arbitrator notes that neither the abdominal mass nor the swelling were noted earlier that day by Dr. Gupta. With regard to a treatment plan, NP Harris-Deaton advised Petitioner to seek a second opinion with a surgeon for evaluation of his groin swelling, and if he had trouble getting it through his employer to call back for a referral. He was cautioned to not

lift over ten pounds, to help prevent further bulging of the swelling in his groin. Petitioner was given a prescription for Meloxicam for pain and Flexeril for muscle spasms and tightness. PX3.

On October 8, 2014, Petitioner presented to Dr. Alan Harad, a general surgeon at St. Mary's Good Samaritan Medical Group. It appears this was a referral from Dr. Gupta, but the record is not clear. Dr. Gupta's records contained a letter from Dr. Harad dated October 8, 2014. In the letter, Dr. Harad noted Petitioner was injured at work on July 16, 2014, when he was pulling, tugging, and pushing down to try and put a header in. He reported that when he went to urinate he saw a bulge, and since then he had a bulge off and on which would sting. He complained of pain on his left side on and off. Petitioner reported he was told at the Salem Emergency Room that he had a high hernia, and he thought he had a hernia on the right side also. Dr. Harad's primary diagnosis was bilateral inguinal hernia, and noted a diagnosis of scrotal fullness was also pertinent. PX2.

Dr. Harad's record from October 8, 2014, noted Petitioner presented with left inguinal hernia and he had intermittent and dull left sided pain. Petitioner related the complaints to lifting and pushing at work on July 16, 2014, and noted that nothing in particular made the pain better or worse. He also stated he had fullness in the right scrotum. There was a history of right inguinal hernia repair in 1986. It was noted Petitioner had frequent urination and nighttime urination. The abdomen was soft and non-tender, with no masses. Examination of the groin revealed bilateral inguinal hernia which was easily reducible. Petitioner stated he had fullness in the right scrotum. No definite mass was noted. With regard to a treatment plan, Dr. Harad discussed a hernia repair with Petitioner, including possible use of mesh in the repair, and he ordered an ultrasound of the testicles. Petitioner was allowed to return to work full duty without restrictions. PX2, PX4.

On October 21, 2014, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Kenneth Bennett. Dr. Bennett obtained a history from Petitioner that he had undergone right inguinal hernia repair in 1986 and had extensive knee surgery, more on the right. It was noted Petitioner had been with County Materials for five years. It was further noted that his off duty activities used to involve some minor weightlifting, and he had coached soccer once or twice a week, which involved very little physical activity. Petitioner related that while on the job on July 16, 2014, he was trying to fit a header into a concrete box and he felt a giving way in his left groin, followed by pain which caused him to bend over and hold his groin. He rated his pain as 6/10, but stated it lasted only a few minutes and he was able to finish his shift. He stated the next time he paused to urinate he saw a bulge in his left groin. Petitioner related he made no report of the incident and he lost no time. He stated the groin discomfort slowed him down but did not make him stop working. He stated he reported the accident in September 2014 and was subsequently seen by Dr. Gupta and referred to Dr. Harad. Dr. Bennett notes, "Here there is some confusion." Petitioner stated he was told he had a hernia on the right and on the left. There was a suggestion of a problem in his right hemiscrotum as well. An ultrasound was recommended but Dr. Bennett noted there was no report in the chart. RX1, Dep.RX2.

On examination, Dr. Bennett noted Petitioner was a trim, muscular man with excellent definition of his musculature and very little body fat. Examination of his groin showed a healed scar on the right. His genitalia were normal and there was no mass or problem in either

hemiscrotum. Dr. Bennett noted that on the right side, the previous hernia repair had held and there was no recurrence. On the left, Petitioner had a well-defined bulge which was easily palpable. Dr. Bennett opined that Petitioner had a left inguinal hernia that was a direct result of the July 16, 2014, injury and that he did not have a hernia on the right side. He further opined there was no underlying condition that was aggravated by the work accident. He found no comorbid factors that contributed to the diagnosis of left hernia and further found no evident of malingering by Petitioner. Dr. Bennett opined Petitioner's complaints were well supported by the finding of left inguinal hernia. He believed Petitioner may have had a right groin strain, but no hernia which would require surgery. Dr. Bennett did not believe further testing was required and he opined Petitioner needed a left inguinal hernia repair. He further stated that Petitioner did not need the surgery prior to the July 16, 2014, incident.

On October 28, 2014, Petitioner presented to Salem Township Hospital Emergency Room and was examined by NP Jesenick. He complained of inguinal hernia pain with radiation to the groin, and an onset three months prior while lifting something at work. He described the pain as aching and sharp, aggravated by exercise, movement and bending over. He reported he got relief from pure apple cider vinegar. Petitioner stated he had constant pain and was supposed to have surgery but something occurred and it was delayed. He was then sent to St. Louis for referral, but surgery was still not scheduled. He presented for the purpose of further testing for the hernias. On examination, Petitioner had suprapubic tenderness and a small bulge in the suprapubic area when going from lying to sitting position. A CT of the abdomen and pelvis was done, which revealed unremarkable findings in the right and left groins, inguinal canals, and femoral canals. A referral appointment was made with surgeon Dr. Murfin for November 10, 2014. Petitioner refused any pain medication and was instructed to continue to take over-the-counter ibuprofen or Tylenol for pain. He was excused from work for one day. PX3.

On November 10, 2014, Petitioner presented to Dr. Mark Murfin, and reported that on July 16, 2014, he was pulling, tugging, and pushing on a structure he was working on when he felt intense pain in his lower abdominal area. He related he had seen a couple of surgeons already and had been told he had bilateral hernias, but was also told he had a hernia only on the left side. He complained of 6/10 pain in his lower abdominal area and stated he could feel a definite hernia on the left. He reported he had been told by Dr. Harad that he had bilateral inguinal hernias. Examination revealed the abdomen was soft and nontender, with no mass. Impression was bilateral hernia and the treatment plan was surgical repair. The Arbitrator notes that the handwritten notes in this record are very difficult to read and decipher. PX1, Dep.PX3.

Dr. Murfin testified by way of deposition on August 20, 2015. He is a general surgeon but no longer board certified. He testified he was board certified for twenty years, but when he came up for recertification a couple of years ago he did not recertify. He is licensed to practice in Illinois, Tennessee, and Indiana. He is on staff at the Surgery Center of Centralia, Crossroads Community Hospital in Mt. Vernon, and Salem Township Hospital in Salem. He performs at least twenty or twenty-five hernia repairs a year, and has done so since 1991. PX1.

Dr. Murfin testified he saw Petitioner on only one occasion, on November 10, 2014, upon referral by NP Crystal Jesenick at Salem Rural Health Center. At that time he obtained a history

from Petitioner that he was pulling or pushing on some sort of structure which was fairly large. He testified he did not get a real good history of exactly what the piece of material was that Petitioner was handling, but in the course of pushing or pulling it Petitioner felt intense pain in his lower abdomen. PX1.

Dr. Murfin testified he conducted a complete physical examination of Petitioner. On his abdominal exam, it was noted Petitioner had a scar in the right lower quadrant, consistent with his history of previous right inguinal hernia repair in 1986 at the age of nineteen. He also had a definite bulge in the left groin consistent with a hernia. Dr. Murfin testified he also noticed Petitioner had a recurrent hernia on the right side. Within a reasonable degree of medical certainty, Dr. Murfin formulated a diagnosis of unrepaired left inguinal hernia and recurrent right inguinal hernia. PX1.

With regard to causation, Dr. Murfin testified that the medical records from Salem never localized the pain to one side or the other and in reviewing the records he did not get a sense that Petitioner was complaining of localized pain, nor did Petitioner localize the pain on examination. Dr. Murfin opined that it was possible Petitioner ruptured both sides at the same time. Based on Petitioner's history of seeing a bulge on the left side, and his complaints with regard to the left side, Dr. Murfin testified within a reasonable degree of medical certainty that Petitioner's left hernia was related to the work incident on July 16, 2014. He could not say within a reasonable degree of medical certainty, however, what the genesis was of the right inguinal hernia. PX1.

Dr. Murfin testified that he recommended Petitioner have both hernias repaired, which he usually does during one operation, rather than separate procedures. Dr. Murfin could not recall whether or not he took Petitioner off work, but stated he usually did not take people off work just because they had a hernia. Dr. Murfin testified Petitioner had not yet reached maximum medical improvement with regard to the hernia conditions. He did not have any opinion with regard to permanency or the need for future treatment other than the hernia surgery. PX1.

On cross-examination, Dr. Murfin testified he did not know the exact details of Petitioner's accident, but knew that he worked with specialty concrete products and railroad beams. Based on Respondent's question whether using a pry bar to pry something off a railroad beam would be sufficient to cause an inguinal hernia, Dr. Murfin testified that it would. He was not able to give any measurements of either hernia, and was able to characterize them only as the left being larger than the right. PX1.

Dr. Murfin conceded it was possible that dead lifting a barbell or curl bar weighing more than fifty pounds from the floor up the to waist and above could cause the type of hernias that he diagnosed Petitioner with. Dr. Murfin testified that the history he obtained from Petitioner was not that he was lifting weights when he was hurt, but rather that he got hurt at work prying on a piece of specialty engineered concrete. He conceded that either activity could have caused Petitioner's injury; however, he testified he was unaware of any literature that specified lifting over a specified amount in weights would cause a hernia. He testified that running and kicking involved in playing soccer would not be a common cause of inguinal hernias. Dr. Murfin testified that most of the hernias he saw fell into two general classes. The first class is a congenital hernia, which a person is born with and which enlarges with time. He opined that

could be the reason for Petitioner's hernia repair at nineteen. The second class is a hernia caused by repetitive stress, lifting, pushing, or the like. He testified he does not have patients coming to him with a hernia they got from playing sports such as football and soccer, and that such mechanism is not common for a hernia. Rather, the more common cause of hernia is repetitive stress on the abdominal wall from lifting or pushing or the like. PX1.

Dr. Bennett testified by way of deposition on August 25, 2015. He has been a Board Certified General Surgeon since 1973 and is licensed in Missouri and Louisiana. Over 90% of his practice is devoted to treating patients, while the other 10% is for medical/legal consultations such as IME's. Through his years of practice he has treated patients for inguinal hernias and has performed surgery to repair them. He has not performed surgery since December 23, 2013, as he decided to stop doing all forms of hospital surgeries. RX1.

Dr. Bennett performed an independent medical evaluation on Petitioner on October 21, 2014, and took a history from Petitioner at that time. Dr. Bennett noted in the history that Petitioner's off-duty activities included some minor weight lifting, but he did not have additional details with regard to that. He testified that weight lifting could cause an inguinal hernia; however, he was unaware of any scientific study that specifies a certain amount of weight which, when lifted, would provoke an inguinal or other type hernia. Dr. Bennett also noted in the history that Petitioner coached soccer once or twice a week and that soccer involved very little physical activity. He testified it would be very unlikely that running and kicking in soccer could cause an inguinal hernia. RX1.

Dr. Bennett testified he performed a physical examination of Petitioner and his findings were as indicated in his report. When he examined Petitioner he did not find a hernia on the right side of his groin, nor did he find any issues regarding the previous right hernia repair that Petitioner had to his right side. He testified that he disagreed with Dr. Murfin that there was a small hernia on the right side of the groin. Rather, Dr. Bennett testified that Petitioner had a right groin strain, which he explained was a condition in which pain was present in the right groin as a result of lifting heavy objects or otherwise straining. Strains are generally thought of as stretching injuries or exertional injuries to musculature or ligaments. RX1.

Based on his evaluation of Petitioner and the history he provided, Dr. Bennett testified Petitioner sustained a strain in the right groin and an inguinal hernia in the left groin. With regard to treatment, Dr. Bennett testified Petitioner needed the left inguinal hernia surgically repaired. The right groin strain could be treated nonsurgically, with rest, medication, and possibly some elements of physical therapy. Dr. Bennett opined that the cause of the inguinal hernia was the incident Petitioner described. Dr. Bennett had no opinion as to whether any weightlifting Petitioner had done prior to the work accident was a causal factor in his left inguinal hernia. Dr. Bennett could not state within a reasonable degree of medical certainty the cause of the strain to Petitioner's right groin. RX1.

On cross-examination, Dr. Bennett conceded that the accident, as described by Petitioner, could have produced a hernia on the right side. He confirmed that his report did not attribute the left side inguinal hernia or the right side groin strain to either weight lifting or coaching soccer. Dr. Bennett was asked to review Dr. Gupta's note of September 22, 2014, and conceded that the

note referenced inguinal pain on the right side as well as the left. He was also asked to review Dr. Harad's note of October 10, 2014, and conceded that the note referenced inguinal hernia bilaterally, reducible and that Petitioner stated he had fullness in the right scrotum. Dr. Bennett explained that the term "reducible" means that the hernia mass slides back and forth freely without impediment or obstruction, as opposed to "incarcerated", which means the mass is trapped and doesn't budge when you try and move it. Dr. Bennett confirmed that he disagreed with Dr. Haran, in addition to Dr. Murfin, that Petitioner had a hernia on the right side. He acknowledged that he was the only doctor who diagnosed a right groin strain. He testified a groin strain could last weeks or months, and such strains are notorious for a long duration. Dr. Bennett again acknowledged that the type of injury Petitioner described is the type of injury that could produce a right groin strain. He conceded it is possible for him to do an examination and, if there was a hernia, just not find it during the examination. RX1.

CONCLUSIONS OF LAW

The arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues at trial as follows.

In support of the Arbitrator's decision relating to issue (E), whether timely notice of the accident was given to Respondent, the Arbitrator finds the following:

Section 6(c) of the Illinois Workers' Compensation Act states, "Notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident...No defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." 820 ILCS 305/6(c).

The notice is jurisdictional, and the failure of the claimant to give notice will bar his claim. *Thrall Car Manufacturing Co. v. Industrial Comm'n*, 64 Ill.2d 459, 465 (1976). However, a claim is only barred if *no* notice whatsoever has been given. *Silica Sand Transport, Inc. v. Industrial Comm'n*, 197 Ill.App.3d 640, 651 (3rd Dist. 1990). The statutory element of undue prejudice to the employer is pertinent only where some notice is given in the first place. *White v. Workers' Compensation Comm'n*, 374 Ill.App.3d 907, 910 (4th Dist. 2007) (citing *Fenix-Scisson Construction Co. v. Industrial Comm'n* 27 Ill.2d 249 (1980)). The purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. *Seiber v. Industrial Comm'n*, 82 Ill.2d 87 (1980).

The Arbitrator finds that Petitioner failed to provide timely notice of the alleged accident to Respondent, and is therefore barred. Petitioner testified that the accident was witnessed by crew leader Josh Finckbone, and that he told co-worker Jacob Heser immediately thereafter. He also testified that he considered Josh Finckbone to be a supervisor and that, by his witnessing the accident, his supervisor therefore had notice of the accident. The Arbitrator finds it significant that Petitioner did not have either of these individuals testify on his behalf as to what they may or may not have witnessed or known at the time of the alleged accident. Further, Petitioner's assertion that Mr. Finckbone was a "supervisor" was rebutted by the testimony of Joe Travis.

Mr. Travis credibly testified that Mr. Finckbone was not a supervisor, was not a member of management, and was simply a "lead man". He described Mr. Finckbone's role as directing the crew on what direction to take when they were not sure of the next step in a procedure. Mr. Travis testified that he himself was Petitioner's supervisor, as well as Mr. Finckbone's supervisor. He further testified that company procedure dictated that accidents were to be reported to an employee's immediate supervisor, which did not include the lead man.

The Arbitrator is persuaded by the testimony of Mr. Travis and finds Josh Finckbone was not Petitioner's supervisor at the time of the accident and therefore his purported knowledge of the accident does not constitute notice to the employer.

Petitioner testified he did not file the paperwork for the accident at the time it occurred because he did not think he had a real injury. The Arbitrator finds Petitioner's own testimony to contradict this assertion. Petitioner testified that when the alleged accident occurred it caused him such great pain that he "went down" and had to rest for a few minutes, prompting Mr. Finckbone to ask if he was alright. He further testified that later that same day he saw a lump in his left groin. While Petitioner tried to explain his lack of reporting the incident by testifying he did not think he had a real injury, the Arbitrator finds this assertion to lack in credibility.

Petitioner's alleged date of accident was July 16, 2014, and the accident should have been reported by August 30, 2014, to comply with the 45 day requirement in Section 6(c). While Petitioner alleges Josh Finckbone was his supervisor and was aware of the accident at the time, the Arbitrator has found that not to be the case. It is undisputed that Petitioner made no written report about the accident until September 22, 2014. At that time he spoke directly with John Clark, the plant manager. He testified he went to Mr. Clark because "he runs it all", he was friends with Mr. Clark, he was the one going to make decisions, and that "anything and everything, I go to John Clark". The Arbitrator finds it significant that, given Petitioner's clear understanding of the need to let management know important things, he did not report an accident that caused him to "go down", required him to rest for a few minutes, and caused a lump in his left groin the same day. Petitioner's assertions are contradictory and lacking in veracity.

Based on the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to provide timely notice of the alleged accident to Respondent, and is therefore barred from recovery. Given the lack of any notice, as opposed to timely but defective notice, it is not necessary for Respondent to have shown undue prejudice.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TROY DAVIS,

Petitioner,

vs.

NO: 14 WC 40851

17IWCC0379

HLAVA INDUSTRIAL WELDING, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Troy Davis, sustained a repetitive trauma injury that arose out of and in the course of his employment, which manifested itself on October 21, 2014. The Commission also finds that Davis' current condition of ill-being is causally related to said accident.

The Commission further finds that Davis is entitled to prospective medical treatment consisting of right carpal tunnel release and a left injection as recommended by Dr. Baxamusa, and all reasonable and necessary medical expenses related to said accident. The Commission notes that Petitioner's attorney selected TTD as an issue on the Petition for Review; however, then stated in his Statement of Exceptions that no TTD was due and owing. Therefore, the issue of TTD is moot. 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).

17IWCC0379

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. Troy Davis filed his Application for Adjustment of Claim on December 4, 2014 alleging injury to both upper extremities on October 21, 2014.

2. Davis was employed by Hlava Industrial Welding from July 17, 2013 through October 20, 2013 and from January 17, 2014 through November 20, 2014, at which time he was terminated. T.8.

3. Between July 2013 and October 2013, Davis performed brazing and sandblasting. Brazing consisted of taking a coil, flipping it up, putting 2 copper tubes in, and then brazing the copper tubes. T.8. Sandblasting required Davis to put the copper coils in a big machine and then hand sandblast the coils. He would then transfer the coil to a second machine where it was sandblasted automatically. He would then take out the coil, blow it out, and wrap it in paper for packing. This did not involve any vibration. T.9.

4. Davis returned from layoff on January 17, 2014 and worked full-time, 40 hours a week. He began working in the liquid controls and also worked the lathe machine for the ice makers. T.9. Sixty to eighty percent of his time was performing liquid controls while the remainder was spent working on the lathe machine. T.10. Davis testified that his job duties varied. T.38. He would work the lathe one to two days per week.

5. Davis stated that the liquid controls involved the use of a chop saw. T.19. If it was a small tube, the chop saw did not require much force to pull down and cut through the tube. *Id.* If he was cutting a half inch tube, the chop saw then required a lot of pressure to cut through the tube. T.19. Cutting the tubing with the chop saw caused vibration and only took a couple seconds per cut. T.20. He also had to deburr the cut tube. Davis testified that deburring caused vibration, but only took a few seconds. *Id.* Davis would then clean the cut tube and put it on the flare machine. T.20. He would then take the tube out of the flare machine and measured it with a micrometer. He used his thumb to operate the wheel on the micrometer. T.21.

6. Davis would cut an equal amount of big and small tubes. T.40. Some days he would do all the cutting and some days he would perform all the deburring. T.42.

7. Davis testified that he would cut 150 tubes on average per shift and up to 300 to 400. T.22. He would also bend the tube in the bender. Davis had to mount the bender on the work station by screwing down the bolts to secure the bender to the table. T.23. He then had to manipulate the tube with his hand and bend it back and forth. *Id.*

8. Respondent's exhibit 5 is a video showing the various job duties within the plant. The first part of the video shows an employee making a coil, which Davis testified he did not perform. The video also shows an employee using a wrench and hammer with some force, and hitting various levers with force. The video did not show the lathe machine in operation. Regarding the chop saw, the employee was required to screw down a clamp and then move the tubing to the right size to be cut, and would then pull the chop saw down. The video did not show the chop saw being used on larger tubing, or the tubing being bent after it was cut, or the tube being deburred. When the employee was using the flare machine, it was clear that he was exerting force to lock the piece into place. There was also a grinder, which required the employee to push the tubing into the machine. The employee is seen putting a cap in the flared tube, which required him to manually push the cap into the tube. RX.5.

9. Davis watched the video and testified that he did not make coils in the viper section. He further stated that the video did not show wrapping of the solder. This, he stated, required him to take a barrel and lock it into the machine. He would then wrap a little bit of solder around the copper tube and then use a foot pedal to spin the barrel. As it was spinning, he would hold the copper wire and pull it through the coils. This required him to forcefully pull on the solder and then cut it. He had to use both hands. T.12.

10. The next portion of the video showed the ice machine tubes. Davis worked the lathe on the ice machine tubes. T.15. This required putting a steel tube on a lathe machine and then putting a bit in the lathe. He had to hit the bit with a hammer. *Id.* He would then lock the tube into place and use a steel piece with a bit to make the cut. He would then use a hand file to remove the steel burr. Davis stated that the hand file caused vibration and he had to hold it at an angle. T.16. He did this one to two times per week. T.17. He would also take the tube and slide the tube in a sleeve. Davis would also pull the tube out and take it back to the lathe and face the front of the flange and pull it off. *Id.* He would also file the flange. T.18. He would do about 50 tubes in a day.

11. Joe Green, owner of Hlava Industrial Welding, testified that there is no job that required an employee to use all their weight. T.54. He agreed, however, with Davis' testimony as to the percentages of the work he performed. *Id.*

12. Green further testified that he did not think it was possible for an employee to cut 500 pieces a day. T.55. They only ship out 50 to 200 of those pieces a week and only keep a little inventory on hand. Only about 50 per day are completed. T.56. A lathe bit was only changed once maybe twice a week. *Id.* Green further stated that using the hand file could

cause vibration. *Id.* This was only a couple seconds however. T.57. The chop saw only required a minimal amount of pressure and only a little more pressure with a larger tube. There was some vibration when using the chop saw, but only a few seconds at a time. *Id.* Rarely would an employee cut 200 pieces a day. T.58. There is some vibration with deburring, but again only a couple seconds at a time. *Id.* Each cut required 2 deburring. T.58.

13. Davis stated that he developed symptoms in his bilateral hands while performing his work duties at some point during September 2014. T.23. He began to experience numbness in his right hand that would wake him at night.

14. Davis presented to Dr. Bassam Soufan of Rockford Health System on October 21, 2014. Davis reported a one month history of a chronic problem with his bilateral wrist pain that would wake him at night. There was no history of trauma and he had constant pain. There had been a gradual onset that he described as dull, sharp and aching. He reported no diabetes, osteoarthritis, repetitive use, gout or rheumatoid arthritis. Examination revealed decreased range of motion and tenderness in both wrists with swelling in the right wrist. The impression was bilateral carpal tunnel. He was provided wrist splints and Naproxen. PX.1.

15. Davis testified that between October 21, 2014 and November 20, 2014, he mentioned his hand issues to his supervisor, Mike Anderson. T.32. Green testified, however that employees were to report injuries directly to him. T.49.

16. Per the employee separation form dated November 18, 2014, Davis last worked on November 13, 2014. He was let go do to a business decision. PX.4.

17. Davis typed a document detailing his telephone conversation with Green relative to his termination. Davis stated that he informed Green that he was having hand problems and saw a doctor on October 21, 2014, at which time he was diagnosed with carpal tunnel. He was advised by his doctor that his condition was work-related. Davis stated that Green told him he was terminated for job abandonment. PX.4.

18. Green stated that Davis did not report any hand issues upon his termination. T.52. Green further testified that Davis missed 28 percent of his work during the last 4 months of employment, and was late 81 percent of the time when he worked. T.53.

19. Davis completed an injury report on December 1, 2014 indicating that his work duties caused his carpal tunnel. PX.3.

20. Davis presented for follow-up with Dr. Soufan on December 9, 2014 with continued wrist pain. The record again noted no history of acute trauma or repetitive use. The diagnosis remained bilateral carpal tunnel. PX.1.

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21. On February 4, 2015, Davis filled out a "request for amendment" indicating that the October 21, 2014 medical record did not accurately state the history he provided to his doctor. Davis indicated that he told the doctor he performed repetitive work for 10 months with his hands including bending and deburring copper tubing with vibration, and he operated a lathe that affected his writs. PX.1.

22. Davis testified that he filed the "Notice to Amend" after his claim was denied. T.33. The doctor agreed to amend the record. T.33. He has not worked since. T.34.

23. On March 4, 2015, Judy Barker from Rockford Health authored a letter to Davis indicating that his "request for amendment" was accepted and his medical record was corrected by the physician. PX.1.

24. Per the corrected October 21, 2014 medical record, it was now noted that Davis performed repetitive work for 10 months using both hands at work. His symptoms were aggravated by repetitive use. The diagnosis remained bilateral carpal tunnel. PX.1.

25. An ergonomic report was completed on June 22, 2015 by Encore Unlimited. Per the report, a score of less than 3 was considered "safe" and a score higher than 7 was considered "hazardous." Scores between 5 and 7 required a "judgment call." The strain index for Davis' job as an assembler was 4.5 bilaterally, which was considered "low relative risk." The report indicated that an assembler's job duties required repetitive bilateral grasping, but the forces were primarily minimal. There was exposure to vibration during the deburring process, but 25-50 parts were deburred throughout the shift each taking 1 to 2 seconds with minimal vibration sensed. There was also downtime. The amount of task varied and built in downtime during the day was beneficial for minimizing the onset of muscular fatigue and risk of injury associated with repetition. The position did not require repetitive forceful exertions, forceful prolonged gripping, or the maintenance of non-neutral postures. RX.5.

26. Green testified that the video and ergonomic report accurately depicted the job duties. T.51.

27. Davis underwent a Section 12 examination with Dr. Taizoon Baxamusa of Illinois Bone & Joint at the request of his own attorney on September 24, 2015. Davis reported that he would bend tubing, which would require him to use his whole body, he would use a chop saw, and deburr tubing that caused vibrations. Davis was 6'1" tall and weighed 285 pounds. Examination revealed a positive Tinels bilaterally and a positive Phalen's on the right. X-ray revealed a mild ulnar positive variance and minimal degenerative changes of the trapeziometacarpal joint. The EMG from March 4, 2015 revealed a normal study on the left upper extremity with no prolongation of the motor or sensory latency of the median nerve in the left wrist. The right showed prolongation of the distal motor latency

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as well as sensory latency on the right median nerve consistent with moderate carpal tunnel. There was no evidence of denervation. The diagnosis was moderate right carpal tunnel that was causally related to his work duties. Dr. Baxamusa thought Davis should be referred to an upper extremity surgeon and would benefit from right carpal tunnel release. Regarding the left, Dr. Baxamusa noted that his condition should heal with conservative treatment. He could work full duty. PX.5.

28. Respondent obtained a Section 12 examination on December 11, 2015 from Dr. Prasant Atluri of Hand to Shoulder Associates. He confirmed the diagnosis of right carpal tunnel syndrome with numbness and tingling in the left hand that was possibly median neuritis. He noted that Davis had some exposure to forceful gripping and pinching when performing certain activities. The ergonomic analysis indicated that the exposure was substantially less than that described by Davis. He found that Davis' hand conditions were not work-related. Dr. Atluri based his opinion off of the video and written information. This was due to the relatively low frequency of exposure to gripping and pinching activities. The magnitude of the gripping activities was relatively low. Davis also had relatively minimal exposure to vibratory apparatus. He noted that if Davis was accurately reporting the frequency and intensity of his usual activities, then his opinion may change. Surgical intervention of the right hand was reasonable. For the left, he recommended cortisone injections and then possibly surgical intervention. RX.1.

29. Currently, Davis testified he has mild pain throughout the entire day and night. T.26. His hand will mainly go numb at night. His hand will cramp up when he uses a screwdriver and will go numb if he does something repetitively. He only gets 3 to 4 hours of sleep a night. *Id.* He experiences symptoms in both hand, but right worse than left. T.27. He has not seen a doctor since his EMG, but would like to undergo surgery. He did not have hand symptoms prior to working for Respondent, and was not previously diagnosed with carpal tunnel and never had a prior EMG. T.28. He is 43 years old and is not diabetic. He does not have thyroid issues, and does not smoke cigarettes. He formally smoked, but quit in July 2014. T.30.

An employee who alleges injury based on repetitive trauma must "show that the injury is work related and not the result of a normal degenerative aging process." *Peoria County Belwood Nursing Home*, 115 Ill. 2d at 530; *Edward Hines Precision Components v. Industrial Comm'n*, 356 Ill. App. 3d 186, 194, 825 N.E.2d 773, 292 Ill. Dec. 185 (2005). In repetitive trauma cases, the claimant "generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability." *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 477, 510 N.E.2d 502, 109 Ill. Dec. 634 (1987); see also *Johnson v. Industrial Comm'n*, 89 Ill. 2d 438, 442-43, 433 N.E.2d 649, 60 Ill. Dec. 607 (1982). In resolving disputed causation issues, it is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence (particularly the medical opinion evidence). *Hosteny v. Illinois Workers' Compensation*

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Comm'n, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999).

There is no requirement that a certain percentage of time be spent on a task in order for the [claimant's work] duties to meet a legal definition of 'repetitive.'" *Edward Hines Precision Components*, 356 Ill. App. 3d at 194. However, to prevail under a repetitive trauma theory, the claimant must establish that she performed "the same task in a repetitive fashion" "regularly or on a daily basis." *Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177, 185 Ill. Dec. 43 (1993). The question whether a claimant's work activities are sufficiently repetitive to establish a compensable accident under a repetitive trauma theory must be decided on a case by case basis upon the particular facts presented in each case. *Id.* at 210-11.

The Commission finds that the evidence establishes that Davis' work duties were repetitive in nature, and that his work duties were a cause of his current condition.

The Commission reviewed the job video and notes that Davis testified that the video did not accurately depict all of his job duties, and did not show all of his job duties he was required to perform. In addition to the video, Davis provided a detailed description of his job duties along with the percentages for each duty he performed. Green did not dispute the percentages.

Based upon its review of the video, the Commission notes that the video did not show the lathe machine in operation and did not appear to show deburring. Two activities that Davis testified he performed. The video did, however, reveal that the job duties required employees to use their hands on a frequent basis. The video also revealed that some of the duties required force to manipulate the tubing and to operate the machines.

Additionally, the Commission reviewed the ergonomic report and finds that it demonstrated that Petitioner's job duties exposed him to risk sufficient enough to be a cause in his condition. Per the ergonomic report, Davis was required to perform repetitive bilateral grasping and was exposed to vibration. While the forces were minimal and there was downtime, the report bolsters Davis' claim that he was exposed to vibration and repetitive grasping that required some force. The report indicated that the risk score for Davis was 4.5, while only a score under 3 was considered "safe." Per the report, this placed Davis at a "low relative risk" to the distal upper extremity. By the report's definition, Davis' exposure was over the safe level and closer to the "judgment call" level defined as a score of 5 or greater. The report demonstrated that Davis was exposed to forces and vibrations sufficient to be a cause in his condition.

The video along with the ergonomic report and Davis' testimony, confirm that Davis was required to use his hands on a frequent basis and was exposed to forceful gripping, pulling, pushing and vibration with the hands and wrist.

Furthermore, the medical records confirm that Davis' condition is causally related to his work duties. Davis first sought treatment on October 21, 2014, almost one month prior to his

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termination. While the original physician's notes reflect no repetitive use of the hands, Davis subsequently filed a request to amend the medical records based upon an error. The doctor granted the request and amended the report to indicate that Davis performed repetitive work. The medical record is supported by the ergonomic report and video, both of which demonstrate that Davis' job duties were repetitive in nature. The medical records also confirm that Davis did not have any significant co-morbid factors that contributed to the cause of his bilateral carpal tunnel.

Moreover, the Commission finds the opinion of Dr. Baxamusa more persuasive than Dr. Atluri's opinion. Dr. Baxamusa opined that Davis' job duties were a cause in his condition. His opinion was premised upon the history provided by Davis and his examination findings. The Commission, on the other hand, finds Dr. Atluri's opinion less persuasive. Dr. Atluri's opinion was premised partially upon the video and the ergonomic report, which he found did not support the description provided by Davis. As stated above, however, the video did not depict all of Davis' job duties and did not show all of the job duties actually being performed. Dr. Atluri acknowledged that if Davis' descriptions were accurate, then he may change his opinion. Given the video was not accurate, and Davis' percentages of work performed was confirmed by Green, Dr. Atluri's causation opinion must be given less weight than Dr. Baxamusa's opinion.

Accordingly, the Commission finds that Davis is entitled to prospective medical as recommended by Dr. Baxamusa. Davis is also entitled to all reasonable and necessary medical expenses related to his October 21, 2014 accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 1, 2016, is hereby reversed for the reasons stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay for prospective medical treatment as recommended by Dr. Baxamusa.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: JUN 22 2017

MJB/tdm
O: 5/2/17
052

Michael J. Brennan

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority. I would affirm Arbitrator Erbacci's thorough and well-reasoned decision in its entirety and without modification.

Kevin W. Lamborn

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

DAVIS, TROY
Employee/Petitioner

Case# **14WC040851**

HLAVA INDUSTRIAL WELDING INC
Employer/Respondent

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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:

1131 GESMER LAW OFFICES PC
BRAD A REYNOLDS
526 E JEFFERSON ST SUITE 118
ROCKFORD, IL 61107

2912 HANSON LAW OFFICE
KURT HANSON
6040 STATE ROUTE 53 SUITE B
LISLE, IL 60532

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
19(b)

Troy Davis
Employee/Petitioner

v.

Hlava Industrial Welding, Inc.
Employer/Respondent

Case # **14** WC **40851**

17IWCC0379

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rockford**, on **June 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. ☒ 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, **October 21,2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$15,131.77**; the average weekly wage was **$369.07**.

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

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

ORDER

The Petitioner failed to prove an accident arising out of and in the course of his employment by Respondent, and failed to prove a causal connection between the alleged accident and his condition of ill-being. The Petitioner's claim for compensation is, therefore, denied.

No benefits are awarded herein.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Arbitrator Anthony C. Erbacci

July 27, 2016
Date

AUG 1 - 2016

FACTS:

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The Petitioner testified that on October 21, 2014, he was employed by the Respondent as a general laborer. The Petitioner testified that he previously worked for the Respondent for a short time in 2013, and began working full-time for the Respondent again in January of 2014. Since that time, his duties included work building and assembling parts for refrigeration units.

The Petitioner testified that for the almost 11 months that he worked for the Respondent during the year of 2014, 60% to 80% of his work duties were in a section called liquid controls, with 20% of his responsibilities performing lathe work in the ice maker Lathe Cell.

The Respondent introduced an ergonomic report from Encore Unlimited, with corresponding video, dated June 22, 2015, demonstrating the work activities performed in the ice maker/lathe "cell," and the liquid control cell, which the Petitioner also identified as the "cell cutting tube." The first six minutes of the video depicts the work activities of "Making Coils" which the Petitioner testified he never performed.

In the cell cutting tube, the Petitioner utilized a chop saw to cut copper tubes that were ½, 1 inch and 2 inches in diameter. The Petitioner testified that the size of the tube would dictate the amount of pressure that may be used while using the chop saw, with smaller tubes requiring more pressure. The Petitioner testified that the number of cuts that he would have to make per day would vary, depending upon whether he was cutting tubes all day or only a portion of the day. The Petitioner indicated that with each use of the chop saw, he would experience some vibration, which would only last a couple of seconds per cut, and with less vibration depending on the size of the tube.

In this cell, the Petitioner would also perform deburring, which involved holding a piece of the copper tube against a deburring machine, with which the Petitioner testified he would experience some vibration, lasting a couple of seconds for each piece. The Petitioner testified that deburring could involve a couple of hundred pieces per day, but the amounts would vary.

The Petitioner also performed the duty of flaring tubes, which involved the use of a measuring device micrometer, and the job of bending tubes, which involved mounting copper tubes to a bender and pulling on a bender arm.

The Petitioner testified that he reviewed the ergonomic report, and the corresponding video, and indicated that he did not perform the depicted duties for the sandblasting in the "viper" cell. The Petitioner also testified that a portion of the work depicted in the lathe section was not performed by him, and he felt that a portion of his duties in this were not fully depicted on the video. The Petitioner also testified that he felt that the video only provided vague depictions of the actual work duties in this area, although on cross-examination he was unable to provide any specific examples of what duties were vaguely depicted.

Joe Green, a part owner of the Respondent's business, testified that he was the Petitioner's supervisor, and was familiar with all of the physical job requirements of the Petitioner's job duties., and had performed all of them himself. Mr. Green testified that he was the supervisor for the four

employees who worked with the Respondent and that, if a work accident occurred, or an absence from work was reported, it was to be reported to him.

Mr. Green testified that he reviewed the ergonomic report, and video, and felt that it accurately depicted the job activities of the demonstrated jobs. Mr. Green admitted that the sandblasting job duties depicted on the video may not have been performed by the Petitioner. Mr. Green also testified that he felt the Petitioner's testimony regarding his description of job activities was fairly accurate, although he disagreed with the Petitioner's estimate for the number of parts that he may have completed per day, and that the Petitioner would have to ever use his entire weight while bending the tubing, as he felt there was minimal pressure involved. Mr. Green did not agree with the Petitioner's testimony that he cut up to 300 to 400 tubes per day with the chop saw. Green testified that the shop itself only shipped between 50 to 250 pieces per week although he did acknowledge that the shop kept a "little bit" of inventory. Mr. Green testified that the Petitioner would cut on average 50 tubes per day. Mr. Green also disagreed with the frequency of changing the bit on the lathe machine. Green testified that the Petitioner would change the lathe machine bit one to two times per week rather than once per day. Mr. Green did acknowledge vibration while using a grinder or a hand file but testified it was for only a matter of seconds. Mr. Green testified that the vibration exposure while using the chop saw was minimal, as not much pressure was needed to push down the chop saw to make the cut, and that any vibration sensation would only last a couple seconds. Mr. Green also testified that the exposure to any vibration during the deburring process would only involve two to three seconds per each end of the tubing, and may be experienced 100 times per day, depending on the number of pieces that were produced.

The Petitioner testified that in September of 2014, he began experiencing symptoms with his hands at night while sleeping. He reported that his wrist pain would wake him, and he would have to shake his wrists in order to "shake off the pain." The Petitioner denied that he ever experienced these types of symptoms before in his lifetime. The Petitioner also testified that he was not diabetic, and had no thyroid issues. Although medical records document the Petitioner had a 20 year history of smoking, the Petitioner testified that he had quit smoking in the year of 2013. Based upon the medical records, the Petitioner was 6'1" and 285 pounds.

The Petitioner testified that he first sought medical treatment at a walk-in clinic on October 21, 2014. The medical records from Rockford Health indicate that the Petitioner saw Dr. Soufan and reported complaints of bilateral wrist pain, waking him at night, which was a chronic problem that started a month prior. The Petitioner reported no history of trauma, and that he had no diabetes, no osteoarthritis, no repetitive use, no gout, and no rheumatoid arthritis. The Petitioner was diagnosed with bilateral wrist pain and carpal tunnel on both sides, and bilateral wrist splints were provided, along with a prescription for Naprosyn. There is no indication the Petitioner was disabled from working.

The Petitioner testified that he continued working full duty, and that he did not report any issues involving his hands until November 20, 2014, at which time he contacted Joe Green of the Respondent and was advised that he had been terminated on November 18, 2014 due to absenteeism. Joe Green testified that the Petitioner had a history of unexcused absences from work and being late for work, and that he was terminated based upon a business decision for job abandonment.

Subsequent to his initial visit with Dr. Soufan, the Petitioner submitted a request to amend his initial medical record pursuant to HIPAA, and his request was approved. The corrected history included the Petitioner's statement that he performed repetitive work for 10 months, using both hands at work including cutting, bending, and burring copper tubing with vibration and operation of a lathe at a certain angle affecting both wrists. The remainder of the amended medical record including physical exam findings and diagnosis was the same. Petitioner was then seen in follow-up by Dr. Soufan on December 9, 2014 with continued complaints of pain, limited range of motion, numbness, stiffness and tingling in both hands. The diagnosis remained bilateral carpal tunnel syndrome and the Petitioner was referred for an EMG.

The Petitioner was seen at the request of the Respondent by Dr. Prasant Atluri on December 8, 2015. In Dr. Atluri's report, dated December 11, 2015, it was noted that the Petitioner reported that he first noticed symptoms in his hand in October of 2014, with numbness and tingling in his hands at night. The Petitioner reported that he was a general laborer, and had been working for the Respondent from January 2014 through November 2014. He reported that he had to cut copper tubes with a chop saw, deburr copper tubing with a motorized device, and bend tubing. He also would pull on a lever to operate a machine to widen the tubing, and operate a manual lathe to file down sharp edges. He described forceful gripping and pinching on a frequent basis. Dr. Atluri diagnosed a right carpal tunnel syndrome and numbness and tingling of the left hand, with a possible median neuritis. Dr. Atluri indicated that he reviewed the ergonomic report and corresponding video, including the sections for flaring tubes, and bending tubes. Dr. Atluri also noted the section involving the use of the operation of a circular saw while applying gentle pressure with the right hand while gripping a handle. Dr. Atluri noted the discrepancy in the work activities described by the Petitioner and those outlined in the report and video, but he also noted general agreement in the overall types of activities performed. While Dr. Atluri noted some exposure of forceful gripping and pinching, the ergonomic analysis indicated that those exposures were substantially less than claimed by the Petitioner. Although the Petitioner complained of prolonged exposure to vibratory equipment, Dr. Atluri noted that was not depicted on the video, and the exposure to vibratory apparatus was relatively minimal. With regards to medical causation, Dr. Atluri opined that if the written information and DVD accurately depicted the patient's work activities then the Petitioner's bilateral hand conditions would not be considered work related. Dr. Atluri acknowledged, however, that if the Petitioner's reporting of the frequency and intensity of his usual work activities was accurate, then his causal connection opinion could change. Dr. Atluri agreed that surgery for the right hand might be reasonable, and that conservative treatment for the left hand should be applied.

The Petitioner was seen at the request of his attorney by Dr. Taizoon Baxamusa on September 24, 2015. Dr. Baxamusa noted that the Petitioner reported that he was a general laborer who performed work, including use of a manual lathe, a chop saw, and deburring. Dr. Baxamusa reviewed the Petitioner's treating records and obtained a history from the Petitioner. Dr. Baxamusa noted that the Petitioner's initial employment involved brazing with welding rods and torches and he had little if any symptoms in his bilateral hands between July and October 2013. He noted that the Petitioner then returned to the employer in January 2014 and was placed in a different job which included manual lathing, chop saw, and deburring. Using the chop saw, deburring to take the edges off while using grinding wheels and multiple vibratory tools exceeded up to 100 times a day of vibratory exposure. It was also noted that the Petitioner bent copper tubing using his entire weight

and placing his wrists in certain positons right greater than left. the Petitioner reported that his symptoms were present at night but were also present during the day, especially with vibratory materials while working. Dr. Baxamusa found that the Petitioner had positive Tinel's of the bilateral medial nerves and positive Phalen's of his right wrist. He had an equivocal median nerve compression test on the left and a positive median nerve compression test on the right. Dr. Baxamusa reviewed electro diagnostic studies dated March 5, 2015 which were reported to demonstrate moderate carpal tunnel syndrome on the right with no prolongation of the motor or sensory latency of the median nerve on the left. Dr. Baxamusa diagnosed the Petitioner with moderate right carpal tunnel syndrome with a history of numbness and tingling of the bilateral hands. Dr. Baxamusa opined that there was a causal relationship between the Petitioner's right carpal tunnel syndrome and the Petitioner's work activities as described with use of vibratory tools, and with certain positions of the wrist, such as bending and cutting copper piping, which could be consistent with an occupational exposure. Dr. Baxamusa felt that the Petitioner might benefit from a right carpal tunnel release, but felt that conservative treatment may also be reasonable. Dr. Baxamusa did not believe that surgical treatment was indicated for the left wrist, and he did not comment upon causal relationship between the Petitioner's work activities and the condition of his left wrist. Dr. Baxamusa indicated that the Petitioner was capable of continuing to work full duty at his regular job.

The Petitioner testified at arbitration that he has not seen any other doctors for treatment since that time, but that he would like to proceed with right hand surgery. The Petitioner testified that he has not returned to, or attempted to return to, any other employment. The Petitioner did not testify that he had any work restrictions which prevented him from returning to any employment.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, and (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is axiomatic that the Petitioner bears the burden of proving all of the elements of his claim by a preponderance of the credible evidence. The Arbitrator also notes that a finding of causation in a repetitive trauma claim must be based upon competent medical evidence. Based upon the Petitioner's testimony, the opinions of Dr. Atluri, the available medical documentation and the ergonomic report and corresponding video, the Arbitrator finds that the Petitioner failed to prove an accidental injury arising out of and in the course of his employment by Respondent, or a causal connection between his work activities and claimed condition of ill-being.

In support thereof, the Arbitrator notes that no causation opinion from any of the Petitioner's treating physicians was offered into the record. Dr. Atluri, the Respondent's examining physician, opined that there was no causal relation between the Petitioner's reported work activities and his bilateral wrist pain. Dr. Atluri concluded that there was not sufficient evidence of forceful gripping or pinching, or exposure to vibratory materials that may lead to the development of the bilateral wrist

pain. The Arbitrator finds that Dr. Atluri's opinions are credible, reliable, and persuasive in the instant matter based upon the reports of the work activities by the Petitioner, in comparison to the ergonomic report and job video, which Dr. Atluri noted in detail in his report.

Dr. Baxamusa, the Petitioner's examining physician, opined that there was a causal relationship between the Petitioner's right carpal tunnel syndrome and the Petitioner's described work activities. Dr. Baxamusa expressed no opinion as to any causal relationship between the Petitioner's described work activities and the condition of his left hand. The Arbitrator notes that Dr. Baxamusa did not review the ergonomic report or job video, and his opinion is predicated upon a history by the Petitioner that he was exposed to significant use of vibratory apparatus at work and that his hands were in certain positions which may lead to the development of carpal tunnel, although those positions are never specified or identified, and those histories are not supported by the available facts.

The Arbitrator notes that although there are some discrepancies between the Petitioner's claimed activities, and the testimony of Joe Green and the ergonomic report with corresponding video, there is overall general agreement as to the type of work activities that the Petitioner performed. The Arbitrator notes further that while it is undisputed that the Petitioner would use his hands at work throughout the day, his exposure to vibratory tools was limited, per the testimony of the Petitioner and Joe Green. The Petitioner's exposure to vibratory tools was only for a couple of seconds each time, amounting to only minutes per day of any vibratory exposure, and was not sustained vibratory exposure. There is also limited evidence of required, repetitive forceful gripping activities using the hands and no evidence of heavy lifting. Dr Atluri's opinions and conclusions are consistent with these facts. Dr. Baxamusa does not appear to have had as complete or accurate an understanding of the Petitioner's actual job activities.

While the Arbitrator notes the opinions of Dr. Baxamusa, based upon the foregoing, the Arbitrator finds the opinions of Dr. Atluri to be more credible, reliable, and persuasive than those of Dr. Baxamusa in the instant matter and adopts the opinions of Dr. Atluri.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner failed to prove that an accident occurred which arose out of and in the course of his employment and failed to prove that a causal relationship exists between the Petitioner work activities for the Respondent and his current condition of ill-being.

In light of the Arbitrator's findings and conclusions with regard to the issues of accident and causation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIO MOYA,

Petitioner,

vs.

NO: 15 WC 07807

TOWN OF CICERO PUBLIC WORKS,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan on Petitioner's Petition to Strike Respondent's Petition for Review of Arbitration Decision 15 WC 007807 and for Penalties, Attorneys' Fees and Costs Pursuant to Sections 19(k), 19(l) and 16 of the Act, which was filed on May 23, 2017 and presented to Commissioner Brennan on June 23, 2017. After due consideration, the Commission finds as follows:

1. Petitioner had two claims pending at the Illinois Workers' Compensation Commission under claim numbers 15 WC 07807 and 15 WC 30570. These cases were heard on Arbitration before Arbitrator Molly Mason;

2. For purposes of trial, Petitioner consolidated claim numbers 15 WC 07807 (claim for right knee) and 15 WC 30570 (claim for back and right knee);

3. The parties proceeded on a Section 19(b) hearing in both claims before Arbitrator Mason on February 10, 2017;

4. At arbitration, the parties agreed to accept service of the Arbitrator's Decisions by email;

5. Arbitrator Mason entered two separate decisions under claim numbers 15 WC 07807

and 15 WC 30570, that were filed with the Commission on March 22, 2017;

6. The Commission emailed the Arbitration Decisions to both parties on March 23, 2017 (See Petitioner's Exhibit 2A and 2B);

7. Respondent subsequently filed its Petition for Review on April 26, 2017 with both claim numbers listed on the Petition for Review. Per the Petition, Respondent alleged that the Arbitrator's Decision was filed March 22, 2017 and that it was received on March 27, 2017; and,

8. Petitioner then filed his Petition to Strike Respondent's Petition for Review arguing that Respondent filed for Review two days past the statutory deadline under Section 19(b) of the Act, thus depriving the Commission of jurisdiction to hear said Review.

Pursuant to Section 19(b) of the Act:

> The decision of the Arbitrator shall be filed with the Commission which Commission shall immediately send to each party or his attorney a copy of such decision, together with a notification of the time when it was filed. As of the effective date of this amendatory Act of the 94th General Assembly, all decisions of the Arbitrator shall set forth in writing findings of fact and conclusions of law, separately stated, if requested by either party. ***Unless a petition for review is filed by either party within 30 days after the receipt by such party of the copy of the decision and notification of time when filed***, and unless such party petitioning for a review shall within 35 days after the receipt by him of the copy of the decision, file with the Commission either an agreed statement of the facts appearing upon the hearing before the Arbitrator, or if such party shall so elect a correct transcript of evidence of the proceedings at such hearings, then the decision shall become the decision of the Commission and in the absence of fraud shall be conclusive. 820 ILCS 305/19(b) (emphasis added).

In this claim, 30 days for the parties to file a Petition for Review of the Arbitrator's Decision in either claim was April 22, 2017. As April 22, 2017 was a Saturday, the parties had until Monday, April 24, 2017 to file a Petition for Review. The Commission finds that Respondent failed to timely file its Petition for Review – filing, instead, on April 26, 2017, two days after the statutory deadline.

Respondent argues that the Commission's email (see Petitioner's Exhibit 2A and 2B), dated March 23, 2017, was not "demonstrative of 'receipt'" and that it did not receive a hardcopy of the Decisions until March 27, 2017.

Section 9015.50(d) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission ("Rules") specifically states: "E-service shall be deemed complete as

of the filed date and time listed by the e-file system. For the purpose of computing time for any party to respond, any document served is deemed to be served the next business day following the date of transmission." 50 Ill. Admin. Code 9015.50(d). Section 9015.50(d) is consistent with Section 12(f) of the Illinois Supreme Court Rules which states, "Service by e-mail is complete on the first court day following transmission." *Ill. S. Ct. R. 12(f).*

Here, the clock began to toll on March 24, 2017, the next business day following the transmission of the Decisions by email, as agreed to by the parties. Therefore, the deadline for either party to file a Petition for Review was April 24, 2017, as the 30-day cutoff fell on Saturday, April 22, 2017, and as provided by the Rules.

The Commission affords no weight to Respondent's argument that March 27, 2017, the date on which Respondent's counsel received the hardcopy of the Arbitrator's Decision, was the date by which the 30-day countdown began. The Commission rejects this argument as the Respondent expressly consented to receiving the Arbitrator's Decision via e-mail.

Our Supreme Court addressed a comparable issue in *Gruszeczka v. Ill. Workers' Comp. Comm'n*, wherein the issue was whether the countdown to initiate a proceeding for review under Section 19(f)(1) of the Act begins when the request for summons is placed in the mail or when it is file-stamped by the circuit clerk. 2013 IL 114212. The Court held that "the date of mailing should control when a party seeks judicial review of a Commission decision." The Court also cited to the Appellate Court's opinion in *Norris v. Indus. Comm'n*, stating that, "a party may rely on the mailbox rule when seeking review of the arbitrator's decision before the Commission." 313 Ill. App. 3d 993 (3rd Dist. 2000). These cases are consistent with the electronic delivery rules of the Illinois Supreme Court and the Illinois Workers' Compensation Commission.

Respondent further argues that Petitioner's timely cross-Petition for Review encompasses both claims although only Claim No. 15 WC 30570 is listed in the caption. (See Respondent's Exhibit A). This argument is without merit as Illinois case law has long established that no blanket rule exists that would allow multiple claims to be consolidated in a single petition for review. This practice would not allow for adequate notice to an opposing party as to which case was being appealed, and would result in unwarranted prejudice to the party defending the claim. In this instance, this matter involves substantive concerns over form. *E.g. Chi. Transit Auth. v. Indus. Comm'n*, 238 Ill. App. 3d 202, 207 (1st Dist. 1992); *Shafer v. Ill. Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC.

The Commission further denies Petitioner's request for penalties under Sections 19(k), 19(l), and attorney's fees under Section 16 of the Act, as the Commission finds Respondent had good cause for its delay in the payment of benefits.

Therefore, it is the Order of the Commission:

1) That Petitioner's Petition to Strike Respondent's Petition for Review of Arbitration Decision 15 WC 00780 is hereby granted;

2) That Respondent's Petition for Review was not timely and review of Claim No. 15

WC 00780 is dismissed;

3) The Arbitrator's Decision in Claim No. 15 WC 00780 is hereby deemed final; and,

4) Petitioner's request for penalties under Sections 19(k), 19(l), and 16 of the Act is denied, at this time.

The party commencing 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:
MJB/pm
6/27/17

JUN 29 2017

Michael J Brennan

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

☒ 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

ZEFERINO A. HERNANDEZ MARTINEZ,

Petitioner,

17IWCC0419

vs.

NO: 15 WC 01708

FARMLAND FOODS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary total disability, and notice, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission, for the purpose of this Decision and Opinion on Review, expounds upon the Decision of the Arbitrator to address Petitioner's credibility.

The Decision of the Arbitrator concluded that Petitioner produced no evidence to corroborate his claim to having sustained an injury on October 4, 2014, that arose out of an in the course of his employment and specifically found Petitioner had provided histories to two medical providers on October 6, 2014, and October 9, 2014, respectively, that his symptoms had begun two weeks earlier and told another medical provider, on October 30, 2014, that he had been symptomatic for the past six months. The Commission takes specific notice of the medical records from October 9, 2014, finding that, on that day, Petitioner actually provided three differing dates as to when he became symptomatic.

Petitioner, on October 9, 2014, returned to the emergency room of OSF Holy Name Medical Center after being seen there only the day before. During this return visit, Petitioner, at 10:24pm, was recorded by an unknown person as stating that his symptoms began on October 2, 2014. At 10:36pm, a nurse, Molly Buckley, recorded Petitioner as stating that he had experienced pain in his right leg for the past week. Thirty-six minutes later, at 11:12pm, Dr. Kenneth Velez wrote of Petitioner complaining of pain in his right lower extremity for the past two weeks. The Commission notes that, not only did Petitioner not indicate to becoming symptomatic on October 4, 2014, Petitioner also failed to indicate that his complained-of symptoms were related to his work activities.

The Commission finds the only medical record in which October 4, 2014, is cited as the day Petitioner came to be injured comes from Dr. Robert Milas, Petitioner's current treating physician but questions how Dr. Milas arrived at October 4, 2014, as the date of onset of Petitioner's symptoms. A review of Petitioner's medical records would not indicate October 4, 2014, as the date of onset of Petitioner's symptoms as noted above. As also noted above, Petitioner revealed himself to be a poor historian. With no other possible source, the Commission concludes Dr. Milas learned the details of Petitioner's claimed injury and claimed symptoms by way of the engagement letter he received from Petitioner's attorney.

The Commission also finds Petitioner to be an equally poor historian with respect to what he was allegedly doing when he was injured as he was with respect to the date of the claimed accident. He provided what is referred to as a job description and that indicates his work activities were to repetitively lift, twist, turn, reach for, push, and pull between ten and thirty-five pounds. He testified that the job description accurately described the work activities he performed on October 4, 2014, He, however, went onto conflictingly testify that, on October 4, 2014, his work activities consisted of twisting to retrieve boxes that he then filled first with paper and then with 3½ pounds of bacon and before pushing the filled box down the assembly line. The Commission finds it more credible that Respondent employed Petitioner to fill empty boxes than simply lifting, pushing, and pulling already filled boxes and less credible that Petitioner would have sustained a disc herniation from twisting and lifting an empty box and then pushing a filled box down an assembly line.

Petitioner's apparent inability to identify the specific date on which he was injured combined with his inability to testify consistently as to what his employment with Respondent entailed leads the Commission to conclude that his testimony is not credible nor are any medical opinions that rely on Petitioner being credible. The Commission, as did the Arbitrator, finds Petitioner failed to prove that he sustained an accident on October 4, 2014, that arose out of and in the course of his employment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 17, 2015, is hereby affirmed and adopted.

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.

JUN 29 2017

DATED:
KWL/mav
O: 05/22/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0419

ZEFERINO A HERNANDEZ MARTINEZ
Employee/Petitioner

Case# **15WC001708**

FARMLAND FOODS
Employer/Respondent

On 12/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5038 BRIBRIESCO LAW FIRM PLLC
ANDREW W BRIBRUESCO
2407 18TH ST SUITE 200
BETTEBDORF, IA 52722

5354 STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

17IWCC0419

Zeferino A. Hernandez Martinez
Employee/Petitioner

v.

Farmland Foods
Employer/Respondent

Case # 15 WC 001708

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **November 4, 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, **October 4, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 N/A causally related to the accident.

In the year preceding the injury, Petitioner earned **$29,705.52**; the average weekly wage was **$571.26**.

On the date of accident, Petitioner was **54** years of age, ***single*** with **1** dependent children.

Respondent is not responsible for any medical in this case.

Respondent has paid no TTD in this case.

ORDER

1. **The Arbitrator finds that the Petitioner failed to establish an accident which arose out of and in the course of employment with the Respondent.**
2. **All other issues become 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.

D. Dyas McCarty

Signature of Arbitrator

12/14/2015

Date

DEC 17 2015

Findings of fact

1. The Petitioner is 55 years old and lives in Monmouth, Illinois. The Petitioner began his employment with the Respondent in July of 2008.

2. The Petitioner testified that the Respondent's business was a process pork company. The Petitioner testified that at the time of trial his employment had been terminated by the Respondent.

3. The Petitioner testified on October 4, 2014, his job title is that of a slab-bacon line 3. The Petitioner testified that his job duties were fast paced. The Petitioner testified he was required to work with boxes and move in rapid motion.

4. The Petitioner testified he worked with bacon and placed them in boxes. The Petitioner testified that the boxes were about 25 pounds. The Petitioner was responsible for moving the boxes down the assembly line.

5. The Petitioner testified as a part of this slab bacon line3 he was required to twist his body and move his back. The Petitioner would move items at the Respondent's place of business in a rapid fashion.

6. The Petitioner identified Deposition Exhibit 3 of Dr. Milas' deposition testimony as a job description that he and his attorney prepared. During cross examination, the Petitioner identified that the job duties provided in that prepared job description were duties that he did on a varying basis. The Petitioner testified during cross examination that the tasks and job titles he did for the Respondent leading up to October 4, 2014, varied day in and day out.

7. The Petitioner testified that on October 4, 2014, he was performing his normal duties for the Respondent. Towards the end of the shift, he noticed a pull in his back and a cool sensation down to his leg. The Petitioner was able to perform his work activities with the respondent on October 4, 2014. the Petitioner testified he did not report any work accident to any personnel of the Respondent on that date.

8. The Petitioner testified he went home and took Aleve. On October 5, 2014, was a Sunday. The Petitioner testified it was on October 5, 2014, when he felt immediate and excruciating pain running from his hip down to his foot. Petitioner testified that this pain developed on October 5, 2014. The Petitioner testified that this pain developed on October 5, 2014. On October 6, 2014, the Petitioner was seen at Knox Clinic Corporation by Dr. Johnson. The Petitioner's Exhibit No. 2, page 9, reveals the history the Petitioner gave was having right buttock pain running down is leg It had been going on for two weeks. The Petitioner advised that the pain had gotten worse over the weekend to the facility at

Knox Clinic Corporation. (Pet. Exh. 2, p. 9) The Arbitrator notes that the records of Dr. Johnson are void of any described work accident occurring on October 4, 2014.

9. The Petitioner testified that he went to Farmland Foods in the afternoon of October 6, 2014. He said that reported his work accident to Bianca Fox, a human resources representative for the Respondent. He said that she did not fill out an accident report at that time.

10. October 9, 2014, the Petitioner was seen at Holy Family Medical Care. The Arbitrator notes the history the Petitioner gave to this facility on October 9, 2014, was that the Petitioner advised him that there was no injury mechanism. (Pet. Exh. 5, p. 58)

11. On October 11, 2014, the Petitioner returned to Dr. Johnson. The Arbitrator notes that the history provided to the Knox Clinic Corporation on October 11, 2014, was void of any work injury. (Pet. Exh. 2, page 13)

12. On October 17, 2014, the Petitioner returned to the Knox Clinic Corporation. The Arbitrator notes that the history the Petitioner gave this facility did not contain a described work-related injury occurring while working for the Respondent. (Pet. Exh. 2, page 18)

13. On October 27, 2014, the Petitioner returned to Knox Clinic Corporation. The Petitioner was referred to Dr. Fassett at INI Neurosurgery facility in Peoria. The Arbitrator notes that the Petitioner did not provide a work accident history to the Knox Clinic Corporation on October 27, 2014. (Pet. Exh. 2, page 25)

14. On October 30, 2014, the Petitioner was seen by Dr. Fassett. On October 30, 2014, Dr. Fassett took a history from the Petitioner. The Petitioner advised Dr. Fassett on October 30, 2014, that he had severe back pain and right lower extremity pain ongoing over the last six months. The Petitioner provided a history to Dr. Fassett on October 30, 2014 that his pain has gotten more severe over the last three months. The Arbitrator notes that there was no work accident described to Dr. Fassett on October 30, 2014, by the Petitioner. (Pet. Exh. 4, page 30)

15. The Petitioner testified that Dr. Fassett performed surgery on November 4, 2014. The Arbitrator notes the surgery performed by Dr. Fassett was an L5-S1 hemi-laminectomy, medial facetectomy, discectomy, decompression of S1 and L5 nerve roots.

16. The Petitioner testified that he went through physical therapy after surgery. The Petitioner testified that his therapy went up to March 15, 2015. The Petitioner was looking for some type of occupational therapy as of March 15, 2015, but could not get the same authorized.

17. The Petitioner testified in April of 2015, he was sent to Dr. Milas at his attorney's request. Dr. Milas testified in this case.

18. Dr. Milas saw the Petitioner on April 9, 2015. Dr. Milas took a history and looked at the medical records. Dr. Milas noted the Petitioner underwent a surgical procedure with Dr. Fassett. This was a lumbar discectomy. Dr. Milas testified on direct examination that he felt the Petitioner's disc was

caused by his work activities at Farmland Foods.

19. On cross examination Dr. Milas admitted he did not know the specifics of the Petitioner's job activities. Dr. Milas further testified he is unaware of any specific complaints the Petitioner had predating October 4, 2014.

20. Dr. Milas testified that if the Petitioner did indeed have prior complaints predating October 4, 2014, this could change his opinions on causation. Dr. Milas further testified that if the Petitioner had prior treatment to his low back predating October 4, 2014, this could change his opinions on causation in this case.

21. Dr. Milas testified on cross examination that he believed the accident date in this case was October 4, 2014. Dr. Milas did not testify that there was any type of repetitive-type trauma that occurred to the Petitioner's back.

22. Dr. Milas was unaware of any type of verbal history that the Petitioner may have given the provider indicating his low back pain was insidious. Dr. Milas would have liked to look at that document if indeed it exists.

23. Dr. Milas admitted that he did not review the records of Galesburg Cottage or Trinity Medical Center.

24. Dr. Milas testified the Petitioner may not be at maximum medical improvement. Dr. Milas did not get any information from Farmland Foods to perform his independent medical examination in this case.

25. Dr. Milas saw the Petitioner one time. Dr. Milas testified he did not have all the complete records.

26. The Petitioner testified he was seen by Dr. Zelby at the Respondent's request. This was performed on July 22, 2015. Dr. Zelby's opinions were that to a reasonable degree of neurosurgical certainty. Dr. Zelby performed an independent medical examination which included taking a history, performed a physical examination and reviewed diagnostic tests. Dr. Zelby was of the opinion that the Petitioner was suffering from the following conditions: (1) Lumbar Degenerative Disc Disease, (2) Herniated Lumbar Disc, and (3) History of Lumbar Microdiscectomy.

27. Dr. Zelby noted in his report that the records revealed the Petitioner did not report any work injury or work activity that caused this condition to the initial treating physicians. Dr. Zelby felt this was important in determining whether or not this was a work-related condition. He also opined that if the Petitioner was injured on a specific date as alleged, and the injury resulted in a large disc herniation, as was the case, he would have noticed more immediate symptoms.

28. Dr. Zelby felt the Petitioner was safe to return to work and was at maximum medical improvement. Dr. Zelby noted that Dr. Fassett indicated the Petitioner should be able to return to work three months after surgery.

ARBITRATOR'S FINDINGS

Based off the foregoing, the Arbitrator finds that it is significant to note the inconsistent histories provided by the Petitioner to multiple medical care facilities. In fact, the Arbitrator notes that the Petitioner testified that he provided Farmland Foods the same history he gave the medical professionals within the month after the alleged accident. The Arbitrator notes that the medical records a month after the accident contact no history of any work injury.

The Petitioner testified that he had to work harder than usual on October 4 because his line was short a worker. He said that he did something that day which caused pain in his lower back. He said that he kept working, but noticed an increase in symptoms in his back with radiation down the right leg before he left work for the day. He said that on the following day, Sunday, while at home, his symptoms intensified, causing him to seek medical care on October 6, 2014.

Despite his claims concerning the recent onset of symptoms while at work, the records from his medical providers do not contain any history of injury. He told the provider at the Know Clinic on October 6 that he'd had symptoms for two weeks. He was seen at OSF St, Mary's three days later and said the pain had been present for two weeks and there was no injury mechanism. He told Dr. Fassett, his neurosurgeon, at his first visit on October 30 that his pain began six months earlier. While there could have been some problems in the medical histories due to translation issues, the Arbitrator does not believe those issues would have been present on three occasions to three different providers.

The Arbitrator also does not believe the Petitioner reported his accident to human relations as alleged. He began medical treatment on October 6 and did not work for the Respondent from that day forward. He had follow up care, an MRI and ultimately surgery long before the Respondent's insurance representative sent him documents to complete. If he had reported his accident on October 6, it is much more likely some investigation would have taken place, including contacting him for follow up information, prior to November 26, the date the insurance forms were first sent.

While the Petitioner is alleging an accident at work on October 4, 2014, he has produced no evidence to corroborate his allegations. In fact, all of the relevant evidence supports the Respondent's position that no accident occurred.

The Petitioner has failed to prove an accident arising out of and in the course of his employment.

Thus, all benefits are denied.

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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Dunham,

Petitioner,

vs.

NO: 15 WC 2059

17IWCC0385

Illinois Department of Corrections,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses and nature and extent, and being advised of the facts and law, affirms 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, with the following three changes:

1. The analysis of the second factor reviewed under section 8.1b of the Act is replaced with the following:

   (ii) The occupation of the injured employee:
   Petitioner is a corrections officer whose job requires him to spend 80% of his time on his feet and 15% of his time using stairs. Petitioner has been able to work without restriction since three weeks after his workplace injury. However, even two years after his injury, he testified that his work causes him discomfort or "burning" pain and that he often compensates by shifting his weight while standing. Both of these problems would be compounded by the extensive standing and stair-climbing required by Petitioner's occupation. This factor receives considerable weight in Petitioner's favor.

17IWCC0385

2. The analysis of the third factor is clarified to indicate that it receives moderate weight "in Petitioner's favor."

3. The analysis of the fourth factor is clarified to indicate that it receives moderate weight "in Respondent's favor."

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 12/9/16 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $682.94 per week for a period of 25.05 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 15% of the right foot.

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

DATED: JUN 26 2017
o:5/25/2017
TJT/knc
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNHAM, DAVID
Employee/Petitioner

Case# **15WC002059**

IL DEPT OF CORRECTIONS-DANVILLE CORRECTIONAL CENTER
Employer/Respondent

17IWCC0385

On 12/13/2016, 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 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1937 TUGGLE SCHIRO & LICHTENBERGER
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PO BOX 19255
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1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA J SMITH
500 S SECOND ST
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
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

DEC 13 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Champaign)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

David Dunham
Employee/Petitioner

v.

Illinois Department of Corrections-Danville Correctional Center
Employer/Respondent

Case # **15** WC **002059**

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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Urbana**, on **November 17, 2016**. By stipulation, the parties agree:

On the date of accident, **07/07/14**, 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 **$59,187.82**, and the average weekly wage was **$1,138.23**.

At the time of injury, Petitioner was **54** years of age, ***single*** with **0** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent and all bills have been or will be paid. Respondent is entitled to a credit for any medical bills paid through its group medical plan and Respondent agrees to hold Petitioner harmless for said bills.

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

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

ORDER

Respondent shall pay Petitioner the sum of **$682.94**/week for a further period of 25.05 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused a **15% loss of use of the right foot.**

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

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

D. Dylan McEarty 12-9-2016

DEC 13 2016

I. STATEMENT OF FACTS and CONCLUSIONS OF LAW

On July 7, 2014, while working as a Correctional Officer at Danville Correctional Center, Petitioner David Dunham suffered an injury when he came upon a 220 pound inmate in cell 78 who was trying to hang himself. During efforts to lift the inmate, Petitioner's foot slipped causing injury to his foot and ankle. Petitioner noticed a slight burning sensation and testified that his foot and ankle began to swell. Petitioner testified that other than the avulsion fracture in 2010 he had not had any problems with his right ankle prior to the accident date.

Petitioner testified that his job duties require him to be on his feet for approximately 80% of the day. 15% of the day was spent going up and down stairs. Other activities include standing, walking, packing property, bending and lifting.

On July 24, 2014, Petitioner sought treatment at Orthopedic Partners in Danville, Illinois.(RX 1) At the time of this visit, it was noted that Petitioner denied any frank trauma but had pain over the medial aspect of his ankle and in the arch of his foot since the incident. Petitioner also advised that the pain was worse with standing and walking and that he noticed swelling in his ankle and foot. Upon examination, the doctor noted that Petitioner had significant pes planus, or flatfoot deformity, and noted that Petitioner had a valgus heel stance when standing. An x-ray of the right foot and ankle confirm that Petitioner had significant pes planus and also indicated osteoarthritic changes of the fibular talar joint and subtalalr joint osteoarthritis. (RX 1).

Also on July 24, 2014, it was noted that a lengthy discussion was held with Petitioner regarding the acute injury on top of a chronic condition and an orthotic was recommended to prevent varus or valgus motion in the heel to protect the hindfoot with an arch support. A referral to an orthopedist was also recommended. (RX 1).

On August 14, 2014, Petitioner had one follow up visit at Orthopedic Partners where it was noted that he had less pain and swelling and notes pain mainly with first few steps of the day that Petitioner described as a "burn" rating his pain 4/10. Again, a referral to an orthopedist was discussed. (RX 1).

On October 15, 2014, Petitioner saw Dr. Idusuyi at the Orthopedic Center of Illinois in Springfield, Illinois. (PX 2). Petitioner described his pain as occurring on the medial side of his right ankle after work or with activities. Moderate swelling was noted in his ankle. Petitioner had been using custom shoe inserts with minimal relief. Dr. Idusuyi noted that the imaging of the foot and ankle were negative for acute fracture or dislocation and noted a planovalgus deformity. (PX 2). Dr. Idusuyi assessed Petitioner's injury as a Stage 3 posterior tibial tendon dysfunction (complete rupture) right foot. (PX 2). Dr. Idusuyi discussed treatment options including a surgical reconstruction of the posterior tibial tendon and an ankle foot orthosis. Petitioner indicated that he would like to proceed with the brace option rather than surgery. (PX 2).

On December 22, 2014, Petitioner underwent an Independent Medical Examination with orthopedic surgeon, Dr. Joseph Monoco. After a review of the relevant medical records, a physical examination of Petitioner and a history of the accident and injury taken from Petitioner, Dr. Monaco opined that "it is unlikely that Mr. Dunham actually twisted the ankle significantly into a varus or valgus attitude. This is certainly something he would have noted specifically. As noted above, Mr. Dunham does have significant pes planofalgus deformity of both feet. He denied any problems with the feet prior to his work-related incident other than the fact that he feels soreness in both feet at the end of the day." (PX 6, p. 9). Dr. Monaco also found

that Petitioner's complaints of a burning sensation were consistent with pes planovalgus deformity and subsequent incompetency of the posterior tibial tendon.

Dr. Monaco concluded that "as a result of the work-related incident of July 7, 2014, Mr. Dunham has a strain of the posterior tibial tendon on the medical aspect of his foot and ankle. The x-rays taken at the time did not show any evidence of acute fracture, dislocation, or trauma. There was evidence of significant pre-existing degenerative changes of the foot and ankle that would be expected with rather severe rigid flatfoot deformity. The x-rays showed significant osteoarthritis of the subtalar joint with degenerative changes of the tibiotalar joint with much more mild changes involving the first metatarsophalangeal joint with hallux valgus. All of these conditions pre-existed the work-related injury and were not caused by the work-related injury of July 7, 2014. With a chronic condition such as rigid hindfoot valgus and ankle valgus, a Stage III-IV flatfoot deformity, inflammation, degeneration and resulting incompetence of the posterior tibial tendon would be expected. Therefore, it is my opinion, to a reasonable degree of medical certainty, based upon a review of the medical records and my evaluation here today, that as a result of the work-related injury of July 7, 2014, Mr. Dunham had a strain of the posterior tibial tendon." (PX 6, p.9-10).

Dr. Monaco opined that a surgical reconstruction of the tibial tendon was not indicated as he was improving and functioning well at the time of the IME and the physical examination showed no discomfort with strength testing, range of motion testing and no limp. (PX 6, p. 10). Dr. Monaco explained that Petitioner was functioning well by working his regular job and walking without a limp and taking no medication for pain which indicated a good chance that the problem would improve with or without the use of a brace but agreed that there could be value in increasing his function with an ankle foot orthosis. However, Dr. Monaco indicated that it would be unlikely that Petitioner would have to wear the brace for the rest of his life due to his level of improvement and functioning. (PX 6, p. 11).

Petitioner's brace is depicted in Exhibit 5 and was viewed by the Arbitrator. The brace covers the lateral side of Petitioner's ankle and extends down into the boot and halfway up the calf. The left side of the brace does not extend up. Petitioner testified that the boot rubs the skin on his ankle and is uncomfortable at times.

Petitioner testified that he did not miss any work but was on light duty in the mailroom for three weeks after the accident and then returned back to performing his regular job but that he no longer performs overtime. Petitioner testified that he notices a burning sensation that caused discomfort and prohibits him from running. Petitioner testified that, every now and then, he takes Advil and that he does not go mushrooming in the woods or play any sports. Petitioner testified that at the end of a work day, he has a slight burn and he tries to shift his weight to his other foot throughout the day. Petitioner also noted that he has not regained his strength back and that he has to buy shoes in a larger size to accommodate the brace. Petitioner testified that he has flat-footedness but it never bother him previously. Petitioner testified that he had a previous injury to his right ankle resulting in a chip fracture. Records from Orthopedic Partners indicated that on March 30, 2010, Petitioner was treated for an avulsion fracture of his medial malleolus of his right ankle while playing basketball and was put in a fracture boot. The examination noted that Petitioner is "extremely flatfooted on exam." (PX 1). A review of the x-rays note that it is uncertain if the avulsions or chips were new or old and it was noted that "I am not convinced that this is at all a recent injury." (PX 1). On April 27, 2010, Petitioner was again seen at Orthopedic Partners for continued right ankle pain. Petitioner was recovering from the possible avulsion fracture and at this time was released from care with no work restrictions noting that he continued to have a burning sensation when stressing the ankle. (PX 1).

Petitioner testified that he was able to perform all of his job duties and that he never asked for any accommodations or modifications of his duties because of the accident. Other than to have his brace fitted, Petitioner has not returned to the doctor since October 15, 2014 and has not experienced any other problems

with his foot or increases in pain. Petitioner did not have to undergo any physical therapy and testified that he did was not denied a promotion or raise since the accident.

II. CONCLUSIONS OF LAW –NATURE AND EXTENT

The Arbitrator takes note of Section 8.1(b), which sets forth the criteria for determining permanent partial disability.

(i) The reported level of impairment pursuant to subsection (a) (AMA rating):

None.

(ii) The occupation of the injured employee:

The Arbitrator notes Petitioner is a Corrections Officer for the Danville Correctional Center and that his job requires 80% of the time to be on his feet and 15% going up and down stairs. Petitioner had not had to modify his work duties and has been able to perform full duty since 3 weeks after the accident. As he has to be on his feet most of the work day, the Arbitrator gives considerable weight to this factor in the Petitioner's favor.

(iii) The age of the employee at the time of the injury:

The Arbitrator notes Petitioner was 54 years old. This factor is entitled to moderate weight as the Petitioner is neither a younger individual nor one who is closely approaching a normal retirement age.

(iv) The employee's future earning capacity:

Petitioner testified that he was not denied a promotion or raise since the incident. This factor weighs for the Respondent.

(v) Corroboration of disability in medical records:

Petitioner has not returned to the doctor since 2014 when he received his brace. Respondent's doctor testified that Petitioner would not have to wear the brace for the rest of his life and would continue to improve.

Dr. Idusuyi, an orthopedic specialist, treated the Petitioner beginning in October 2014, just over three months from the accident. At that time, the Petitioner had objective examination findings including bogginess over the posterior tibial tendon, a positive single heel rise test, maximal tenderness over the medial ankle and hindfoot over the region of the posterior tibial tendon, limited range of motion and walking with an antalgic gait. Based upon the examination and history, the doctor diagnosed a complete rupture of the posterior tibial tendon. (PX 2)

When the Petitioner was seen two months later by Dr. Monaco he continued to display very similar examination findings. He had mild swelling over the medial malleolus, weakness performing the single raise test and tenderness to palpation over the PT tendon. The doctor noted that the Petitioner's subjective complaints were consistent with his objective findings. (PX 6)

This factor favors the Petitioner's claim.

Based upon the above, the Arbitrator finds that Petitioner sustained 15% loss of use of the right foot.

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

Angel Fuentes,

Petitioner,

vs.

NO: 15 WC 4527

17IWCC0386

Marriott International,

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, 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 October 5, 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.

17IWCC0386

The party commencing 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: JUN 26 2017
TJT:yl
o 5/16/17
51

Kevin W. Lamborn

Michael J. Brennan

DISSENT

In order for an injury to be compensable under the Workers' Compensation Act, the injury must "arise out of" and "in the course of" the employment. (Ill. Rev. Stat. 1987, ch. 48, par. 138.2.) The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. *Orsini v. Industrial Comm'n* (1987), 117 Ill. 2d 38, 44.

Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to arise in the course of the employment. *Mores-Harvey v. Industrial Commission*, 281 Ill.Dec. 791, 804 N.E.2d 1086 (Ill.App.3 Dist. 2004); citing *Caterpillar Tractor Industrial Commission*, 129 Ill.2d 52, 57, 133 Ill.Dec. 454, 541 N.E.2d 665, (1989); *Doyle v. Industrial Commisison*, 95 Ill.2d 103, 106, 447 N.E.2d 310, 69 Ill.Dec. 93 (1983).

However, where an employee slips and falls at a point off of the employer's premises while traveling to and from work, the resulting injuries will not be considered to have arisen out of and in the course of the employment unless (1) the injuries were sustained in a parking lot provided by and under the control of the employer or (2) the employee's presence at the place where the accident occurred was required in the performance of his or her duties and the employee is exposed to a risk common to the general public to a greater degree than other persons. *Illinois Bell Telephone Co. v. Industrial Commission*, 131 Ill.2d 478, 484, 546 N.E.2d 603, 137 Ill.Dec. 658 (1989); *Mores-Harvey*, 345 Ill.App.3d at 1037-38.

Slips or falls on an employer-provided parking lot when hazardous conditions are present are generally compensable. See *Archer Daniels Midland Co. v. Industrial Commission*, 91 Ill.Dec. 210, 217, 437 N.E.2d 609, 62 Ill.Dec. 921 (1982) (injury arose out of and in the course of employment where employee slipped on ice while walking from employer's parking lot through gate to plant grounds because injury resulted from a risk incident to employment); *Hiram Walker & Sons v. Industrial Commission*, 41 Ill.2d 429, 431, 244 N.E.2d 179 (1968) (injury arose out of and in the course of employment where the claimant injured his hand after he slipped and fell in snowy and icy company parking lot after he had parked his car in the lot because "his presence in the lot was due entirely to his employment"); *De Hoyos v. Industrial Commission*, 26 Ill.2d 110, 114, 185 N.E.2d 885 (1962) ("an employee who falls on a parking lot provided by his employer while proceeding to work, we believe, is subjected to hazards to which

the general public is not exposed"). The rationale for awarding compensation is that the employer-provided parking lot is considered part of the employer's premises. See 1 L. Larson, Larson's Workers' Compensation Law § 13.04[2][a], [b], at 13--40-13--41 (2002).

The *Mores-Harvey* case, supra, is particularly instructive in the case at bar. That case involved a slip and fall on snow/ice that was found to be compensable given the hazardous condition (snow/ice) and restricted parking choices of the employees. As in the present case, the claimant in *Mores-Harvey* was directed by his employer as to where to park in the parking lot that surrounded the employer's suburban location. The court found that the claimant's injuries arose out of her employment, noting that "[a]lthough the general public was free to park anywhere in the lot, claimant's choices were restricted... [and] [b]y restricting where claimant could park her vehicle, the employer exercised control over its employee's actions. In this way, the employee faced risks to a greater extent than the general public." *Mores-Harvey*, 804 N.E.2d 1086, 1093.

The *Mores-Harvey* court also rejected the argument that it would be adopting the positional risk doctrine if it found in favor of the claimant, noting that the doctrine involves an injury caused by a neutral risk (See *Brady v. Louis Ruffolo & Sons Construction Co.*, 143 Ill.2d 542, 55253, 578 N.E.2d 921, 161 Ill.Dec. 275 (1991)) and that it "... need not address employer's argument [in this regard] at length because claimant's fall resulted from a hazardous condition on employers' premises. In other words, her fall resulted from an employment-related risk and not a neutral force." Id., 1093-1094.

In the present case, the risk of injury was similarly employment-related. Thus, a neutral risk analysis need not be applied. (See *Steak 'n Shake v. Illinois Workers' Compensation Commission*, 67 N.E.3d 571, 409 Ill.Dec. 359 [3rd Dist. 2016]; *Mytnik v. Illinois Workers' Compensation Commission*, 67 N.E.3d 946, 409 Ill.Dec. 491 [1st Dist. 2016]).

Since the Arbitrator appears to focus on the personal benefit derived by the Petitioner in engaging in the activity in question and failed to adequately consider the employment related risks involved – namely, the condition of a parking lot owned and/or maintained by the Respondent and the amount of control Respondent exercised over its employees with respect to where they parked – I would reverse the decision of the Arbitrator and find that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment. And for that reason, I respectfully dissent.

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FUENTES, ANGEL
Employee/Petitioner

Case# **15WC004527**

MARRIOTT INTERNATIONAL
Employer/Respondent

17IWCC0386

On 10/5/2015, 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 0.10% 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:

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2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE M JAGODZINSKI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602-4195

17IWCC0386

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

ANGEL FUENTES,
Employee/Petitioner

Case #15 WC 04527

v.

Consolidated cases:

MARRIOTT INTERNATIONAL,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DAVID KANE**, Arbitrator of the Commission, in the city of **CHICAGO**, on **September 22, 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

17IWCC0386

On **2/1/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,415.13**; the average weekly wage was **$681.06**.

On the date of accident, Petitioner was **32** years of age, ***single*** with **3** dependent children.

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

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

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

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

ORDER

Denial of benefits

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.

David A. Kane
Signature of Arbitrator

October 5, 2015
Date

OCT 5 - 2015

STATE OF ILLINOIS)
) SS 17IWCC0386
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angel Fuentes

Petitioner,

v.

Marriott International

Respondent.

Court No. **15 WC 04527**

Findings of Fact and Conclusions of Law
Memorandum of Arbitrator's Decision

I. Statement of Facts

Angel Fuentes testified that he works as a maintenance engineer for Renaissance Convention Center in Schaumburg, Illinois. He has worked for the Renaissance for 8 years. His job duties included answering guest calls, changing refrigerators, painting, changing light bulbs, as well as other maintenance work.

On February 1, 2015, Mr. Fuentes testified that he worked from 7:00 a.m. to 3:30 p.m. He then punched out and walked to the south parking lot to a parked vehicle where his wife waited to pick him up. Mr. Fuentes stated that he reached in his pocket to remove his cell phone and a couple

dollars felt out. The money blew in front of his car. He testified that he walked to get the money, bent down, and slipped and fell onto his back. Mr. Fuentes stated that there was snow on the ground and it was packed down. He testified that he had the wind knocked out of him and strong low back pain after he fell.

Mr. Fuentes testified that associates park in the south parking lot where he fell. If he did not park in that location, he would be disciplined. Mr. Fuentes acknowledged that a video camera was present near the area where he fell. This camera was located by the parking lot close to a smoking area where associates smoke. Mr. Fuentes stated that he knew the incident was videotaped, but he did not see the video.

After his fall, Mr. Fuentes testified that he presented to St. Alexius Medical Center. He then sought treatment at Alexian Brothers Medical Group and was referred to Dr. Babak Lami. Dr. Lami ordered physical therapy. Mr. Fuentes stated that he then elected to treat at Midwest Bone and Joint Institute. He agreed that his diagnosis was low back pain with radiculopathy. He underwent MRI studies and attended physical therapy. Mr. Fuentes stated that physical therapy helped his low back. He was released from treatment in May, 2015. Mr. Fuentes stated that he did not lose any time from work as his employer provided light duty work. While on light duty, he folded towels in the housekeeping department and unpacked boxes.

On direct-examination, Mr. Fuentes testified that he has low back pain and takes over the counter medication. He noted that he does have a pre-existing condition called ankylosing spondylitis. He claimed that his ankylosing spondylitis became worse after this incident.

On cross-examination, Mr. Fuentes stated that he was not directly in front of his vehicle when he fell, but he was close to his car. When asked whether he jogged to get his money, Mr. Fuentes denied jogging and testified that he is barely able to walk, let alone jog. Mr. Fuentes agreed that it was his choice to pursue the money after it blew out of his pocket. He also admitted that he had safely made it to his vehicle before he decided to chase after his money.

Mr. Fuentes agreed that he had low back pain and stiffness before February 1, 2015 as evidenced in the records of Midwest Orthopaedics at Rush. Every six weeks, Mr. Fuentes testified that he undergoes a Remicade infusion for ankylosing spondylitis at Rush. He also admitted that he took over the counter medication for his low back prior to February 1, 2015.

The video of the incident initially shows Mr. Fuentes at the passenger door of the vehicle driven by his wife. Mr. Fuentes then walks toward the front of the car. He then changes direction and jogs in pursuit of his money. After he started jogging, Mr. Fuentes slipped and fell onto his back.

II. Conclusions of Law

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

Mr. Fuentes alleges that he sustained a work related injury to his low back on February 1, 2015 when he slipped and fell while pursuing some dollar bills that flew out of his pocket. In a workers' compensation claim, "...an employee bears the burden of showing, by a preponderance of the

evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment." *820 ILCS 305/1(b)3(d) (2011).*

An injury "arises out of" a person's employment if its origin is in some risk connected with or incidental to the employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58 (Ill.1989). The injury occurs "in the course of" the employment if it occurs during a reasonable time before or after work, at a place where the claimant may reasonably be in the performance of his duties and, while he is fulfilling those duties, or engaged in something incidental thereto.

Illinois courts have consistently held that injuries that arise from a personal risk, rather than an employment related risk, are not compensable. (See, *e.g. Orsini v. Industrial Comm'n,* 117 Ill.2d 38, (Ill.1987) (claimant suffered leg injuries while repairing his personal auto); *Jones v. Industrial Comm'n,* 78 Ill.2d 284 (Ill. 1980) (claimant injured hand while closing car door). Further, the Arbitrator finds this case factually similar to the situation in *Dodson v. Industrial Comm'n*. 308 Ill.App.3d 572 (Ill. App. Ct. 5th Dist. 1999). In *Dodson*, the employee initially left work and traveled down a concrete sidewalk toward the parking lot. The employee then decided to cut across a sloping, grassy path. This occurred during a rainstorm. The employee fell and broke her ankle while walking on the sloping, grassy path. The Illinois Appellate Court in *Dodson* affirmed the Commission's decision, finding that an injury does not arise out of the employment when an employee voluntarily exposes himself to an unnecessary personal risk solely for his own convenience. *Dodson,* 308 Ill.App.3d at 577.

Mr. Fuentes testified that he safely arrived at the passenger door of

his vehicle after he left work on February 1, 2015. Shortly thereafter, he chose to walk away from the vehicle to pursue a couple dollar bills which flew out of his back pocket after he removed his cell phone. Mr. Fuentes slipped and fell while in pursuit of his money. The video evidence confirms that Mr. Fuentes safely arrived at his vehicle and then jogged after his money during the snowstorm, despite his testimony that he is barely able to walk, let alone jog. Like the claimant in *Dodson*, Mr. Fuentes voluntarily exposed himself to an unnecessary personal risk for his own benefit. His actions did not benefit his employer.

Based upon the credible evidence, the Arbitrator finds that Mr. Fuentes failed to demonstrate that his injuries arose out of his employment when he chose to jog after his money in the parking lot during blizzard conditions on February 1, 2015. The Arbitrator finds that Mr. Fuentes' actions only benefited himself and there was no benefit to his employer.

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

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

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

M. Should penalties or fees be imposed upon Respondent?

As the Arbitrator finds that Mr. Fuentes failed to prove by a preponderance of the evidence that he sustained an accidental injury that

arose out of his employment on February 1, 2015, all remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry A. Utley,
Petitioner,

17IWCC0367

vs.

NO: 15 WC 8193

Cahokia School District,
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, 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 31, 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: JUN 16 2017
o6/8/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0367

UTLEY, JERRY A
Employee/Petitioner

Case# **15WC008193**

CAHOKIA SCHOOL DISTRICT
Employer/Respondent

On 8/31/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0071 BONIFIELD & ROSENSTENGEL PC
JON E ROSENSTENGEL
16 E MAIN ST
BELLEVILLE, IL 62220

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62220

17IWCC0367

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)

Jerry A. Utley
Employee/Petitioner

v.

Cahokia School District
Employer/Respondent

Case # 15 WC 8193

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 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 _____

17IWCC0367

FINDINGS

On the date of accident, **July 25, 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.

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$37,024.00**; the average weekly wage was **$712.00**.

On the date of accident, Petitioner was **63** years of age, ***married*** with **0** dependent children.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent, and that his current condition of ill-being is casually related to his alleged accident. All benefits are denied; the remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

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

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

Melinda M. Rowe Gallivan

Signature of Arbitrator

8/24/16

Date

ICArbDec19(b)

AUG 31 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Jerry A. Utley
Employee/Petitioner

Case # 15 WC 8193

v.

Consolidated cases: N/A

Cahokia School District
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he was employed by Respondent as a janitor, that he worked there for about 22 years full-time and that he worked there for 26 years in total. He testified that he retired on June 30, 2015. He testified that he was claiming injuries to his hands, elbows and shoulders, and that as a janitor he had a job that involved the repetitive use of his hands and arms. He testified that he worked full time, 8 hours per day, including during the summer. He further testified that he had different duties in the school year versus in the summer.

Petitioner testified that during the school year, he unlocked all of the doors in the building, and that before school started he was required to move the furniture and sweep each classroom. He testified that he used both of his hands and arms to move the furniture and that he used his right arm and hand to sweep. He testified that he was required to clean restrooms during the course of the day, and that he did a morning clean-up as well as performing periodic checks throughout the day. He testified that he used both arms to do such tasks as cleaning toilets, washing basins and cleaning kick marks or graffiti on the walls, as well as mopping the floors. He further testified that in order to clean the classrooms before school, it took approximately 20 minutes to clean each classroom and that he had six classrooms.

Petitioner testified that as for cleaning restrooms, there were two restrooms to clean and that it took 25-30 minutes to do a restroom and that he would check periodically for the rest of the day. He testified that the students would sometimes clog the sinks and that he would need to clean toilet paper or rocks from the sinks, and that he usually had to mop because it would overflow the sinks.

Petitioner testified that during his last four years, he had to set up for lunch and breakfast. He testified that for breakfast, he would have to drop the lunch tables and set up trash barrels. He testified that when he worked for ESAC from 2006-2010 there were 12 tables that had to be pulled out from the wall, and that it was more difficult to put them back up because he would have to force them into the wall. He testified that the benches had to be pushed in as well. He testified that he did this activity with both of his hands out and his palms flat in order to shove the tables, and that it would require force on both his hands and arms. He testified that he would also do this at lunchtime as well. He testified that after breakfast and lunch, he would have to remove bags of trash and place them in the dumpster. He testified that there would be approximately 18 bags of trash during the course of lunch. He also testified that he had to sweep and clean between lunch hours and afterwards as well, which required use of his hands and arms.

Petitioner testified that during summer, the school needed a significant "deep" cleaning and that he prepped the classrooms for the next school year. He testified that for each classroom, he would have to wash the furniture, stack it (both desks and chairs) and take it out into the hallway. He testified that each room then needed to have the walls either washed or painted. He testified that he would then sweep the rooms and get ready to scrub them, and that he would scrub with an electric hand scrubber which caused vibration into his hands and arms. He testified that after scrubbing and rinsing, they used mops to apply five coats of wax for each room. He testified that they would get 2-3 rooms scrubbed per day and waxed, and that while the wax was drying, they would be working on another room.

Petitioner testified that they also waxed the hallways, gym and kitchen as well, and that it took the entire summer to do this. He testified that the custodial workers included himself on days and a person on nights, and that they occasionally had a substitute to help but typically only in the summer. He denied having diabetes or having any hand-intensive hobbies. He denied having any treatment for carpal tunnel syndrome or cubital tunnel syndrome before 2013, and testified that starting in 2013 he started having pain in both hands, elbows and shoulders.

Petitioner testified that he saw his primary care physician, Dr. Magner, in late 2012, and that he was then seen by Dr. Schwarze. He testified that Dr. Magner sent him to Dr. Schwarze, who examined him, obtained a history and ordered nerve conduction studies. He testified that he was diagnosed with both cubital and carpal tunnel syndrome, and that they also talked about his shoulder issues. He testified that Dr. Schwarze wanted to do surgery on both elbows and both hands.

Petitioner testified that since he retired, the symptoms in his elbows had improved but the symptoms in his hands remained. He testified that with his hands, it felt like there was a needle sticking in his hand on the palm and the top of his hand between the first finger and thumb. He testified that occasionally his forearm near the wrist had soreness. He testified that when doing his work near the end of his career, he would sometimes drop the mop and the broom because of the condition of his hands. He testified that his hands had not improved since he retired.

Petitioner testified that surgery was offered for both the elbows and the hands, but that he was only looking for treatment for the hands. He testified that he was not looking for approval for surgery on his elbows because his symptoms had improved to the point where he could live with it. He testified that he has not missed any work as a result of his condition.

On cross examination, Petitioner testified that from 2006-2010 he was at ESAC, and that from 2010/2011 until his retirement he was working at Huffman School. He testified that in the 26 years he was employed as janitor for Respondent, he worked at about nine different schools and that each had a different number of classrooms and different set-ups.

On cross examination, Petitioner testified that the cafeteria tables that had to be pushed into the wall were just at ESAC and that he did that for about four years. He testified that all of the other buildings also had tables that were foldable and that he had to pull them together in order for them to lock into place, but that ESAC was the only one where they went in the walls.

On cross examination, Petitioner testified that he was a smoker up three weeks prior to arbitration and that prior to quitting, he had smoked for 45 years. He testified that at the peak, he smoked a pack of cigarettes per day.

On cross examination, Petitioner testified that he was still having symptoms in his hands even though he was retired. He testified that he notices symptoms when driving. He agreed that when he saw Dr. Schwarze in February of 2013, he reported that he had been having the symptoms for many months He agreed that when he saw Dr. Kostman, he reported that he had been having symptoms for about two

years. He agreed that he had been having symptoms since at least 2012 and that they would come and go. He denied ever reporting anything to a supervisor when he first began having symptoms, and he further denied going to his primary care physician and mentioning it to him.

On cross examination, Petitioner denied having any kind of a slip and fall or a motor vehicle accident that brought on his shoulder complaints when he went to see Dr. Schwarze. He testified that he just assumed it was probably from the trash. He testified that most of the time he would have at a minimum 50 pounds of trash, which he would pull out and "sling up" to the 5 foot-high dumpster. He testified that he noticed that it would aggravate his shoulders when he threw out the breakfast and lunch trash.

On cross examination, Petitioner agreed that when he first saw Dr. Schwarze in 2013, he reported that he was having problems with reaching, pushing, pulling and lifting. He agreed that he noticed these problems at work and also when outside of work He agreed that he told Dr. Schwarze that he did repetitive activities including lifting, pushing and pulling, but that he did not remember if he gave him any other description of his job activities. He testified that he gave a verbal job description. He further testified that he gave Dr. Schwarze all of the same information that he testified to as to his job activities.

On cross examination, Petitioner agreed that he eventually had an EMG in June of 2013 after he had seen Dr. Schwarze in February of 2013. He denied seeing any other doctors for his complaints during that timeframe. He testified that Dr. Manger recommended that he use a splint but that he did not use one. He testified that during that timeframe, he was taking prescription medications for his arm symptoms, and that he did not know the name but that it was a pain pill from Dr. Magner. He testified that he also occasionally took aspirin and Aleve. He denied ever requesting that his job duties be modified.

On cross examination, Petitioner agreed that he attended the IME with Dr. Kostman. He testified that he was cooperative with the evaluation, and that he provided him with a history of his job duties. He testified that he was honest when he told him about his work activities and symptoms. He testified that a short physical examination was performed. He agreed that from July of 2013 when he last saw Dr. Schwarze up until the time of his retirement, he continued to work full duty and that his job duties were never modified.

On cross examination, Petitioner testified that he was still taking pain medications for his hands or arms but only occasionally and that they were not prescribed. He agreed that up until his retirement, he was safely able to do his job duties.

On redirect examination, Petitioner agreed that Ultram and Tylenol sounded like the medications Dr. Magner gave him. He agreed that his symptoms got worse at the end of 2012 and beginning of 2013 and that this was why he saw Dr. Schwarze.

On redirect examination, Petitioner agreed that all of the schools he worked at were within the same district. He agreed that even though not all of the tables and benches were in the walls, he still had to set them up.

The medical records of Dr. John Magner were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen on October 26, 2012 complaining of pain in his upper extremities for three months. It was noted that Petitioner had a history of lifting 40-50 pound trash bags. The assessment was that of shoulder pain. Petitioner was instructed to undergo an x-ray of the right shoulder. The interpretive report for x-rays of the right shoulder performed on October 30, 2012 noted acromioclavicular osteoarthritis. (PX1).

The records of Dr. Magner reflect that Petitioner was seen on December 10, 2012, at which time a referral to orthopedics was given. Petitioner was seen on April 5, 2013, at which time it was noted that Petitioner requested a referral for an EMG/nerve conduction study. It was noted that Petitioner had pain in his left hand/thumb and that his shoulder popped daily and that he also had right shoulder pain for years. The assessment was that of left wrist pain and left shoulder pain. (PX1).

The records of Dr. Magner reflect that Petitioner was seen on November 7, 2014, at which time it was noted that Petitioner's carpal tunnel syndrome was getting worse. The assessment was that of mild carpal tunnel syndrome. A referral to orthopedics was given, and bilateral splints were ordered. (PX1).

The medical records of Dr. Daniel Schwarze were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. At the time of the February 21, 2013 visit, Petitioner was seen for bilateral shoulder and upper extremity pain. It was noted that it had been going on for many months and that it was originally on the right shoulder. It was noted that Petitioner described it over the anterior lateral aspect, and that it bothered him with reaching, pushing, pulling and lifting. It was noted that the episode resolved and that over the last month or two he had developed left shoulder pain very similar to the right, but could not recall any injuries. It was also noted that there was an associated left greater than right wrist and hand pain, numbness and tingling and that it would occasionally awaken him at night. It was also noted that Petitioner was employed as a custodian doing manual labor, and that Petitioner noted that he did a lot of repetitive activities including lifting, pushing and pulling. The impression was that of (1) left greater than right shoulder pain; rotator cuff tendonitis/sprain with impingement and arthritis; (2) left greater than right hand pain, tendonitis, probable carpal tunnel. Petitioner was referred for an EMG. (PX2).

Included with the records of Dr. Schwarze was the interpretive report for a nerve conduction study performed on June 27, 2013, which was interpreted by Dr. Reddy as carpal tunnel syndrome on the right as well as cubital tunnel syndrome on the right. The report for an EMG performed on June 13, 2013 noted carpal tunnel syndrome on the left and cubital tunnel syndrome on the left. (PX2).

The records of Dr. Schwarze reflect that at the time of the July 25, 2013 visit, it was noted that Petitioner had completed his diagnostic work-up and that he noted on that date that his right hand was worse than the left. It was noted that Petitioner was considering filing a workers' compensation claim. The impression was that of (1) bilateral elbow pain, tendonitis and cubital tunnel syndrome; (2) bilateral wrist and hand pain, tendonitis and carpal tunnel syndrome. It was noted that given the type of manual work Petitioner did which was mostly repetitive, filing a worker's compensation claim may be reasonable. It was noted that it was suggested that Petitioner consider surgery. (PX2).

The transcript of the deposition of Dr. Daniel Schwarze was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Dr. Schwarze testified that he is an orthopedic surgeon and first saw Petitioner on February 21, 2013. He testified that Petitioner reported that for several months he had been having bilateral upper extremity pain, that originally it was on the right shoulder and that it bothered him with any type of reaching, pushing, pulling or lifting, that he went on to develop left shoulder pain and that he could not recall any specific injury. He testified that Petitioner reported that the left-sided symptoms were similar to the right-sided symptoms, that he was occasionally being awakened at night and that with certain activities his hands would fall asleep. He testified that he thought that Petitioner had carpal tunnel syndrome and suggested that he have nerve conduction studies. (PX3).

Dr. Schwarze testified that when Petitioner returned on July 25, 2013, he reviewed the nerve conduction studies which showed carpal tunnel syndrome and carpal tunnel syndrome. He testified that Petitioner reported that his right hand was worse than the left and that he was considering filing a claim. He testified that the right and left elbows showed a positive Tinel's on that date, and that the right and left hand exams were similar to the previous exam. He testified that the diagnoses were bilateral elbow pain,

tendonitis and cubital tunnel syndrome, bilateral wrist and hand pain and carpal tunnel syndrome. After being given a hypothetical as to the specifics of Petitioner's job duties, Dr. Schwarze testified that the manual repetitive work that Petitioner did was certainly an aggravating factor, if not the causative factor, of nerve compression neuropathies at the hand and elbow. He testified that he suggested Petitioner undergo the carpal tunnel surgery and the cubital tunnel surgery on both extremities. (PX3).

On cross examination, Dr. Schwarze denied that Petitioner gave an in depth explanation as to what he meant on February 21st when he said he had had the symptoms for many months. He denied reviewing any of the medical records from any other providers besides his own and the diagnostic tests he testified to. He denied placing any restrictions on Petitioner's activities at the time of the July 25th visit. He further denied having any recommendations as of the time of the July 25th visit for any type of conservative treatment and indicated that he believed that compression neuropathies were one of the few things that he thought were truly a surgical problem. (PX3).

On cross examination, Dr. Schwarze denied seeing anything in Petitioner that made him think that he was not potentially a surgical candidate. He agreed that there were non-occupational risk factors for the development of carpal tunnel, including malunions of wrist or elbow fractures, diabetes and some of the inflammatory arthropathies like rheumatoid. He testified that in his experience, body weight by itself had not lead to carpal tunnel syndrome but that he had very few patients who were obese that were not diabetic. He testified that to his knowledge, hypertension was not a contributing factor to the development of carpal tunnel syndrome, nor was age. He testified that the biggest non-occupational risk factor for the development of cubital tunnel syndrome was fracture malunion about the elbow. (PX3).

On cross examination, Dr. Schwarze testified that a neck condition was always the differential diagnosis, but that he felt comfortable that with the diagnostic studies that he had that Petitioner's conditions were not originating from the neck. He denied that gout had any play with the diagnosis of carpal tunnel or cubital tunnel syndrome. (PX3).

On cross examination, Dr. Schwarze testified that he was not aware of anything else in Petitioner's history that could explain the problems with his bilateral upper extremities. He denied having seen any formal job description, and he further denied having seen any photographs of the areas where Petitioner worked or any of the tools that he uses. He testified that he did not have any information about how frequently Petitioner performed pushes, pulls or lifts when at work, nor did he have anything about what Petitioner did in a given day versus a week versus a month. (PX3).

The Custodian Job Description was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The description made reference to cleaning the multi-purpose room and all adjoining rooms; cleaning the boys' and girls' restrooms and water fountains; cleaning all rooms on the east hallway and boiler room; cleaning all glass in the building; cleaning all restrooms twice daily; sweeping all halls twice daily; assisting with all deliveries; assisting keeping the grounds free of debris; assisting with any setups and breakdowns in the building; painting as necessary; and working closely with all campus administrators. (RX1).

The IME report of Dr. Christopher Kostman was entered into evidence at the time of arbitration as Respondent's Exhibit 2, and the transcript of the deposition of Dr. Kostman was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Dr. Kostman testified that he is an orthopedic surgeon and treats only upper and lower extremity injuries, including nerve compressions and trauma. He testified that nerve entrapments probably encompassed 15-20% of his practice, and that he performs several surgeries for nerve entrapments per month. (RX3).

Dr. Kostman testified that when he saw Petitioner on January 28, 2014, Petitioner described that he had bilateral hand numbness and pain that he related to his work activity as a custodian. He testified

that Petitioner described that he had the symptoms for approximately two years but then estimated that they started in 2010-2011 and that he did not recall a specific incident that he would relate as an injury. He testified that Petitioner denied any previous difficulty with his hands or wrists before the year of 2010. He further testified that Petitioner described using a mop and dusting, along with moving furniture, lifting trash bags and performing carrying and lifting activities, and that Petitioner described use of a motorized scrubber in the summer but denied using any other equipment or vibratory equipment other than that. (RX3).

Dr. Kostman testified that Petitioner reported that he described himself as a smoker, and that he described his left hand was worse than his right as far as numbness and pain and that it could awaken him at night. He testified that Petitioner stated his bilateral hands and fingers became numb. He testified that Petitioner described that his regular duties included sweeping floors, moving furniture and emptying trash, washing furniture and frequent lifting from 45-60 pounds. He testified that he believed that Petitioner could have a mild condition of carpal tunnel syndrome based on his nerve conduction study and his history, but his physical examination findings did not specifically reflect that diagnosis and that it was his impression that Petitioner had not sustained a work-related injury. (RX3).

Dr. Kostman testified that the most common presentation for carpal tunnel syndrome was that a certain number of people would develop a nerve compression in their carpal canal of the median nerve and that it was not specifically related to heavy use of vibratory equipment or something that specifically caused the injury or condition. He testified that in Petitioner's case, the bilateral symptoms, the description of his work activities, the onset and the EMG nerve conduction having found mild presentation all fit with an idiopathic cause. He testified that in his practice, 80-90% of the patients that he treated had idiopathic carpal tunnel syndrome. (RX3).

Dr. Kostman testified that aside from idiopathic, other reasons that an individual could develop carpal tunnel syndrome included the use of a lot of vibratory equipment or a direct trauma to the carpal canal, such as a penetrating injury or a laceration that would cause swelling to the area. He testified that smoking can be considered a contributory factor for the development of carpal tunnel syndrome because it had been shown to decrease blood flow to the smallest of the arteries, the arterioles. He further testified that it could also be a degenerative process in that an adjacent joint caused swelling and compression of the canal. (RX3).

Dr. Kostman testified that Petitioner did not specifically relate to him that his symptoms improved when he was not at work, and that he listed one of his primary problems was at night when sleeping. He testified that there was nothing that jumped out at him that he thought were definitely risk factors for Petitioner being predisposed to the development of carpal tunnel syndrome other than his smoking history and the history of gouty arthritis, which he admitted he was not sure were significant factors in this case. He testified that it was not his impression that Petitioner's work activities contributed to the development of his carpal tunnel syndrome. (RX3).

On cross examination, Dr. Kostman admitted that he did not review Dr. Schwarze's deposition. When asked if he was suggesting that he did not believe that Petitioner needed surgery, Dr. Kostman responded that if he was the treating physician, based on the examination he did not believe that he would offer surgery as a treatment option. He testified that if Petitioner had failed conservative measures, it would be a consideration. He testified that he was always suspicious when things did not "line up" as to whether surgery was really the best solution for someone. He further testified that his answer would be the same for cubital tunnel except that he was less inclined to try a steroid injection for cubital tunnel because the space was tighter and a little more sensitive area. (RX3).

On cross examination, Dr. Kostman admitted that he was not given a job description by Respondent, but he did note what Petitioner described and that he believed what he stated that he did was

true. He admitted that he did not know how long Petitioner was a custodian, but that it would not make a difference to him based on what Petitioner relayed to him as far as his activity levels and what he did at work. He testified that he did not believe that the things Petitioner described would have been a causative or aggravating factor because he sees such a significant portion of people who develop symptoms idiopathically. (RX3).

On redirect examination, Dr. Kostman testified that he did not have any findings regarding a cubital tunnel diagnosis for Petitioner, and that he did not believe that his cubital tunnel findings by EMG related to his work activities. (RX3).

On further cross examination, Dr. Kostman agreed that cubital tunnel symptoms can wax and wane. (RX3).

The medical record of Dr. Daniel Schwarze for services rendered February 21, 2013 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The document was duplicative of that as contained in Petitioner's Exhibit 2. (RX4; PX2).

The Response to 19(b) Petition was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

CONCLUSIONS OF LAW

With respect to disputed issues (C) and (F), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on July 25, 2013, and that his current condition of ill-being is causally related to his work activities.

In so concluding that Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment with Respondent, the Arbitrator finds the opinions of Dr. Kostman to be more persuasive than those as provided by Dr. Schwarze. The Arbitrator finds the causation opinions of Dr. Schwarze to not be well-founded and based upon a hypothetical description of Petitioner's job duties posed at the time of his deposition, and notes that he admitted on cross examination that he did not seen any formal job description nor did he see any photographs of the areas where Petitioner worked or any of the tools that he used, and, perhaps more significantly, that he did not have any information about how frequently Petitioner performed pushes, pulls or lifts when at work, nor did he have anything about what Petitioner did in a given day versus a week versus a month. (PX3).

The Arbitrator finds that Dr. Kostman, on the other hand, was able to secure much more specific information regarding Petitioner's work activities and therefore places greater weight upon his opinions. The evidence demonstrates that Petitioner reported to Dr. Kostman that his work activities included "using a mop and dusting, along with moving furniture, lifting trash bags, carrying and lifting activities...he described the use of a motorized scrubber in the summer...denied using any other equipment or vibratory equipment other than that". (RX3). The Arbitrator further finds to be significant in this case Dr. Kostman's testimony that in Petitioner's case, the bilateral symptoms, the description of his work activities, the onset and the EMG nerve conduction having found mild presentation all fit with an idiopathic cause. (RX3). As a result of the foregoing, the Arbitrator finds 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 25, 2013, and that his current condition of ill-being is causally related to his work activities.

Additionally, the Arbitrator finds to be significant in this case that Petitioner's job duties over the years with Respondent were varied in several respects, including the type, the amount of time spent on each activity, the locations at which his job duties were performed and the frequency of performance of specific activities, and that according to the written job description, Petitioner's job activities were quite varied. (RX1). In fact, on cross examination Petitioner testified that in the 26 years he was employed as a janitor for Respondent, he worked at about nine different schools and that each had a different number of classrooms and different set-ups. As such, the Arbitrator places great weight on the fact that Petitioner's job duties were varied in nature in support of the findings in this case.

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 25, 2013, and that his current condition of ill-being is causally related to his work activities. All benefits are denied. The remaining issues of medical bills and prospective medical treatment are moot, and the Arbitrator makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

☒ 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

Cecilia Olivo,
Petitioner,

vs.

17IWCC0360

NO: 15 WC 10088

Gonnella Baking Co,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 7, 2016 is hereby affirmed and adopted.

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

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

The party commencing 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: JUN 15 2017
KWL/vf
O-6/6/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0360

OLIVO, CECILIA
Employee/Petitioner

Case# **15WC010088**

GONNELLA BAKING CO
Employer/Respondent

On 7/7/2016, 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 0.34% 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:

5122 PORRO NIERMANN & PETERSEN LLC
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

0507 RUSIN & MACIOROWSKI LTD
JAOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

☐ 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
19(b)

17IWCC0360

CECELIA OLIVO
Employee/Petitioner

Case # 15 WC 10088

v.

GONNELLA BAKING CO. .
Employer/Respondent

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Jessica A. Hegarty, Arbitrator of the Commission, in the city of Geneva, on 4/13/16. 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 _____

FINDINGS

On the date of accident, 2-27-15, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $27,950.00 ; the average weekly wage was $537.50 .

On the date of accident, Petitioner was 42 years of age, single , with 3 children under 18.

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

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

ORDER

The Arbitrator finds that Petitioner failed to prove accidental injury arising in and out of the course of her employment on February 27, 2015. Wherefore, Petitioner's claim for compensation is denied.

The Arbitrator further finds that Petitioner failed to prove a causal connection between any current condition of ill-being and the incident of February 27, 2015. Wherefore, Petitioner's claim for compensation is hereby denied.

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.

Jason C. Knott

Signature of Arbitrator

7/5/16
Date

JUL 7 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CECILIA OLIVO,	)	17IWCC0360
Plaintiff,	)	
vs.	)	No.: 15 WC 10088
GONNELLA BAKING,	)	
Defendant.	)	

ADDENDUM TO THE DECISION OF THE ARBITRATOR

Petitioner was employed by Respondent as a quality control operator on the alleged accident date, February 27, 2015. According to Petitioner, she was walking down some steps at her workplace when her right foot got stuck on the bottom stair while her left foot made contact with the production floor, causing her to fall forward onto her left knee and hands. Petitioner testified that she was wearing boots at the time.

The steps involved in the accident were of metal construction with a stamped-in tread pattern. (RX8)

Petitioner was transported to Provena Mercy Hospital where she was diagnosed with a left groin strain, bilateral knee contusions and a sacral contusion after a fall down at work. (PX5). Petitioner was taken off work and referred for occupational treatment. (Id.).

Petitioner presented to Respondent's occupational medicine provider on March 2, 2015, where she was diagnosed with low back and bilateral groin strains and released to sitting work duties. (Id.). Petitioner sought treatment the same day with her own physician, Dr. Abdul Qadir, who noted complaints of low back and hip pain. The doctor further noted that Petitioner had already seen the occupational provider who advised her to return to work despite her continued complaints of back pain and difficulty sitting and walking. Dr. Qadir diagnosed a back strain and prescribed muscle relaxants and Tylenol #3 as needed. (Dr. Qadir clarifies in his notes that this March 2, 2015 visit is mislabeled as occurring on February 17, 2015 visit.)

On March 9, 2015, Dr. Woodward at the occupational health clinic noted Petitioner's complaints of discomfort in her mid to low back and the inability to sit or walk due to pain. (RX7, Dep. Ex. 5). Examination of the back revealed no palpable spasm. The doctor released her to work, no lifting over 15 pounds. Dr. Woodward noted that he observed Petitioner walking down the hallway without difficulty. (Id.).

The following day, Petitioner returned again to the Provena Mercy emergency room reporting low back and bilateral knee pain. She reported feeling incapable of holding up her body weight. Physical and neurological examinations were normal. A Toradol injection was administered for pain relief. (PX5). Petitioner also returned to her personal physician, Dr. Qadir, on March 10, 2015 with complaints of low back pain. The doctor prescribed Norco 5 which he instructed her to use before going to work. (PX4) Petitioner returned to the occupational health center the following day, March 11, 2015, excruciating back pain after one hour of work. Dr. Woodward noted negative straight leg raise on exam, further noting that light touch elicited complaints of

17IWCC0360

pain. Petitioner was returned to work with restrictions of no lifting over 10 pounds, no repetitive bending or stooping. (RX7, Dep. Ex. 5). Petitioner then presented to Provena Mercy Medical Center emergency room later that day, March 11, 2015, where she reported work restrictions of no continuous standing and/or lifting greater than 5 pounds. She stated her back pain was 9 on a scale of 10. (PX5).

During her return visit to the occupational clinic on March 16, 2015, Petitioner reported whole back discomfort and increased pain with bending and twisting as well as occasional radiating pain to her knees. The clinic doctor noted that Petitioner refused to flex her back due to pain and that she mounted the exam table and moved about easily. Meloxicam and Celebrex were prescribed and work restrictions were maintained. (Id.)

On March 18, 2015 Petitioner was examined by Dr. Theodore Suchy, pursuant to Respondent's Section 12 request. Evidence with respect to his findings and conclusions is discussed below.

Video surveillance of Petitioner on March 16, 18 & 20, 2015 shows her exiting and entering her SUV, unassisted, with little apparent difficulty. (Rx 4).

Petitioner returned to Dr. Woodward on March 20, 2015 reporting pain to her back, bilateral hips and groin. The doctor noted that Petitioner ambulated well and that she mounted the examination table with little trouble. Physical examination revealed negative straight leg raising bilaterally and negative bilateral logroll test. Petitioner reported that her legs became weaker the longer she stands. She was released to work with a 10 pound lifting restriction. (RX7, Dep. Ex. 5). Later that day, March 20, 2015, Petitioner returned to Dr. Qadir stating she was unable to work eight hours shifts even with the restrictions. Dr. Qadir's physical exam was unremarkable.

On March 24, 2015, Petitioner returned to Dr. Qadir with complaints of bilateral burning and numbness in her thighs, right greater than left, when standing for more than a few hours. (PX4) Dr. Qadir documented that Petitioner was forced to work 8 hours the evening before even though he had given her a note recommending only four hours of work per day. Dr. Qadir interpreted a CT scan taken the same day as showing diffuse disc bulge at L4-5 and L5-S1 with mild central canal stenosis. Dr. Qadir noted that Petitioner did not have any back pain or problems until she had the fall at work and he felt that her complaints were most likely related to the bulges. Dr. Qadir agreed with the company clinic's prescription for a lumbar MRI. His examination also documented pain in the lower back with tenderness in the hip joint area, and tenderness and mild pain with hip movement. Dr. Qadir also recommended that she hire a lawyer to help her with the trouble she was receiving from her job. (Id.).

Petitioner indicated that on March 27, 2015 she was let go, but not fired, by Respondent. She never returned to the company or contacted them regarding an attempt to return to work since that date. Respondent has paid no TTD to Petitioner.

Petitioner returned to Dr. Qadir on March 31, 2015 complaining of back and leg pain. (PX4) She reported that her employer had been forcing her to work full eight hour shifts despite the work restrictions instituted by the doctor. According to the note, with the findings on the CT, the employer was now allowing her to take time off work to get better. Dr. Qadir again agreed with the recommendation for a MRI. Respondent did not authorize an MRI.

Petitioner then came under the care of Dr. Lorenz on April 9, 2015 at Hinsdale Orthopedic Associates. (PX2) Complaints included low back pain radiating down the bilateral extremities

and into bilateral groin area. On examination of Petitioner's right hip, Dr. Lorenz noted discomfort and some pain into the groin with internal and external rotation bilaterally. Dr. Lorenz's examination further revealed strength 5/5, no atrophy, and negative straight leg raise. (R. Ex. 7, Deposition Exhibit No. 7). Dr. Lorenz diagnosed Petitioner's condition as involving a central disc herniation or annular tear, he restricted Petitioner from work and he sent her for therapy at ATI.

An MRI of the lumbar spine was performed on April 16, 2015.

Petitioner began physical therapy started on April 16, 2015. (PX3) Petitioner advised the physical therapist that her limitations were pulling, pushing, sleeping greater than six hours, squatting, and sustaining standing or walking. (Id.). Hip complaints and motion deficits were also documented in the notes. A slow gait pattern, limitations in hip flexion, hip abduction, hip adduction, knee extension and knee flexion. The initial course of therapy ran through June 8, 2015 at which time Petitioner complained of pain with sustained standing, twisting, turning or shoveling. At that point, the therapist noted that Petitioner had made gains with mobility and range of motion in her lumbar spine, but continued with limitations in her activities of daily living due to pain. The therapist noted that her pain reports were consistent with her testing and exercises and that her pain levels had increased over the last three to four weeks. Pain levels ranged from 7 to 9/10. Petitioner reported having trouble with daily activities such as cooking, laundry and caring for her children. The therapist further documented the fact that Petitioner's hip strength deficits had not changed since the start of therapy. Petitioner's slow gait pattern was also documented throughout therapy.

Hinsdale Orthopaedics noted on June 11, 2015, that Petitioner had difficulty walking and was utilizing a cane. (RX10).

Petitioner was seen on June 16, 2015 by Julie Morgan, PAC to Dr. Benjamin Domb at Hinsdale Orthopaedics. Petitioner complained of hip and low back pain that was aggravated by walking, and going from a sitting to standing position. She noted that Dr. Lorenz did not feel there were enough of her symptoms coming from her low back to consider warranting further treatment. (Id.).

Dr. Lorenz referred Petitioner to hip specialist, Dr. Benjamin Domb, who examined Petitioner noting a negative hip roll test, bilaterally. Pursuant to the doctor's recommendation, bilateral hip MRI arthrograms were performed on June 22, 2015. The radiologist noted an ill-defined signal of the right hip with clinical correlation necessary, and probable uterine fibroids which might be further correlated with pelvic ultrasound. The left hip arthrogram showed findings suspicious for a tear, with clinical correlation again suggested. (RX9, Deposition Exhibits 2 and 3). Dr. Domb later reviewed the films noting the presence of bilateral labral tears with incidental findings of cam morphology. (PX1 p. 5-6) The doctor opined Petitioner's condition was caused by the work related injury. (Id.). Dr. Domb recommended that Petitioner continue with therapy and noted bilateral hip arthroscopy may be needed to address the tears if Petitioner's condition failed to improve. (Id., p.6) The doctor opined his recommended treatment was necessitated by the work related accident, given the mechanism of injury the temporal relationship between the onset of symptoms. (Id. p.11-12) Dr. Domb further noted the presence of high grade, left-sided chondromalacia was also likely related to the accident, given the acute onset of pain which she reported from the accident. (Id., p.22) Dr. Domb noted that groin pain is a finding consistent with labral tears. (Id., p.25-26)

On August 6, 2015, Petitioner's discharge summary from physical therapy noted objective

improvements in strength, posture and gait. Strength deficits were also noted. The therapist felt that Petitioner remained temporarily and totally disabled even though she had obtained maximum benefit from therapy. The therapist recommended a Functional Capacity Exam ("FCE") to determine Petitioner's capabilities for work. (PX3)

Petitioner resumed therapy on December 2, 2015 at Presence Mercy, with the admitting diagnosis of bilateral hip pain. (PX5) The Outpatient Intake reported the alleged work accident at issue, the relief she obtained through the earlier therapy and the fact that she was still experiencing pain from the accident. Her pain was documented at a 9 out of 10. The *Lower Extremity Evaluation* documents deficits in range of motion of both hips, bilateral strength deficits. Petitioner was using a cane at the time of evaluation and reported more trouble climbing stairs than descending stairs. She further reported that hip extension was far more painful than any other range of motion movement. Therapy records document progress in pain relief, range of motion and strength. She was also performing home exercises while in therapy. However, the relief provided temporary relief only. Therapy was discontinued on January 28, 2016 with complaints of increased pain with therapy and activities.

Petitioner was last seen at Hinsdale Orthopaedics August 31, 2015. She was given a release to return to work with no lifting greater than 5 to 10 pounds. Petitioner has not looked for work within this capacity. She complained of her pain on the trial date being a 9 in intensity.

Witnesses' presented by Respondent

Ms. Marcucci, Corporate Safety Director, viewed the videotape surveillance of the area of incident on February 27, 2015 on March 1 or March 2. She indicated she was initially able to view the video in a frame by frame sequence. She testified that Petitioner had reached the cement portion of the landing, was off the stairs, and appeared to have tripped on an untied shoelace. Petitioner fell forward, rolled over, and then got up. Ms. Marcucci indicated that her viewing of the videotape showed Petitioner bending down, and she appeared to be tying her right shoe.

Mr. Butera indicated upon his return from the hospital he inspected the stairs, and there were no defects. The pictures were introduced as Respondent's Exhibits 8(a) through (d). He indicated the stairs were not raised in any fashion and were level.

Dr. Suchy IME and Evidence Deposition

Dr. Suchy noted an accident history of Petitioner tripping over two or three stairs. (RX7, Dep. Ex.2). Petitioner denied a prior history of pelvic or low back pain. (Id., Exhibit 3, p. 2). Petitioner also denied any pre-existing inguinal pain. (Id., p. 11).

Dr. Suchy reviewed the records of Dr. Qadir, Mercy Hospital, Dr. Woodward, ATI Physical Therapy and Dr. Lorenz. (Id., p. 7). According to his testimony, the complaints Petitioner voiced to Dr. Woodward on March 2, 2015 of tenderness in the right and left inguinal area were of a similar nature to complaints voiced (that pre-dated the work accident) to Dr. Qadir on January 28, 2015 of tenderness in the suprapubic and bilateral lower quadrant. (Id., p. 21, 22, 23; Dep. Ex. 4). Dr. Suchy testified that inguinal and hip pain are anatomically very similar, as that is where the hip joint is located. (Id., p. 62-64).

Regarding Petitioner's physical examination that he performed on March 18, 2015, Dr. Suchy noted Petitioner walked in a hesitant fashion. The doctor noted no spasm but reduced range of motion, which he felt was effort dependent. Reflexes and straight leg raising were normal. (Id., p. 29, 30). The doctor further noted that Petitioner's complaints were diffuse and did not fit any particular explainable pattern. (Id., p. 30-32). Dr. Suchy observed that Petitioner left his office and walked through the parking lot with a normal gait. In light of this observation, he suspected symptom magnification. (Id., p. 33). Dr. Suchy's diagnosis was a lumbosacral strain with no objective evidence. He believed Petitioner was at maximum medical improvement and capable of regular duty work. (Id., p. 34, 35).

The doctor further testified that a negative straight leg raise on exam would indicate no evidence of radiculopathy. With respect to the lumbar CAT scan performed on March 24, 2015, Dr. Suchy opined the findings were degenerative and pre-dated the alleged accident at issue. (Id., p. 28, 29).

Dr. Suchy reviewed additional therapy records from ATI, records from Dr. Lorenz, Dr. Domb's visit, and viewed the films of the hip arthrograms. He gave a second deposition on January 19, 2016. (RX9). He interpreted the right hip arthrogram as not significantly different than the radiologist other than noting a small osteophytic formation in the superior aspect of the acetabulum but no evidence of any significant labral pathology. The left hip arthrogram showed no evidence of a significant labral tear but was positive for arthritic findings. (Id., p. 7). Dr. Suchy testified that 30 to 40% of labral tears are insidious in onset. (Id., p. 8). He indicated an individual could have findings on the right hip and left hip arthrograms and be asymptomatic. (Id.). It was his opinion that the bilateral arthrogram findings are unrelated to the alleged work accident. (Id. p. 9).

Dr. Suchy reviewed the MRI of April 16, 2015, noting disc bulging at L5-S1 but no evidence of herniation and minimal nerve root compression with some mild degenerative changes. Dr. Suchy testified that the incident of February 27, 2015 did not cause the pathological process noted on the MRI. (Id., p. 37, 39).

With respect to surveillance tape that Dr. Suchy viewed of Petitioner, the doctor noted Petitioner can be seen flexing her hips to 90 degrees getting in and out of her SUV, rotating her legs, with no sign of difficulty or discomfort. He felt that Petitioner's activities on the surveillance tape were inconsistent with a symptomatic labral condition in either hip. (Id. p. 12). Dr. Suchy testified that an individual with significant, symptomatic labral pathology would have difficulty getting in and out of a car which required flexing one's hip to 90 degrees. (Id. p. 12-13). Based upon his examination and review of all records and videotapes, Dr. Suchy found no causal relationship between the incident of February 27, 2015 and Petitioner's complaints. (Id. p. 13). He indicated Petitioner did not need hip surgery and was capable of working in a regular duty capacity. (Id. p. 13-14).

CONCLUSIONS of LAW

In support of the Arbitrator's decision relating to (C) Accidental Injury, the Arbitrator makes the following findings of fact and conclusions of law:

Regarding Petitioner's credibility, the Arbitrator noted the following:

- On March 9, 2015, the occupational health clinic noted Petitioner's complaints of discomfort in her mid to low back and the inability to sit or walk due to pain. (RX7, Dep. Ex. 5). Dr. Woodward noted Petitioner walking down the hallway without difficulty.

- Dr. Suchy testified during his examination of March 18, 2015 Petitioner presented with difficulty walking, but he observed her leaving the exam walking through the parking lot walking in a normal fashion.

- Petitioner saw Dr. Woodward and Dr. Qadir on March 20, 2015 with complaints of pain and difficulty standing, videotape was introduced of that date showing Petitioner walking without a cane with a normal gait entering and exiting an Office Depot. (RX4).

- Petitioner complained of difficulty standing and walking and told Hinsdale Orthopaedics on June 11, 2015, she needed to ambulate with a cane. Despite this report, Petitioner is not seen using a cane at any time during the seven days of videotape surveillance footage.

- July 20, 2015 videotape shows Petitioner at 4:50 p.m. walking into a Jewel without assistive and with a small child. She then exits the Jewel at 5:05 pushing a cart that the child is riding on and loads groceries into her Jeep. She is then observed at 5:15 near her residence exiting the Jeep. She does not appear to have any difficulty walking.

- On July 21, 2015 she is observed driving and walking at a shopping facility at 12:59 pm. She is again observed on July 21 and July 26 walking and shopping at Wal-Mart, Hallmark, and Aldi's without any assistive device and entering and exiting her vehicle without any apparent difficulty. (RX5).

- The Arbitrator notes that this matter was previously set for trial in Wheaton on November 24, 2015. Petitioner appeared at that hearing utilizing a cane. The Arbitrator notes the videotape of November 19, 2015. (RX6). Petitioner is observed on that date bending at 90 degrees looking on the rear floor of the backseat of the vehicle, kneeling on the backseat, reaching in, twisting and turning with no apparent difficulty and not utilizing any assistive device. (Id.).

The Arbitrator notes the disparity between Petitioner's demeanor and activity level in the surveillance footage with the medical records in which Petitioner reported whole back discomfort, increased pain with bending and twisting, occasional radiating pain to her knees.

Petitioner testified that her right foot was stuck on the step and her left foot went forward, with her falling on her left knee while the right foot remained stuck on the step. The Arbitrator has carefully reviewed the videotape of the incident, multiple times. The footage does not appear to depict Petitioner's left knee striking the cement with her right foot caught on any stair or extended backward. She can be seen walking away from the alleged accident without difficulty.

The Arbitrator does not find Petitioner's testimony to be credible.

Based on the above findings and the record as a whole, the Arbitrator finds Petitioner has failed to sustain her burden with respect to accident.

Assuming Petitioner had prevailed on the issue of accident, the Arbitrator would not find in her favor with respect to causation.

The medical records indicate a paucity of objective clinical findings. The doctor at the hospital indicated that the CT findings of the lumbar spine were chronic in nature. The MRI arthrogram findings of the hip could be incidental and individuals could have those findings and be completely asymptomatic.

The Arbitrator noted the inconsistency, stated above, between Petitioner's complaints to medical providers and her activity level on the surveillance footage obtained by Respondent.

Dr. Domb saw Petitioner on only one occasion. He reviewed no records other than Dr. Lorenz's office visit of April 9, 2015 and the MRI arthrogram studies of the hip. (PX1, p. 19). Dr. Domb conceded that half of labral tears are insidious in onset. (Id. p. 21). He could not date the age of the labral tears evident on the arthrogram studies. (Id.). An individual could have the findings demonstrated on the arthrograms and be asymptomatic. (Id. p. 22). His examination revealed bilateral negative logroll test, strength 5/5, with no complaint of locking, catching or giving way. (Id., p. 30). Dr. Domb's causation opinion is predicated on Petitioner's description of the mechanism of injury and temporal onset of her pain complaints.

Dr. Suchy reviewed all records of treatment, including the films. The Arbitrator would therefore adopt the opinions of Dr. Suchy that Petitioner, at best, had a lumbar strain with no objective evidence of its presence and that no causality would exist relative to Petitioner's hip condition or the findings noted on either hip arthrogram.

The Arbitrator in addition to finding no accident, would find that Petitioner failed to prove a causal relationship between any current condition of ill-being and the claimed date of accident of February 27, 2015.

Wherefore, all remaining issues related to Petitioner's claim for compensation are moot. All claimed benefits are denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tiffany Adams,
Petitioner,

17IWCC0368

vs.

NO: 15 WC 11645

Advance Auto Parts,
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, 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 8, 2016, is hereby affirmed and adopted.

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

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

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

JUN 16 2017

DATED:
o6/8/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0368

ADAMS, TIFFANY
Employee/Petitioner

Case# **15WC011645**

ADVANCE AUTO PARTS
Employer/Respondent

On 8/8/2016, 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 0.39% 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:

4463 GALANTI LAW OFFICES
LESLIE N COLLINS
PO BOX 99
EAST ALTON, IL 62024

0560 WIEDNER & McAULIFFE LTD
MATTHEW J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

17IWCC0368

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)

Tiffany Adams
Employee/Petitioner

v.

Advance Auto Parts
Employer/Respondent

Case # 15 WC 11645

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 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, **March 21, 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.

Per the stipulation of the parties, in the 18 weeks preceding the injury, Petitioner earned **$5,149.14**; the average weekly wage was **$286.06**.

On the date of accident, Petitioner was **19** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$0.**

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

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

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

Melinda M. Grove-Sullivan
Signature of Arbitrator

8/4/16
Date

ICArbDec19(b)

AUG 8 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Tiffany Adams
Employee/Petitioner

Case # **15** WC **11645**

v.

Consolidated cases: **N/A**

Advance Auto Parts
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that in March of 2015 she worked at Advance Auto Parts in St. Louis on Gravois as a sales person. She testified that on March 21, 2015 she was working with the general manager "Steve" as well as a guy in training and a security guard.

Petitioner testified that she was grabbing an item for a customer and was using as the item was about 7 feet off the ground. She testified that she was grabbing a ladder and coming around the corner with it when her kneecap popped out of place. She testified that she was retrieving an oil cap for a customer, and that it was about seven feet from the ground and definitely above so that she could not reach it without a ladder. She testified that the racks were about 10 feet tall, so it was near the top.

Petitioner testified that the inventory was located behind the counter and that it was almost like a warehouse in the back. She testified that there were 10 foot tall shelves and that they were all behind the counter. She testified that the ladder may have weighed up to 100 pounds, was at least 6 feet tall and was like a moveable set of stairs on wheels. She testified that she was retrieving the ladder from the next aisle over when she injured her knee, and that she was pulling the ladder around a corner when she was injured. She testified that when she pulled the ladder around the corner, as she was moving her kneecap popped out of place and she fell to the ground. She testified that there was no one back in the stockroom with her and that she was not sure if anyone saw her injure herself. She denied that anyone came back to help her and stated that she popped her kneecap back into place and called the store phone. She testified that she was told they were too busy so she shouted and was told they were too busy, and after she got herself up using the shelving next to her the security guard finally came to the back. She testified that she worked until 8:20-8:30 p.m. or so after the injury, which happened around 6:30 p.m.

Petitioner testified that she was not able to walk on her leg and had to use crutches that were in the lobby of Advance Auto Parts. She testified that Steve found the crutches in the parking lot. She testified that because there was no accident report done and no ambulance was called, she did not know what she was supposed to do so she sought treatment two days later at the emergency room. She testified that she went there on her own. She testified that after Gateway, she went to Concentra which was where Respondent directed her to go. She testified that they recommended light duty and told her to take Ibuprofen.

Petitioner testified that she then went to Multicare Specialists, where she did some physical therapy. She testified that she was then sent to Dr. Choi and was eventually seen by Dr. Paletta, who was

recommending surgery on her knee which she wants to have performed. She testified that she is still having problems with her knee, and that since she still has to work she has just been "dealing with it" for now. She agreed that she was also seen for an IME with Dr. Browdy.

On cross examination, Petitioner agreed that she was no longer employed at Advance Auto Parts and testified that she currently works for Marco's Pizza as an assistant manager. She testified that she lost no time from work while treating for her injury other than the time she was out of work between Respondent and her current position. She agreed that while the accident occurred in Missouri, she was originally hired in Illinois and there was no break in her employment when she transferred from Illinois to Missouri.

On cross examination, Petitioner testified that she sustained a soccer injury when she was about 10 years old, and that another child kicked her in the knee but there was no medical treatment. She testified that she had told some of the doctors she had seen about prior dislocations with her left leg. She agreed that throughout her treatment she was honest with the doctors she had seen, agreed that it was important to be honest with them and agreed that she had given them histories of what happened.

On cross examination, Petitioner agreed that she testified that she went to the back to grab a part, that she had grabbed a ladder and that she was pulling the ladder at the time of the accident. She testified that after the accident she yelled and then called the store phone, and they told her they were too busy to come back and help her. She agreed that she testified that the security guard was the one that eventually came back.

Respondent called Steve Weniger as a witness at the time of arbitration. He testified that he is employed by Respondent and did not currently work at the St. Louis store where the accident occurred, but that he previously worked at the same store where Petitioner worked and left that location in July of 2015. He testified that he knew Petitioner as an employee, and that he was the general manager. He testified that part of his job as general manager was to document reports of work-related injuries, and further testified that he was also working on March 21, 2015 as well.

Mr. Weniger testified that on the date of accident, he was there along with Petitioner, one other guy they were training and a security guard. He testified that he believed it was the evening hours when the incident took place, and that Petitioner had gone back to grab a part for a customer that she was waiting on. He testified that he was up front, and that they had quite a few customers. He testified that Petitioner had not come back up and the phone rang. He testified that he was unable to make out who it was or what it was, but Petitioner stated that that she was in the back of the store and could someone come back. He testified that he said that he would be back in a minute. He testified that as soon as he got done taking care of his customer he went back, and that that was when he found her leaning on one of the plastic sorting carts that they loaded the stock on to put it away.

Mr. Weniger testified that he asked Petitioner what happened, and that she stated she had turned to come back up front from picking the part and that she twisted her knee. He testified that he asked her what kind of shape she was in, and further testified that she looked like she was uncomfortable. He testified that she told him that it was "not a big deal" and that it happened all the time. He testified that he had some crutches that were left behind, and helped her up to the front of the store so she could sit down. He testified that the crutches were inside the store and had been there for 8-12 days or so and that he found them leaning against the wall outside in the parking lot.

Mr. Weniger testified that when he went back and found Petitioner in the back stockroom, she was leaning against a cart. He testified that he did not notice a ladder nearby. He testified that when an

employee reports an accident he asks them if they need to see someone, and that Petitioner stated that she just needed to go home and take the weight off, and that it happened all the time.

Mr. Weniger testified that he completed an incident report for the claim the next working day, which he believed was two days later. He testified that it was the store's practice to keep copies of the accident report. He testified that Respondent's Exhibit 1 was the incident report, which was a standard report that gets filled out and then faxed to their workers' compensation provider. He testified that he completed the report, and that it contained a section that discussed the accident as reported to him. He stated that the report was dated on the 23rd, which was two days after the accident.

On cross examination, Mr. Weniger testified that he did not recall whether Petitioner had the oil cap in her hand that she was retrieving for the customer. He testified that if she had retrieved the part it may have been on the cart in front of her but he did not recall, and that he assumed that she would have still had it. He agreed that it was his understanding that she was on her way back up front. He testified that he did not see a ladder when he went back, nor did he see any type of stepping device. He testified that the aisle where the oil caps were located was directly behind her, and that the shelves ranged from floor level to 6-7 feet high. He agreed that the ladder was usually needed to retrieve items from the higher shelves. When asked if Petitioner would have had to use one of the ladders to retrieve an oil cap in light of her height, he responded that it would depend on the part number and the location where it was and that he did not know exactly what part number she was retrieving.

On cross examination, Mr. Weniger testified that he was the person that came back and assisted her, and that he found her standing and leaning against cart. He testified that the security guard was up front where he should have been.

On rebuttal, Petitioner testified that Mr. Weniger was not the individual that assisted her after she fell and that it was the security guard from the front who came and brought her the crutches. When asked if she had already retrieved the oil cap from the shelf, she responded that she had not yet gotten to it. She testified that there was a cart that was about 12 feet away from her when she fell, and that she used the shelving next to her to get up. She testified that she did not recall whether anyone actually retrieved the part for the customer.

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 March 21, 2015, and that Petitioner hurt her right knee while grabbing a ladder. (AX2).

The medical records of Gateway Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen in the Emergency Department on March 23, 2015, at which time she complained of a knee injury and that the symptoms/episode began/occurred 2 days while walking at work and that her patella popped out of place. It was noted that Petitioner had limited active range of motion, limited passive range of motion and limited active and passive range of motion due to pain. Petitioner underwent x-rays of the right knee on the same date, which were interpreted as revealing no radiographic evidence of acute bony abnormality. The impression was that of knee contusion and knee effusion, and Petitioner was given a knee immobilizer. (PX1).

The medical records of Concentra were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Petitioner was seen on March 31, 2015 at which time she complained about her leg which was injured on March 21, 2015. Petitioner stated that she had discomfort in her right knee around the patella, and that she was at work some 10 days ago when she made a quick turn to grab a ladder and in the process her right knee cap popped out of place after which she pushed it back in its

normal position. Petitioner denied giving way, locking, snapping, clicking, popping, redness, swelling, bruising and radicular symptoms. The assessment was that of sprain/strain knee/leg and clinical history of dislocation of patella 10 days ago. Petitioner was fitted with a hinged knee brace and ordered to undergo physical therapy. Petitioner was also issued work restrictions, allowing her to return to work on March 31, 2015 with restrictions of needing to wear the brace, should be sitting 50% of the time, no climbing stairs or ladders, no squatting and no kneeling. (PX2).

The medical records of Multicare Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Included within the records were those reflecting that Petitioner underwent physical therapy for the timeframe of April 1, 2015 through June 18, 2015. At the time of the May 5, 2015 visit, it was noted that Petitioner was not compliant with physical therapy. (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on June 18, 2015 for right knee pain, at which time Petitioner stated that her knee was still sore and that she would like a second surgical opinion. The assessment was that of ongoing complaints of knee pain. It was noted that, per her request, she would be referred to Dr. Paletta. At the time of the June 11, 2015 visit, it was noted that Petitioner was very frustrated and was still having pain. At the time of the June 10, 2015 visit, it was noted that Petitioner complained of ongoing pain in her right knee and that the swelling was down since she had been taking Ibuprofen. It was noted that Dr. Eavenson was going to speak to Dr. Choi about her condition. At the time of the June 8, 2015 visit, it was noted that Petitioner took some Motrin and her swelling was down on that date. It was further noted that Petitioner was better on that date. (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on June 4, 2015, at which time it was noted that she took off the brace and had been working but unfortunately continued to suffer with knee pain. The assessment was that of increased pain, and Petitioner was instructed to go back to the brace for the weekend. At the time of the May 27, 2015 visit, it was noted that Dr. Choi released her and told her that he did not want to do anything else and that she continued to have pain. The assessment was that of ongoing subjective complaints of pain, and per Dr. Choi Petitioner was to discontinue therapy and she was to return as needed. At the time of the May 26, 2015 visit, Petitioner indicated that she had had inflammation and pain all weekend. The assessment was that of ongoing knee pain with swelling, and it was noted that Petitioner was to see Dr. Choi the following day. (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on May 20, 2015, at which time Petitioner stated that her knee felt warm. It was noted that her knee was slightly warm to the touch but otherwise she was improving. It was noted that she was to continue physical therapy per Dr. Choi, to use the brace at all times and to continue the home exercise program. At the time of the May 19, 2015 visit, Petitioner reported that her knee was sore on that date and that she felt like there was less swelling. The assessment was that of ongoing knee pain with some improvement. At the time of the May 18, 2015 visit, it was noted that Petitioner stated that her knee was sore and swollen on that date. The assessment was that of ongoing knee pain with swelling, improving slowly. At the time of the May 14, 2015 visit, it was noted that Petitioner stated her knee was sore and swollen. The assessment was that of ongoing pain in the right knee. (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on May 13, 2015, at which time she stated that her knee was sore. The assessment was that of "[t]he patient is still sore." It was noted that Petitioner was to continue physical therapy per Dr. Choi. At the time of the May 12, 2015 visit, it was noted that Petitioner stated that she had occasional pop that was painful and that she also had some grinding in her knee. It was noted that Petitioner was improving slowly and steadily, and that she "promise[d] to stay on track with her therapy." At the time of the May 11, 2015 visit, Petitioner stated that she had no significant changes and remained compliant with the brace but continued to have pain along the inside of her knee. The assessment was that of right knee no change, and she was instructed to

continue physical therapy per Dr. Choi. At the time of the May 7, 2015 visit, Petitioner stated that she felt the same as yesterday and continued to have medial knee pain. (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on May 6, 2015, at which time it was noted that Petitioner had not been there the week before but stated she remained compliant with the brace. The assessment was that of right knee had regressed slightly from missing the prior week. At the time of the April 23, 2015 visit, it was noted that Petitioner complained of increased tenderness over the medial knee, that she had a positive valgus stress test, that she had pain with overpressure, that she had full motion and that her quadriceps strength was improving. The assessment was that of ongoing right knee pain, and Petitioner was instructed to continue physical therapy. At the time of the April 20, 2015 visit, Petitioner stated that her knee was very sore and that she got her brace. The assessment was that of ongoing pain in the right knee with swelling, and Petitioner was instructed to continue physical therapy. At the time of the April 16, 2015 visit, Petitioner reported that she still had not gone to get her brace and that "[s]he has had an excuse every day." The assessment was that of ongoing right knee pain/instability, and it was noted that Dr. Eavenson "strongly encouraged her to put this in the forefront of her day and get her brace." (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on April 15, 2015, at which time Petitioner stated her knee was still quite sore. The assessment was that of ongoing right knee pain with weakness. At the time of the April 14, 2015 visit, it was noted that Petitioner remained about the same and was still waiting for her brace to come in. The assessment was that of right knee no change. At the time of the April 14, 2015 visit, Petitioner reported that she was still very sore and that she was fitted for a brace the day prior. At the time of the April 9, 2015 visit, it was also noted that Petitioner reported that she was still very sore and that she was fitted for a brace the day prior. The assessment was that of ongoing pain in the right knee with swelling. At the time of the April 7, 2015 visit, Petitioner reported that she was very sore because she had to work the day prior after physical therapy. The assessment was that of ongoing right knee pain fell [*sic*] mostly medially. At the time of the April 6, 2015 visit, Petitioner stated that her knee still felt unstable. The assessment was that of ongoing pain in the right knee. At the time of the April 2, 2015 visit, Petitioner also stated that her knee still felt unstable. The assessment was that of right knee patellar subluxation. It was noted that Petitioner would be referred to Dr. Choi. (PX3).

The records of Multicare Specialists reflect that Petitioner was seen on April 1, 2015, at which time Petitioner stated that she was working at the South County store on March 21, 2015, went to grab a part, realized she needed a ladder, went to grab the ladder and that her right knee popped. It was noted that Petitioner stated that her right kneecap popped out of place, and that she had to manually manipulate the kneecap back in place. It was noted that Petitioner fell to the ground, and that 1½ hours later she was finally sent home. The assessment was that of right MCL tear/medial meniscus tear and loose body off the medial patellar. An MRI was ordered and Petitioner was also instructed to see Dr. Choi the next day.

The medical records of Dr. Choi were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on May 27, 2015, at which time she complained of inflammation in her knee and popping but she had not experienced any patella dislocating episodes. The impression was that of right knee patella dislocation/subluxation. It was noted that there was no role for surgical intervention, and that Petitioner had undergone a physical therapy program with activity modification with the use of a knee brace. It was noted that Petitioner had achieved maximum medical improvement and no further treatment was recommended. (PX4).

The records of Dr. Choi reflect that Petitioner was seen on April 2, 2015, at which time it was noted that Petitioner stated that on March 21, 2015 she was walking to grab an oil cap for a customer which was above her reach, she pulled a ladder and that when she twisted to get on the ladder she felt significant pain and felt a popping sensation. It was noted that Petitioner fell to the ground and manually

pushed her kneecap back in place, and that she had significant pain along the medial aspect of the knee. It was noted that Petitioner called out for help and reported that no one was available to help her out, that she was eventually able to have the security guard help her to her feet and that there were some crutches in the back room that she was able to use. It was noted that Petitioner reported that she dislocated her left knee in the past from a soccer injury, that she had no subsequent injury with her left knee and that regarding her right knee she had never had an episode or injury. The impression was that of right knee patella dislocation/subluxation. It was noted that Petitioner had classic findings on MRI with a bony contusion that was localized to the medial aspect of the patella and the distal lateral femoral condyle, and that he did not see a clear disruption of the MPFL and the medial retinaculum. Conservative treatment was recommended. It was also noted that there was no role for surgical intervention but it would be considered if, despite the rehabilitation program, Petitioner continued to experience patellar instability. (PX4).

The medical records of Dr. Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on July 23, 2015 for evaluation of a chief complaint of right knee pain and a history of an apparent right patella instability episode. It was noted that Petitioner's history of injury dated back a number of weeks ago, that she was working at an auto parts store, that she was positioning a ladder and was stepping back and pulling the ladder, at which time her kneecap popped out of place. It was noted that Petitioner described a self-reduction maneuver, that she had pain and noted swelling and that she reported the injury but did not initially seek medical attention. It was noted that she complained of ongoing pain in the right knee and that she noted a sense of instability of the kneecap. Petitioner stated that it felt like the knee wanted to give out and that the kneecap wanted to pop out, but she did not describe any true additional patella dislocation episodes. Dr. Paletta noted that he reviewed an MRI performed on April 1, 2015. The impression was that of (1) acute patella instability, likely lateral dislocation; (2) probable chondral injury medial facet of the patella secondary to patella instability; (3) persistent knee pain and subtle patella instability status post probable patella dislocation. It was noted that treatment options would include intraarticular injection, continued use of the brace and continued symptomatic treatment versus consideration for surgical treatment. It was noted that Petitioner wished to consider the options. A work slip was issued on that date, allowing Petitioner to return to work full duty effective July 23, 2015. (PX5).

The IME report of Dr. Browdy was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report noted that Petitioner was seen on December 2, 2015 regarding her right knee and that the chief complaint was right knee pain. It was noted that Petitioner stated that on March 21, 2015 she was working for Respondent and injured her right knee while she was attempting to move a ladder and grab a product for a customer. Petitioner stated that as she was moving the ladder she turned around a corner and her patella popped out of place, causing her to fall to the ground. It was noted that she reduced the patella herself and sought assistance from the onsite security guard, and that she was able to get to the front of the building where she was able to find a pair of crutches that happened to be onsite. Dr. Browdy noted that Petitioner contacted a lawyer and was referred to Dr. Eavenson, who recommended physical therapy and eventually an MRI and that she was then referred to Dr. Choi. It was noted that Dr. Choi recommended non-surgical treatment and eventually recommended that she discontinue a brace she had been using, and that Petitioner stated she was "not happy" that she was still having symptoms despite being released from his care and requested another opinion. (PX6).

The report reflects that Dr. Browdy's impression was that of right patellar dislocation, and that the injury Petitioner sustained while working on March 21, 2015 caused the patella to dislocate and caused the MRI findings consistent with a transient patellar dislocation. Dr. Browdy noted that Petitioner described a vague sense of instability, but did not describe any overt instability events. He noted that typically patellar stabilization procedures were most commonly indicated after one experienced recurrent instability, and that it was fairly unusual for one to complain of a "sense of instability" without an overt

instability event of the patella. He further indicated that medial patellofemoral ligament reconstruction may provide Petitioner with symptom relief, but he would be very guarded in pre-operative discussions regarding her prognosis. He also indicated that a medial patellofemoral ligament reconstruction would not address her pain, and that it was possible that her pain was related to malalignment. (PX6).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Incident Report was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report was dated March 23, 2015 and noted a claimed incident date of March 21, 2015 at 6:45 p.m. It was noted that the team member (*i.e.*, Petitioner) was picking a part, and that she said she hurt her knee as she turned to walk back up front. No reference was made to the involvement of a ladder. (RX1).

The IME report of Dr. Browdy was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report was duplicative of that as contained in Petitioner's Exhibit 6. (RX2; PX6). The Benefit Payout was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

CONCLUSIONS OF LAW

Tto obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* 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; *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.*

With respect to disputed issue (C), the Arbitrator finds that Petitioner failed to prove that she sustained an accidental injury on March 21, 2015 that arose out of and in the course of her employment with Respondent. Although Petitioner's trial testimony suggests that she sustained an injury directly associated with her employment, the preponderance of the evidence in this case simply does not support her claim and the Arbitrator notes that Petitioner's testimony regarding the history of accident -- specifically, that she was grabbing a ladder and coming around the corner with it when her kneecap

popped out of place -- is not supported by any of her treatment records. In fact, the only record that indicated that Petitioner felt pain while pulling the ladder was Dr. Browdy's IME report of December 2, 2015, which was recorded some nine months after the alleged incident and was inconsistent with the more contemporaneous medical records generated after the alleged incident. (PX6; RX2).

The Arbitrator finds that Petitioner's testimony at the time of arbitration is inconsistent with the medical records entered into evidence in this matter, and is actually rebutted by the contemporaneous medical records upon which the Arbitrator places significant weight. The Arbitrator notes that not only was Petitioner's testimony at the time of arbitration inconsistent with the medical records, but there was not even a consistent history of accident throughout the medical records themselves. Related thereto, the Arbitrator notes that the initial emergency room visit noted a history of a knee injury and that the symptoms/episode began/occurred 2 days while walking at work and that her patella popped out of place, while at Concentra the medical records noted that Petitioner stated that she had discomfort in her right knee around the patella, and that she was at work some 10 days prior when she made a quick turn to grab a ladder and in the process her right knee cap popped out of place after which she pushed it back in its normal position. (PX1; PX2).

The Arbitrator further notes that when seen at Multicare Specialists, it was noted that Petitioner went to grab a part, realized she needed a ladder, went to grab the ladder and that her right knee popped, yet when seen by Dr. Choi Petitioner stated that on March 21, 2015 she was walking to grab an oil cap for a customer which was above her reach, she pulled a ladder and that when she twisted to get on the ladder she felt significant pain and felt a popping sensation. (PX3; PX4). Then, when seen by Dr. Paletta, Petitioner stated that she was positioning a ladder and was stepping back and pulling the ladder at which time her kneecap popped out of place. (PX5). Given the lack of any contemporaneous medical records or evidence to support Petitioner's trial testimony, the lack of any consistent history in the medical records supportive of Petitioner's claim and the fact that her testimony was further rebutted by the testimony of Mr. Weniger in this matter, the Arbitrator finds that the Petitioner failed to meet her burden of proof. The Arbitrator further finds that Petitioner has also failed to prove any increased risk associated with her employment was a causative factor in her injury in light of the multitude of inconsistencies in the evidence surrounding the involvement of the ladder, if any.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that she sustained an accidental injury on March 21, 2015 that arose out of and in the course of her employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F) pertaining to causation, (J) pertaining to reasonable and necessary medical expenses and (K) pertaining to prospective medical treatment, as those issues are rendered moot. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
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

Bart Brakett,

Petitioner,

vs.

NO: 15 WC 12666

17IWCC0390

Caterpillar, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

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: JUN 27 2017
TJT:yl
o 5/22/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

BRAKETT, BART
Employee/Petitioner

Case# **15WC012666**

CATERPILLAR INC
Employer/Respondent

17IWCC0390

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:

1727 LAW OFFICE OF MARK N LEE LTD
KEVIN MORRISON
1101 S SECOND ST
SPRINGFIELD, IL 62704

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

17IWCC0390

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)

Bart Brackett
Employee/Petitioner

v.

Caterpillar Inc.
Employer/Respondent

Case # 15 WC 12666

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **June 27, 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 _____

17IWCC0390

FINDINGS

On the date of accident, **2/25/2015**, 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 **$37,370.00**; the average weekly wage was **$718.66**.

On the date of accident, Petitioner was **54** years of age, ***single*** 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 bilateral carpal tunnel releases and bilateral epicondylitis treatment.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

9/10/16
Date

ICArbDec19(b)

SEP 20 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim alleging repetitive trauma injuries arising out of and in the course of his employment for Respondent, specifically bilateral carpal tunnel and bilateral epicondylitis. Petitioner is 54 years old, single and has 0 dependent children. Petitioner is currently unemployed after being let go by Respondent.

Petitioner began working for Respondent in 2005 and had worked a variety of jobs for the Respondent. Regardless of where the Petitioner worked, he worked full 8 hour shifts and full time for the Respondent. Petitioner testified that he had noticed symptoms in his hands and arms for years prior to reporting it to medical. Petitioner testified that he simply worked through the pain.

Petitioner's most recent job title with Respondent was as a painter, a job he started a few months prior to filing his claim on 2/25/2015. Petitioner testified that as a painter he was required to use a sander, similar in nature to Petitioner's Exhibit 5 for half of his shift. Petitioner testified that the sander required some force to use. Petitioner's symptoms would increase with use of the sander. Jim Novacek, Petitioner's supervisor, agreed that half of the Petitioners' shift would involve the use of a sander, and the other half using a power washer and also agreed that Petitioner's Exhibit 5 was an accurate portrayal of the sander used by Petitioner. Mr. Novacek disagreed with when the Petitioner started the painting job and testified that the Petitioner had only been on the painting job for a week possibly two weeks at the time he reported his injuries.

Respondent provided a video of two employee's using a sander. The Arbitrator, Petitioner and both counsels viewed this video prior to testimony. The Petitioner testified that it was more or less consistent with what he did with a sander but he would use more force to do it faster and to meet quotas. Petitioner later admitted that different items would be prepared for painting and would take varying levels of sanding and time. Molly Meyers, safety manager, testified that she used the sander in question and it did not require very much force and only vibrated to a low degree. Mrs. Meyers testified that to use the sander effectively it would not require any force but that the machine did all the work itself. Mrs. Meyers testified that the sander did not vibrate nor require enough force to contribute to the development of carpal tunnel syndrome.

The other half of his shift, the Petitioner would use a power washer to spray off equipment for paint preparation. Petitioner testified that the power washer required a great deal of force to use. Petitioner testified it was returning to his job as a painter that further aggravated his symptoms, which he had for years, to the point where he sought medical treatment. Respondents' Exhibit 3 was an incident report dated 2/25/2015. It was in the handwriting of the Petitioner that stated he changed jobs because of the vibration from sanding, hurting elbows and his inability to sleep.

In both the Petitioner's Exhibit 1 and Respondent's Exhibit 1, a second incident report was entered into evidence, it was dated on 2/25/2015 as well. In its description, the Petitioner wrote; "moved back to paint dept. using vibrating tools again and pain began. When identifying said tools, the Petitioner wrote sander and wash. Petitioner only complained about his left and right elbows as well as his left hand thumb in this report.

Jim Novacek, described that the power washer would require the same force as the one in a car wash, but later testified that it may be somewhat greater than the ones used at a car wash. Molly Meyers, testified that the force of a power washer was the same as a car wash. She also prepared a report regarding the power-washer that stated the power washer used 1800 PSI.

Prior to working as a Painter, Petitioner testified that he worked in rust prevention. This job required him to use a sprayer. Petitioner testified that while his symptoms were consistent throughout this job bid, but that this job was not as strenuous as his prior jobs, so his arm and hand symptoms were manageable.

Prior to working in rust prevention, Petitioner worked on motor grader using heavy impact wrenches. This testimony was confirmed by the testimony of Jim Novacek who was not familiar with the motor grader work area but was aware that the Petitioner came from that job bid prior to working rust prevention. Petitioner stated the impact wrenches were similar in nature to those used in NASCAR and required a great deal of forceful gripping and vibration. The Petitioner testified that he used a variety of these tools during his 8 hour shift and it was in this job that he started noticing problems with his elbows and increased problems with his hands. Because of these problems, he bid to a less strenuous job with rust prevention.

When Petitioner was first hired, he worked in the painting department. He was required to sand, paint, and wash various items, using a power washer, for Respondent. Petitioner used a sander similar in fashion to what was pictured in Petitioner's Exhibit 5. He used a power washer, and a spray gun. Petitioner testified that he did notice that his hands were becoming become numb when he sanded during his shift and he would be forced to switch hands often.

Petitioner started treatment with Caterpillar medical. He stated he worked full duty and was treated with heat which was effective in managing his pain. On 3/3/15 his claim was written as denied. During this treatment Petitioner complained of his elbows and left thumb.

Petitioner then followed up with Dr. Sawlaw at Kirby Medical Group on 3/24/2015. The record reflects that the Petitioner was there for a repetitive injury from work. It noted he used his elbows to push pressure against vibrating machinery. With progressive elbow pain that radiated into his thumbs and 8/10 pain in the left hand and 5/10 pain in the right hand. But no numbness was noted. Dr. Sawlaw ordered an EMG study and suggested possible ulnar tunnel.

Petitioner then underwent an EMG at DMH hospital on 4/3/2015. Petitioners' EMG results were abnormal with evidence of impaired conduction through the carpal tunnel region, more pronounced on the left.

Petitioner then followed up with Dr. Kefalas on 4/20/2015. The medical note recorded that the Petitioner recently started a job as a painter using sanders and a spray gun. Dr. Kefalas impression was of the right and left carpal tunnel syndrome and right and left lateral epicondylitis. He advised that the Petitioner should undergo a left carpal tunnel release and his right side possibly after that point. He then injected Petitioners' left elbow.

Petitioner followed up with Dr. Kefalas on 12/28/2015. It reported that the last injection into the elbow provided moderate relief. Dr. Kefalas again injected Petitioners' left elbow and released him to regular duty work.

Petitioner saw Dr. Kefalas again on 2/1/2016. Dr. Kefalas ordered an MRI of the cervical spine but Petitioner denied cervical pathology.

Dr. Kefalas was deposed on 9/2/2015. Dr. Kefalas reviewed his treatment up until that date and confirmed he would still recommend bilateral carpal tunnel release and would suggest 1 or 2 more injections into Petitioners elbows before trying surgery. Dr. Kefalas agreed that vibratory tools could contribute to the development of carpal tunnel syndrome to a moderate degree. (PX4-p.10) He also agreed that the forceful gripping over extended periods of time had a strong evidence that force and repetition could contribute to the development of carpal tunnel PX4-pg. 10-11). Dr. Kefalas was then handed a copy of a picture of a sander that was entered into evidence at trial and identified by both Petitioner and Respondent's witness Jim Novacek.

Dr. Kefalas was then given a hypothetical job history that was similar in nature to what was testified to at the date of trial. After hearing the hypothetical job history and reviewing the picture, Dr. Kefalas testified that the Petitioner's employment with the Respondent contributed to the development of both Petitioner's bilateral carpal tunnel syndrome and bilateral lateral epicondylitis. (PX4- pg. 16-18)

Petitioner saw Dr. Phillips for a section 12 Examination on 11/17/2015. Petitioner gave an occupational history similar to what was testified and the hypothetical given during Dr. Kefalas' deposition. Dr. Phillips diagnosed Petitioner with Bilateral CMC joint arthritis, bilateral lateral elbow pain most likely lateral epicondylitis, and bilateral carpal tunnel. Dr. Phillips did not believe that Petitioner's bilateral CMC joint arthritis was work related, nor was his bilateral carpal tunnel. Dr. Phillips did not feel that Petitioners' occupation put him at a high risk for developing work-related carpal tunnel syndrome.

Dr. Phillips did believe it was possible for the Petitioner's lateral epicondylitis was exacerbated by activities at Caterpillar.

Dr. Phillips was deposed on March 1, 2016. In his testimony, he confirmed the opinions of his Section 12 examination that he did not believe the bilateral first CMC joint arthritis was either caused or exacerbated by Petitioner's work at Respondent. He based this opinion on arthritis not being caused by any activity and the activities he described did not make those matters to become worse. He gave the same opinion in regards to bilateral carpal tunnel due to the Petitioner already having arthritis which puts the Petitioner at higher risk for development of carpal tunnel. Dr. Phillips also testified that it was because the Petitioner did not get symptoms of carpal tunnel until recently and were really secondary symptoms to his thumb arthritis. (RX- pg. 20-21) Dr. Phillips then expanded on this opinion on this by testifying that if the Petitioner did not develop the symptoms immediately from the activities, he concludes that the timing of the Petitioner's symptoms worked against the factor of it being work related. (RX- pg. 23).

Dr. Phillips also confirmed that he thought Petitioner's work with Respondent could lead to the development of the Petitioners' lateral epicondylitis. He further testified that the Petitioner would require work restrictions for his condition. (RX2- pg. 24-25)

On Cross examination, Dr. Phillips agreed that a person could have arthritis similar to what was suffered by Petitioner but a trauma or intervention could render it symptomatic without changing the autonomy of the arthritis. (RX2-Pg. 29) He also agreed that Petitioner's symptoms could be more noticeable when he's doing activities requiring gripping for long periods of time. (RX2-Pg. 29)

Dr. Phillips also gave the opinion that a power washer would require more forceful gripping then a spray gun but would have no impact on his opinion regarding causation. (RX2-pg. 32-33) He later agreed that carpal tunnel could be aggravated by forceful gripping and vibratory work. (RX2- pg. 35) He also agreed that a person with arthritis suffered by Petitioner could have a more easily aggravated condition than someone with a standard carpal tunnel and possibly require less vibratory tools and forceful gripping than a person with a standard carpal tunnel. (RX2- pg. 39)

Conclusions of Law

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

The Arbitrator concludes that Petitioner sustained repetitive trauma injuries arising out of and in the course of his employment with Respondent that manifested itself on February 25, 2015.

In support of this conclusion the Arbitrator notes the following:

In both of Petitioner's original reports of injury to Respondent he cited vibration and referenced to the vibratory nature of his work as a painter with the sander and power washer.

Petitioner's testimony regarding his work activities was largely unrebutted. Petitioner's job history was consistent from the deposition of Dr. Kefalas, his section 12 exam and his testimony at trial. Indeed, Respondent's own witness's and video demonstrated use of a sander, and power washer which both witnesses agreed vibrated to a degree. The large disputes on Petitioner's job duties revolve around when Petitioner started his job as a painter but not the job he was performing or his job history. Jim Novacek even confirmed that prior to working in rust prevention Petitioner worked in the motor grader line.

It should also be noted that Respondents own section 12 physician agreed that Petitioner's work could cause Petitioner's bilateral epicondylitis. While Dr. Phillips did not give the opinion that the Petitioner's bilateral carpal tunnel was work related, he did agree that the carpal tunnel could be aggravated by forceful gripping and vibration. He even agreed that the arthritis suffered by Petitioner would make him more vulnerable to aggravation of his bilateral carpal tunnel. Based upon inconsistency, the Arbitrator finds the opinions of Dr. Kefalas to be more persuasive then Dr. Phillips.

Ultimately, Petitioner's testimony of his 10 years of work for Respondent all requiring either sanding, use of a paint gun, sprayer, power washer or impact wrench and how it impacted his symptoms was what was found to be most significant by the Arbitrator. Petitioner testimony appeared truthful and credible, he even agreed that his symptoms were not made worse by a lighter job as rust proofer but testified that was why he took the job to continue working diligently for his employer. He came from a job that the respondent's own physician thought was heavy enough in nature to contribute to his bilateral epicondylitis. This all establishes that his work aggravated and made symptomatic his conditions to the point of necessitating treatment.

In regard to disputed issue (J), the Arbitrator makes the following conclusions of law:

The medical bills admitted into evidence, are awarded consistent with the findings above on accident and causation, subject to any Section 8(j) credit and subject to the fee schedule.

In regard to disputed issues (K), the Arbitrator makes the following conclusions of law:

Both Dr. Kefalas and Dr. Phillips agreed that Petitioner suffered from bilateral carpal tunnel and bilateral epicondylitis. While Dr. Phillips would not operate without more conservative care, the Arbitrator finds the testimony of Dr. Kefalas more persuasive. Having determined both conditions to be related to Petitioner's work activity for Respondent, the Arbitrator finds the proposed surgeries and treatment necessary and orders Respondent to pay for same, subject to the fee schedule.

Edward Lee, Arbitrator

9/10/16
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

BRIAN STUART,

Petitioner,

vs. NO: 15WC 14032

COMMUNITY PARK DISTRICT OF LaGRANGE PARK, 17IWCC0381

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, medical, perspective medical, temporary total disability, "evidentiary issues", penalities, 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 January 28, 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.

17IWCC0381

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: JUN 22 2017

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CJD/rlc
049

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

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

STUART, BRIAN
Employee/Petitioner

Case# **15WC014032**

COMMUNITY PARK DISTRICT OF LaGRANGE PARK
Employer/Respondent

17IWCC0381

On 1/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% 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:

0154 KROL BONGIORNO & GIVEN LTD
MICHAEL BRANDENBERG
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
TAMMY A PAQUETTE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

17IWCC0381

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)

BRIAN STUART,
Employee/Petitioner

v.

COMMUNITY PARK DISTRICT OF LAGRANGE PARK,
Employer/Respondent

Case # 15 WC 14032

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 1, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0381

FINDINGS

On the date of accident, **January 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*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$29,474.64**; the average weekly wage was **$566.82**.

On the date of accident, Petitioner was **40** years of age, ***married*** with **6** dependent children.

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

Respondent shall be given a credit of **$3,781.57** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,781.57**. 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 **$377.88/week** for **20-4/7th** weeks, commencing **January 20, 2015** through **April 8, 2015** and **April 18, 2015** through **June 21, 2015**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid against this award.

Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$382.82**, 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 for and authorize the prospective medical treatment recommended by Dr. Chekka on March 31, 2015 and by Dr. Saleem on May 12, 2015 and all incidental care thereto.

Respondent shall pay to Petitioner penalties of **$0**, as provided in Section 16 of the Act; **$0**, as provided in Section 19(k) of the Act; and **$0**, as provided in Section 19(l) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS UNLESS a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE IF the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

1-28-2016
Date

ICArbDec19(b)

JAN 28 2016

FINDINGS OF FACT

Brian Stuart ("Petitioner") and Community Park District of LaGrange Park ("Respondent") proceeded to Arbitration on December 1, 2015 in Chicago, Illinois pursuant to Petitioner's request for hearing and petition for fees and penalties. Ax1, Ax2. Respondent submitted its response to the petition for fees and penalties, denying Petitioner's claim in part. Ax3. At trial, the following issues were in dispute: causal connection, liability for unpaid medical bills, temporary total disability, penalties and fees and prospective medical care. Ax1.

Petitioner testified that on January 19, 2015, he was a 40-year-old left-hand dominant employee of Respondent as a maintenance assistant and had been so employed since April 1, 2009. His job duties included overseeing part-time help, instructing part-time help on jobs, weed whacking, blowing pathways clean, working with mulch, planting trees, cleaning up parks, removing debris and garbage, trimming trees and mowing grass.

The parties do not dispute Petitioner sustained an accident on January 19, 2015. Ax1. Petitioner testified that on that day, he was out in a truck by himself disposing of garbage, when he was called to a sled hill in Memorial Park to remove a Jacuzzi hot tub at the top of the hill. He dragged the tub down the hill to his truck, stood it on its end, crouched down to lift it and tried to push it into the truck bed. As he was lifting the tub, he started to slip on ice so he pushed the tub of into the truck, grabbed the truck gate with his right arm and his whole body shifted down to the left. He immediately felt pain in the neck down to the left shoulder running down to his left hand. Petitioner testified that he reported the accident to his employer and that he was referred to LaGrange Medical Center.

That same day, Petitioner treated with Dr. Khan at LaGrange Medical Center. Px1, Rx6. He reported an injury to his left arm after slipping while trying to load a hot tub onto a truck along with a prior history of fibromyalgia, bipolar and heart problems. He reported the injury felt like a tear in the left arm. Pain was 4 out 10 and 10 out of 10 with movement. Review of symptoms showed low grade low neck pain on the right. Upon examination, Petitioner was unable to lift his left arm over ten degrees and was able to abduct and forward flex to ten degrees. There was mild swelling distally and moderate swelling at the left elbow. X-rays of the left shoulder were normal. The diagnosis was left shoulder contusion post fall and left biceps swelling. Dr. Khan recommended that Petitioner remain off of work and undergo MRI's of the left elbow and shoulder.

On January 21, 2015, MRI of left humerus was unremarkable. MRI of the left elbow revealed a grade 1-2 strain of the biceps tendon at its insertion on the radial tuberosity with mild surrounding fluid and mild to moderate tendinosis of the common extensor tendon at the insertion. MRI of the left shoulder revealed: moderate tendinosis of the supraspinatus tendon with a small partial thickness undersurface tear at the anterior insertion; suspicion for a small to medium intra-substance tear within the supraspinatus tendon at the subacromial location; mild tendinopathy of the infraspinatus tendon with suspicion for a small partial thickness tear at the insertion; mild to moderate tendinosis of the subscapularis tendon; mild AC osteoarthritis; mild subacromial/subdeltoid bursitis; and a possibility of supraspinatus outlet impingement. PX1.

On January 22, 2015, Petitioner followed up with Dr. Khan. Exam of the left shoulder exhibited mild swelling and diffusely tender at the shoulder joint. Petitioner was unable to lift his left arm greater than 60 to seventy degrees. The diagnosis was left shoulder injury and left trapezius muscle spasm. Petitioner remained off of work.

On January 26, 2015, Petitioner began a course of physical therapy at LaGrange Medical Center for a left shoulder injury after falling down on the left shoulder while loading a tub. Petitioner complained of pain on the

left to the anterior proximal 1/3 of the forearm, at elbow at the bicep area and upper arm, anterior and posterior. He reported no pain on the left shoulder and elbow before the injury. On January 28th, Petitioner returned to therapy reporting severe left arm pain in the morning that he almost cried. Therapists noted poor tolerance to exercises due to pain. On January 29, 2015, Petitioner was released to work with no use of the left arm. Petitioner was referred to Dr. Arif Saleem for orthopedic consultation for the shoulder. Therapy was continued.

On February 4, 2015, Dr. Khan noted Petitioner was able to take his arm out of the sling more comfortably and that he was improving until he went to work and drove and that he was not supposed to use his left arm. The doctor restricted Petitioner to no driving at work and no forceful grasping with the left hand and recommended further physical therapy. Petitioner testified he notified Respondent of the new restriction and that work was not accommodated.

On February 5, 2015, Petitioner was examined by Dr. Saleem at Castle Orthopedics and Sports Medicine, reporting left shoulder pain since an injury on January 19, 2015 when he pushed a Jacuzzi up into a work truck. Rx4. He reported slipping and trying to brace his fall when he felt a forceful, jerking away motion of his left arm, followed by immediate sharp pain and a pulling/popping sensation. He reported pain in his left shoulder, shoulder blade and neck going down into the left elbow with some numbness.

Upon examination, the left arm had limited mobility upon active elevation to eighty degrees at most, and passive elevation was limited due to pain. External rotation went to forty degrees and resisted abduction went to about fifty degrees. Rotator cuff internal and external rotation was intact. He complained of discomfort and tenderness in the bicep tendon. Petitioner had pain with Speed, Hawkins, and Neer tests. Cervical spine range of motion caused significant pain radiating down left shoulder blade. MRI of left shoulder showed evidence of rotator cuff, capsular, ligament or bicep pathology. The doctor appreciated a small intrasubstance tear of the supraspinatus that did not explain all symptoms. The diagnosis was left upper extremity significant pain, paresthesias and diffuse symptomatology. The doctor suspected possible brachial plexopathy. An EMG was recommended, along with work restrictions and therapy.

On February 10, 2015, Petitioner underwent an EMG at Neurologic Care Associates. The doctor noted Petitioner was previously there in August 2010 for significant problems with the left arm and upper back pain along with tingling in the arm and hand. Petitioner presented for pain and tingling in the same arm resulting from a fall on January 19th wherein he fell off a truck and was reaching rapidly to brace himself with his left resulting in a snap of the left shoulder. He complained of pain in the shoulder down the arm into the forearm, radiating to the biceps as well as intermittent swelling of the fingers and hand. He also complained of mild neck pain. Clinical exam showed good range of cervical motion but pain with extension. Deep tendon reflexes were 1+ at the biceps and 1 at the brachial radialis and triceps bilaterally. Motor exam was normal. Strength exam of the shoulder was difficult due to pain. The only abnormality noted involved the mild motor unit configuration changes in proximal arm muscles most consistent with a mild myopathy likely of a toxic/endocrine type. Potential etiologies were numerous but highly suggestive of those secondary to "statin" medications. There was no evidence of cervical radiculopathy, brachial plexopathy or of a median, ulnar or radial mononeuropathy in the left upper extremity. The findings suggested symptoms were of a musculoskeletal basis.

On February 13, 2015, Petitioner followed up with Dr. Saleem, reporting persistent discomfort in the left shoulder with pain radiating down the arm, worsened by activities and laying down at night. Upon examination, the left shoulder had limited range of motion and was very tender throughout the left arm, especially the anterior elbow, lateral epicondyle, and the anterolateral shoulder. Dr. Saleem administered a differential injection to the left shoulder and prescribed an MRI of the cervical spine and continued physical therapy. Following the injection, Petitioner reported shooting pain to his therapists.

On February 19, 2015, MRI of his cervical spine showed foraminal stenosis at right C5-6, secondary to a disc herniation and spondylitic ridging and mild degenerative changes of the remaining cervical levels. During this time, Petitioner continued physical therapy, reporting significant left upper extremity pain down to the left hand as well as left-sided neck pain. Px4.

On March 5, 2015, Petitioner saw Dr. Saleem, reporting only temporary relief from his injection and radiating pain in his left forearm and lateral elbow. The doctor noted diffuse pain. On examination, Petitioner was tender over the lateral and medial epicondyle and mobile wad, with some mild tenderness over the pronator on medial side. The left shoulder exhibited limited range of motion with significant discomfort. Petitioner had pain with Hawkins and Neer tests, as well as resisted elevation over the anterolateral and posterolateral shoulder. Impression was left upper extremity pain, multifactorial. The doctor explained that Petitioner's pain was relatively diffuse and it was hard to localize the definitive source of pain. He reviewed the MRI of the cervical spine, which did not show any signs of nerve root impingement on the left. He recommended tertiary care evaluation. The doctor did not think there was anything else he could offer Petitioner. Dr. Saleem referred Petitioner to Dr. Anthony Romeo with Midwest Orthopedics at Rush. Light duty was continued.

On March 9, 2015, Dr. Khan administered an injection to Petitioner's left mid trapezius. The diagnosis was left shoulder impingement and Dr. Khan recommended that Petitioner remain off of work. Petitioner testified he notified Respondent of his off work status.

On March 11, 2015, Petitioner was examined by Dr. Anthony Romeo. Px3, Rx3. Petitioner reported an injury to his left arm on January 19, 2015 while pushing a bathtub into a work truck bed. He grabbed the truck with his right arm and jerked his left arm, immediately feeling intensely sharp pain in the left shoulder. Chief complaint was pain in the shoulder, elbow, forearm and left side. He reported constant and worsening pain, sharp and throbbing in quality. He reported pain with walking, sitting, lifting, carrying, bending, twisting and sleeping. Other symptoms included stiffness, swelling and weakness.

He reported spasms in the left biceps and pain located at the anterior shoulder, radiating down to the first three fingers in the left hand with a swollen sensation. Upon examination, Petitioner had significant tenderness to palpation over the left biceps tendon in the bicipital groove and was very guarded. He had limited range of motion in the left arm. The diagnosis was left shoulder pain with small partial thickness supraspinatus tear, a grade 1-2 strain of the biceps tendon and biceps tendinitis. Dr. Romeo opined that he agreed with Dr. Saleem in that he was unsure of the exact cause of the pain. The doctor noted that although Petitioner had a partial thickness tear of the supraspinatus and bicep strain/tendonitis, clinical exam did not match findings on imaging. He referred Petitioner to see a pain management specialist and issued work restrictions of sedentary work with no lifting over ten pounds. Petitioner testified he notified Respondent of this light duty and that work was not accommodated. Px3.

On March 16, 2015, Petitioner returned to Dr. Khan. The doctor noted Petitioner's recent visit with Dr. Romero and that Petitioner already had an injection with no improvement reported. The doctor noted greater range of motion to abduction. Diagnosis was left shoulder and arm pain. Dr. Khan referred Petitioner to pain management and issued work restrictions. Petitioner testified he notified his employer. On March 19th, LaGrange noted Petitioner's visit with McNeal Pain Center was "approved" and that Petitioner recently called wanting some of his restrictions lifted.

On March 31, 2015, Petitioner was examined by Dr. Kiran Chekka at MacNeal Hospital, reporting left arm symptoms that developed in January while lifting a hot tub into a truck bed when he felt severe pain radiating into his left shoulder and arm. Px4, Rx7. He currently felt tingling, pins and needles sensation, muscle pain, neck and back pain, muscle cramps, fatigue and joint swelling. Past medial history was positive for myofascial pain syndrome. Upon examination, there was some subtle change in sensation at C6, Spurling's test was positive on the left with tenderness and discrete trigger points in the paracervical musculature. Cervical range of motion was limited with rotation to the left and extension was restricted. The diagnosis was left upper extremity cervical radiculopathy in a clinical C6-7 dermatomal distribution as evidenced by a positive Spurling's sign, cervical degeneration, cervical facet syndrome, myofascial pain, cervicalgia and mild rotator cuff pathology. Dr. Chekka opined that Petitioner likely suffered an aggravation of a preexisting condition and that there was no overt disc herniation on MRI but Petitioner did not have any significant neck pain or radicular symptoms prior to the work-related injury and now he was having severe functionality limiting his pain. Dr. Chekka prescribed an epidural steroid injection to C5-6, use of a TENS device, physical therapy or chiropractic care and work restrictions of no lifting over twenty pounds and no overhead lifting.

On April 2, 2015, Petitioner returned to Dr. Kahn, who recommended the same work restrictions as Dr. Chekka. Petitioner testified he notified his employer and he returned to work light duty on April 9, 2015 in a janitorial position. The duties of that position, included mopping, sweeping, vacuuming and wiping down counters and windows. He testified that using the mop when it got wet and heavy caused pain in his left shoulder going down the arm as well as when pushing a broom. Petitioner further testified that on April 15, 2015, he stopped working light duty that Friday because when he came into work to clean mirrors; Martin Healy brought Petitioner his paycheck and explained that Roy Rogers was coming back as a janitor and therefore Petitioner would be off work as of Monday. Petitioner testified that he never refused to work light duty and never complained about working light duty. He never told his supervisor that he could not do his light duty job. On cross, Petitioner testified that he did not tell Martin Healy he could not do light duty due to Petitioner's wife's work hours.

On April 16, 2015, Petitioner was examined by Dr. M. Bryan Neal at the request of Respondent. Rx1. Dr. Neal summarized prior medical history from 2009 through 2014. The doctor noted the Employee Injury Report noted an incident occurred when he was picking up a hot tub left in the park and when lifting his foot slipped and he felt something in his shoulder and left arm. The doctor then summarized Petitioner's post-accident medical treatment as noted, *supra*.

Petitioner gave a history of slipping while loading a hot tub into his truck at work and grabbing the truck with his right hand, causing his left arm to pull away from his body and sharp pain to shoot down the left arm. Petitioner related he thought he was there for exam of his left side, pointing to his left shoulder and arm. He related he was told he has something with his cervical spine and that it is causing the pain in his arm and that other doctors have also told him he has tendinitis. Petitioner had no opinion as to where his pain was coming from. Petitioner disclosed only one prior work injury to the left hand. Petitioner admitted to prior treatment with Dr. Chekka and a prior diagnosis of fibromyalgia. Dr. Neal noted Petitioner's left arm and shoulder were "awesome" before. On cross, Petitioner disagreed he made this statement to Dr. Neal.

Upon examination, Petitioner demonstrated pain and discomfort with movement and strength testing of the left arm. He had good internal and external rotation. Diagnosis was "left lateral neck pain and left diffuse shoulder, shoulder girdle and left upper extremity pain and paresthesias of unknown etiology superimposed upon underlying biopsychosocial currently fibromyalgia." Dr. Neal found the mechanism of injury to be unusual. He could not conclude that Petitioner's current left shoulder condition was or was not related to the work accident without further review of Petitioner's medical records up to 5 years pre-dating the accident. Dr.

Neal offered that he found it "implausible that this history of a perfectly normal and asymptomatic shoulder and left upper extremity prior to January 19, 2015." He opined that Petitioner could work with the same restrictions issued by Dr. Chekka. Dr. Neal found it reasonable for Petitioner to treat with pain management and a trial TENS unit but could not say if that was related to the work accident. He did not agree with cervical injections. Dr. Neal was not able to project a point of maximum medical improvement.

On May 12, 2015, Petitioner was reexamined by Dr. Saleem, exhibiting limited range of motion in the left shoulder with significant pain and positive Hawkins and Neer tests. Px2, Rx4. There was tenderness over the anterior and posterior areas of the left shoulder, mild AC joint tenderness, and lateral and medial epicondylar tenderness. Impression was persistent myofascial pain with small partial rotator cuff tear. Dr. Saleem opined that Petitioner's symptoms are likely an aggravation of a preexisting condition, and, while orthopedic intervention is not required, pain management is reasonable. Dr. Saleem recommended work restrictions of no lifting over eight pounds, lifting only between knee and chest level, no use of the left arm, no repetitive or forceful grasping, and no overhead work. Petitioner testified he notified his employer of the restrictions. He stated he was not accommodated and that he would call Alex, who told him to call every Friday.

On June 5, 2015, Petitioner was examined by Dr. Khan, who provided work restrictions based on his review of Petitioner's medical treatment and a job description. He concluded Petitioner was not fit to return to work full duty as defined by the job description but could work modified duty. He added that although EMG/NCV was negative for cervical radiculopathy, Petitioner's symptomatology suggest the diagnosis should be pursued by pain management. He recommended pain management and restrictions of no overhead work, no lifting over ten pounds, and occasional grasping. PX1.

Petitioner testified that he returned to work at light duty on June 22, 2015 pursuant to the light duty restrictions issued by Dr. Khan on June 5, 2015. He testified that he had been off of work completely from April 18, 2015 through June 21, 2105.

Petitioner testified that on September 22, 2015, Petitioner underwent an epidural steroid injection to his neck, performed by Dr. Chekka. He further testified that between June 5th and September 22nd, he did not undergo any medical treatment because none was authorized. Following the September 22nd injection, Petitioner testified that no further treatment has been authorized. He wants the treatment recommended by Dr. Chekka so that he can get fixed and get back to work and take care of his family.

Petitioner testified that he was not having any problems with his left shoulder, arm or neck, and was performing his full duties, prior to the accident on January 19, 2015. Petitioner testified that he currently has constant pain. He has difficulty taking care of his kids and cannot change his daughter's diaper. He gets assistance from him wife and kids with household chores that he was able to do prior to the accident, such as fixing his car. He no longer plays basketball with his kids because it aggravates his pain. Prior to the accident he averaged 6-7 hours of sleep per night. He now averages about 2.5-3 hours of sleep per night. He has little difficulty driving a vehicle, but sometimes uses his right hand. His pain intensifies when the weather gets cold or rainy, and his left arm experiences swelling when the weather is hot.

He currently works light duty for Respondent. His duties include cleaning parks, putting up Christmas lights, mowing lawns and removing garbage. He requests assistance from his boss if the item is too heavy or he just leaves it for someone else. He testified that his boss bought him a hand blower that requires only use of his right arm. He testified that his symptoms are aggravated depending on how much carrying he has to perform and how his body shifts.

Cross Examination & Prior Medical History

On cross examination, Petitioner was questioned extensively on his prior medical history, treatment, symptoms and complaints before the work accident.

In March 2007, Petitioner was seen at Weiss for left arm pain at the site of where a prior IV was placed. Studies were ordered to rule out retained foreign body. Petitioner did not recall this visit. He later went to Loyola for the same complaints and a second opinion. Rx10.

In January and February of 2008, Petitioner is seen and treated at Weiss for complaints of neck, right shoulder and hip pain. On cross, Petitioner testified he did not recall this treatment but did not dispute that it could be correct. In June 2008, Petitioner presents to Loyola with chest pain down the left side with numbness to the left side. TIA was identified. Rx10. On cross, Petitioner testified he did not recall but the notes could be correct. Petitioner returned to Loyola in September 2008 for separate head and rib injuries.

Petitioner could not recall a December 2009 MacNeal visit for left arm pain and weakness symptoms and left side jerking and left facial numbness. Records show Petitioner ultimately diagnosed with a seizure.

Regarding a July 2011 MacNeal visit, Petitioner could not recall a CT scan of the cervical spine. Records show Petitioner presented with head trauma and CT scan of the cervical spine was negative.

Regarding several August 2012 visits to MacNeal for chronic upper back and cervical pain, Petitioner testified that he could not recall but perhaps he treated for same. Records show he was treated for cervical and lumbar radiculopathy, right upper extremity pain and headaches after falling on ice 3 weeks prior. He was also treated that same month for lumbar axial back pain and radiculopathy. Finally, records show Petitioner was treated on a separate occasion for neck, back and shoulder pain, which was ultimately diagnosed as myofascial pain for low back pain. Trigger point injections were completed but an SI injection was attempted but aborted.

Petitioner was also questioned on cross regarding treatment with Salud. Rx2. Records show that on October 14, 2008, Petitioner was treated at Salud for abscess under the left arm with cellulitis. On November 1, 2008, Petitioner was seen at Salud for lumbar pain. On January 7, 2009, Petitioner was seen at Salud for right shoulder pain and low back pain and was diagnosed for the low back. It does not appear the right shoulder was evaluated or diagnosed. On September 17, 2009, Petitioner was seen at Salud for tremors. Petitioner said he did not recall this visit. In August 2010, EMG/NCV was negative for peripheral neuropathy, individual neuropathy in either upper extremity or negative for evidence of cervical radiculopathy or brachial plexopathy on the left side. The doctor noted a striking feature of the described severe pain possibly related to over sensitivity or irritation in the connective tissue around the muscle (i.e. tendinitis and/or connective tissue disorder, etc.).

On February 22, 2011, Petitioner is seen by Salud for "pain everywhere," including the neck, shoulders, arms and legs. He reported he stopped taking his medications and reported swelling of the hands and fingers that look like "sausages." He was diagnosed with chronic pain syndrome but fibromyalgia was suspected. Petitioner was given Lyrica with possible referrals to rheumatology and an MRI of the cervical spine. Petitioner testified he recalled this visit.

In March 2012, Petitioner complained to Salud of pain in the lower back radiating to the right leg, bilateral arm pain, numbness and tingling, short term memory loss, headaches, loss of balance and slurred speech. Etiology was unclear and a referral to rheumatology was again discussed. Petitioner was referred to

neuropsychology. On July 24, 2012, Salud noted Petitioner had pain in the upper neck and chest, not well controlled. He was diagnosed with myalgia and myositis, unspecified. In August 2012, Petitioner returned to Salud for follow up of fibromyalgia and body aches.

In November 2013, Petitioner returned to Salud with complaints of severe frontal headache and coughing with pain in the neck, head and lower back. On cross, Petitioner did not recall.

In April 2014, Petitioner was seen at Salud for chest pain radiating to the left arm and was diagnosed with unspecified chest pain and chronic pain syndrome. Petitioner testified he recalled this visit and recalled pain in both arms with a prior diagnosis of fibromyalgia. In September 2014, Petitioner presented to Loyola for dizziness, slurred speech and left upper extremity weakness. Tightness in the neck and back were noted. Slight dysarthria was noted. Petitioner was tested for possible stroke or TIA. Rx10:216-491. He returned in October, November and December for follow up of same. *Id.* at 514-686. On cross, Petitioner did recall left arm weakness, tingling down the left hand, dropping items and left elbow pain during these visits. Petitioner also testified that during this time, his Lyrica was increased which allowed him to be functional in that it decreased the pain in the legs, arms and hands.

Further, in February 2015, Petitioner returned to Loyola for follow up of "weakness and spells." Fibromyalgia was noted. Rx10:690.

On May 8, 2015, Petitioner followed up with Loyola and Dr. Evans for complaints of neck and shoulder pain. *Id.* at 718. Petitioner was noted to have seen a shoulder specialist and received injections followed by a bad reaction resulting in shooting pain and numbness in his left arm and fingers. He had been sent to a pain specialist. Diagnosis of cervical radiculopathy due to degenerative joint disease, cervical facet syndrome, cervicalgia was made. Petitioner was referred to pain management. On 6/9/15, Petitioner followed up with Dr. Evans for bipolar disorder and pain. *Id.* at 730. Regarding the pain, the doctor noted that it was severe in the left shoulder that Petitioner was unable to change daughter's diaper and that Petitioner "gives several stories about how he sadly has to watch his children do things for him that he can no longer do because of the arm pain." The doctor noted his non-involvement in workers' comp. On 10/12/15, Petitioner is seen by Dr. Nickolas Garbis of Loyola for an acute visit regarding an orthopedic surgery referral. Rx10. Petitioner's January 2015 accident is noted with injury to the left shoulder. He complained of left shoulder pain that radiated to the arm as well as pain in the left upper back and left neck. Exam of the shoulder showed no tenderness, ability to raise to 110 degrees with pain. Exam of the neck showed full range of motion with some pain.

Video Surveillance

Without objection Rx8 was admitted into evidence. The video, approximately 18 minutes in total length, concern surveillance conducted on April 19, 2015, April 20, 2015 and April 23, 2015. It begins at approximately 10 am and around noon, a man. The Arbitrator notes that no stipulation was made on the record whether the man in the video is in fact Petitioner. Nevertheless, the Arbitrator notes the similarity between the man in the video and Petitioner at trial. The man is seen speaking with an unidentified woman and near a vehicle. He leans against the car somewhat using the right arm in a raised and later in a flexed position. Movement with the left arm, if any, is not visualized. On April 20th and 23rd, individuals are seen on the video behind window and door of a residence. No individual is visualized coming out of the residence. On April 23rd, at approximately 11:35am, a man appearing to be Petitioner is visualized grabbing mail using both hands.

A second DVD was also admitted into evidence. Rx9. The DVD contains approximately 34 minutes of total surveillance over the course of the following dates in 2015: March 17th, March 18th, March 20th and March 27th. Again, the Arbitrator notes that no stipulation was made on the record whether the man in the video is in fact Petitioner. Nevertheless, the Arbitrator notes the similarity between the man in the video and Petitioner at trial. On March 17, 2015, the video begins at approximately 6:20am. Around 1:21pm, a man, woman and child are observed leaving a residence. The man walks through a parking lot with a child hand using his left hand and arm. Later, the man is seen leaving that same store with a large grocery type bag using right hand and arms. The man opens rear of the SUV and using the left hand and arm, he lifts the window, moves objects aside and places grocery bags in SUV using right arm. The parties are later seen shopping and the man uses the right hand and arm for moving materials and places grocery bags inside of car using both arms and hands. The man then returns the cart to the cart corral, pushing with both arms. The man adjusts the rear view driver's side mirror. The man is observed maneuvering the steering wheel with both hands. At around 2:27pm, the man is again seen in another parking lot exiting the vehicle. Uses left arm and hand to close door. He exits a store with a large bag in the right hand, loads it into the SUV using primarily the right arm and hand and uses the left to support. He again adjusts the rear view mirror. Later, the man is observed carrying gallon of milk in left hand toward the same residence previously visualized. The man later re-enters home with mail in left hand.

On March 19th, the same residential home is visualized. No activity is noted. On March 20th, a man resembling Petitioner is seen leaving residence carrying a young child with both hands. The man then leaves the residence and is observed maneuvering the steering wheel with both hands. The man exits the car and walks to and from a building. On March 27th, a man is visualized standing inside of a building gesturing using the left hand and arms. This continues for some time. The man, similar in appearance to Petitioner, leaves through a parking lot and once again adjusts the rear-view mirror. On March 30th, the man is visualized adjusting or fixing the rear view driver's side mirror using both hands. The man is later visibly observed at a gas station using both hands to grab the pump.

Petitioner entered into evidence the following medical bills: Castle Orthopaedics Sports $183.00 for date of service May 12, 2015 and MacNeal Hospital $199.82 for date of service March 31, 2015. Petitioner also submitted a payroll time sheet from April 9, 2015 through April 17, 2015 indicating a total of 48 hours worked and initialed by Petitioner. Px6.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator has carefully considered Petitioner's testimony and finds Petitioner to have testified in a credible and candid manner regarding the circumstances of his work accident, his recollection of his medical treatment following the accident, his time off of work, and his functional capabilities and as to his current condition. Further, the Arbitrator finds the surveillance video of little weight on the issue of credibility as more fully set forth below.

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

At trial, the parties disputed causal connection between the undisputed work accident and Petitioner's neck, left arm and left shoulder condition(s) and complaints. Ax1.

Petitioner testified that prior to the accident on January 19, 2015, he was not having any problems with his neck, left arm or left shoulder. He said he was able to perform his full work duties that day prior to the accident occurring. Prior medical history reveals a lengthy course of medical treatment for a variety of

complaints and symptoms. Of note, Petitioner did in fact have a prior history of left arm and some neck complaints, the most recent having been in 2014. Respondent asserts Petitioner's testimony that he had no prior history of such pain is directly contradicted by the prior medical records and therefore Petitioner should be afforded less credibility. Petitioner's testimony is not incongruent with his prior medical records, however. Petitioner, at various points during cross examination, admitted that he did not recall various visits and did not disagree as to what those records stated. Petitioner disclosed what he could recall. Petitioner disclosed a prior history of myofascial pain to Dr. Chekka at the March 31, 2015 visit. In addition, Petitioner's complaints in his prior medical records present in the context of a larger problem rather than direct injury to the area of complaint. This was not fully explored during cross nor re-direct. For example:

2007 – Left arm pain where an IV had been placed;
2008 – Neck pain after waking up in back pain;
2008 – Left arm pain for an abscess;
2008 – Chest pain radiating down left side, a TIA is identified as the cause;
2009 – Left arm pain ultimately diagnosed as a seizure;
2011 – A negative cervical spine exam for head trauma after a fight;
2011 – Pain "everywhere," suspected fibromyalgia;
2012 – Chronic cervical pain after falling on ice ultimately diagnosed as lumbar myofascial pain;
2012 – Bilateral arm pain, numbness and tingling, fibromyalgia is diagnosed;
2013 – Pain in the neck with coughing;
2014 – Chest pain radiating to the left arm for chronic pain syndrome,

Petitioner's current diagnosis is persistent myofascial pain, small partial rotator cuff tear (Saleem), left upper extremity cervical radiculopathy in a clinical C6-7 distribution, cervical degeneration, cervical facet syndrome, cervicalgia, mild rotator cuff pathology, myofascial pain (Chekka), left shoulder and arm pain (Kahn), left shoulder pain with small partial thickness supraspinatus tear, grade 1-2 strain of the biceps tendon and biceps tendinitis (Romeo).

None of the conditions ultimately identified as the cause of Petitioner's symptoms in the prior treatment records appear to be Petitioner's current diagnosis, nor are they the subject of his post-accident treatment nor are they the subject of Petitioner's proposed future treatment. The Arbitrator does note that Petitioner's pre-existing diagnosis of fibromyalgia and myofascial pain is perhaps implicated in Petitioner's current condition. Drs. Chekka and Saleem both concluded that Petitioner likely aggravated his pre-existing condition in the work accident.

There is no evidence that immediately prior to the work accident, Petitioner directly or indirectly injured his neck, left arm and/or left shoulder or that he had pain in those areas immediately prior. Based on these facts, the Arbitrator concludes that Petitioner was symptom and treatment free with respect to the neck, left arm and left shoulder immediately prior to the work accident. Immediately after Petitioner slipped while pushing the hot tub into his work truck, he felt a pop in his left shoulder and sharp pain running from his neck down his left arm to his hand. Petitioner's recollection of the work accident is corroborated by the subsequent medical records. Px1-4.

Dr. Chekka opined that Petitioner's condition was caused by an exacerbation of a preexisting condition. Px4. Dr. Saleem also opined that Petitioner's preexisting condition was aggravated by his work accident. Px2. The Arbitrator finds that these medical opinions are consistent with one another and support the medical history in that to the extent Petitioner had a prior history of neck, left arm or left shoulder pain, that pain was significantly increased or aggravated following the work accident. Respondent's Section 12 Examiner, Dr.

Neal, was equivocal on the issue of causation and reserved further opinion until further review of additional medical records was done. Rx1. There is no evidence additional medical records were reviewed. In considering the video surveillance, the Arbitrator finds it does not directly bear any weight on the issue of causation. The video depicts a man using the left hand and arm minimally to perform tasks such as driving, adjusting a mirror, carrying groceries that do not appear significant in weight or size and carrying mail.

Based on a preponderance of the evidence, the Arbitrator adopts the medical opinions of Petitioner's treating doctors over those of Dr. Neal on the issue of causation and concludes that Petitioner has proven his current condition of ill-being as to the neck; left arm and left shoulder are causally related to his work accident.

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

Having found in favor of Petitioner on the issue of causal connection, the Arbitrator resolves the issue of liability for unpaid medical bills in favor of Petitioner. Ax1.

The records reflect that Petitioner treated with Dr. Khan at LaGrange Medical Center on January 19, 2015. On January 29, 2015, Dr. Khan referred Petitioner to see Dr. Saleem, with whom Petitioner treated through May 12, 2015. Dr. Saleem referred Petitioner to Dr. Romeo on March 5, 2015. Drs. Romeo and Khan both referred Petitioner to pain management and Petitioner was evaluated by Dr. Chekka on March 31, 2015. Petitioner last treated with Dr. Chekka on September 22, 2015. Px1-Px4. The records show that this treatment was all in relation to Petitioner's condition of ill-being following the work accident and therefore it is reasonable and necessary treatment. Based on the Arbitrator's findings in Section "F", the bills are awarded as follows:

1. Castle Orthopedics & Sports Medicine—DOS 5/12/15: $183.00
2. MacNeal Hospital—DOS 3/31/15: $199.82

Petitioner testified that, as of the date of hearing, he had not received any bill for treatment on the date of service September 22, 2015. Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$382.82**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (K) Is Petitioner entitled to any prospective medical care?

Based on the foregoing, the Arbitrator finds that Petitioner's causally related current condition of ill-being has not yet stabilized and that he is otherwise in need of further additional medical treatment. Dr. Chekka has recommended a cervical epidural steroid injection, a TENS unit and further physical therapy and additional chiropractic care. Similarly, Dr. Saleem agreed that Petitioner could benefit from pain management care. Irrespective of causation, Dr. Neal found it reasonable for Petitioner to treat with pain management and a trial TENS unit irrespective of causation.

Petitioner testified that subsequent to these recommendations, he did undergo a cervical epidural steroid injection on September 22, 2015. He has not received a TENS unit nor returned for follow up. Drs. Kahn, Saleem or Neal have not considered Petitioner to be at maximum medical improvement for his symptoms or condition of ill-being. The Arbitrator adopts the opinions of Drs. Kahn and Saleem in this regard.

Petitioner testified that he currently has constant pain, has difficulty taking care of his kids, averages about 2.5-3 hours of sleep per night and his pain intensifies when the weather gets cold or rainy and his left arm experiences swelling when the weather is hot. Petitioner also testified he currently is working light duty for Respondent and that his symptoms are sometimes aggravated and he requires assistance. Petitioner testified he wishes to continue treatment. In weighing the surveillance conducted by Respondent in this matter, the Arbitrator assigns it little weight on its probative value on the issue of prospective medical care as the video fails to identify the man in video as Petitioner and, assuming it is Petitioner in the video, does not depict Petitioner performing activities of daily living that are in contradiction to his credible trial testimony nor are the activities in contradiction to subjective complaints made to his medical providers. The man observed in the video is seen carrying mail, a grocery back, milk and driving and adjusting the mirror using the left side. He is also seen using both upper extremities to carry a child and to place groceries. The man did not appear outwardly to exhibit any signs of pain or difficulty and there is nothing in the record to suggest he could not perform these activities.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being has not yet stabilized and that he is need of further medical treatment and that therefore the treatment recommendations of Drs. Chekka and Saleem to be reasonable and necessary. Respondent shall pay for and authorize the prospective medical treatment recommended by Dr. Chekka on March 31, 2015 and by Dr. Saleem on May 12, 2015 and all incidental care thereto.

ISSUE (L) What temporary benefits are in dispute?

Petitioner claims that he is entitled to temporary total disability (TTD) benefits for the period between January 20, 2015 up to and including April 8, 2015 (11-2/7th weeks) and again from April 18, 2015 up to and including June 21, 2015 (9-2/7th weeks), a period representing 20 and 4/7th weeks. Ax1. Respondent claims that it only owes TTD benefits for the period between January 20, 2015 and April 5, 2015.

Petitioner's uncontradicted testimony is that he was off work completely from January 20, 2015 through April 8, 2015. Respondent began accommodating his light duty work restrictions on April 9, 2015, but informed him it would no longer accommodate them as of April 18, 2015. The work log submitted as Petitioner's Exhibit 6 shows that Petitioner worked light duty from April 9, 2015 through April 17, 2015. Px6. Petitioner testified that he was off work completely from April 18, 2015 until Respondent began accommodating his restrictions as of June 22, 2015. At trial, there was cross examination as to whether Petitioner left light duty perhaps due to his wife's work hours. However, this was credibly answered and explained that Petitioner was replaced by the original janitor for that position.

On January 19, 2015, Dr. Khan restricted from working completely. From January 29, 2015 through the date of hearing, Petitioner's treating physicians have restricted him to light duty work. As of the date of hearing, no treating physician had released Petitioner to return to work at full duty. The Arbitrator has reviewed the evidence and finds Petitioner is entitled to TTD benefits for 20 and 4/7th weeks, representing the periods between January 20, 2015 through April 8, 2015 and April 18, 2015 through June 21, 2015.

Respondent shall pay Petitioner temporary total disability benefits of **$377.88/week** for **20-4/7th** weeks, commencing **January 20, 2015** through **April 8, 2015** and **April 18, 2015** through **June 21, 2015**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid against this award.

ISSUE (M) ***Should penalties or fees be imposed upon Respondent?***

Petitioner seeks penalties and fees against Respondent for non-payment of TTD and non-payment of certain outstanding medical bills. Ax1. Petitioner asserts and the evidence showed that he worked light duty from April 9, 2015 through April 17, 2015. Respondent stopped accommodating his restrictions as of April 18, 2015 and did not accommodate them again until June 22, 2015. From April 18, 2015 through June 21, 2015, Petitioner was off of work, but did not receive TTD.

In April 2015, Section 12 examiner, Dr. Neal, opined that work restrictions were appropriate for Petitioner but could not provide an opinion whether Petitioner's condition was or was not causally related without further review of Petitioner's pre-injury medical records. Further, the doctor found it implausible that Petitioner's shoulder was perfectly normal or asymptomatic prior to the work accident. Dr. Neal did comment he found the mechanism of injury to be peculiar.

Petitioner asserts that Dr. Neal's opinions do not operate as a valid defense in light of the mandates of Sections 19(l), 19(k) and 16 for Respondent's refusal to pay TTD benefits. The Arbitrator disagrees. While Dr. Neal's ultimate opinion is entitled to less weight in light of a preponderance of the evidence, simply because the doctor's opinion was reserved on the issue of causation, it is clear from the record that his opinions tended to suggest that the doctor could not find a causal relationship because he found the mechanism peculiar and because he thought a review of Petitioner's pre-injury medical record relevant. That alone would be sufficient for Respondent to rely on in terminating benefits. Stated differently, it cannot be said that a reasonable person in Respondent's position would not have acted similarly in discontinuing payment of benefits based on what Dr. Neal's report tended to suggest. Therefore, Petitioner's request for penalties and fees is hereby ***denied***.

Signature of Arbitrator

1-28-2016
Date

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 Accident/Causation	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher B. Jensen,

Petitioner,

vs.

No. 15 WC 20758

Bratschi Plumbing, Inc.,

17IWCC0375

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 accident, notice, causal connection, medical expenses, temporary disability and permanent disability, and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

Petitioner's amended application for adjustment of claim alleges that on May 28, 2014, Petitioner injured his right shoulder while moving a hot water heater. Petitioner, a 25-year-old right hand dominant residential apprentice plumber at the time of the alleged accident, testified on direct examination that he worked for Respondent since 2009. His job was very physically demanding. Petitioner described the alleged accident as follows:

> "I *** had an incident with my shoulder. We were delivering two hundred-gallon water heaters to a house which was in turn meaning we were removing two old hundred-gallon [heaters] that day. We brought the two new ones inside. Everything went smooth with that.
>
> We brought the first of the old ones out, me and another guy that I was working with. We brought it up the stairs, get it to the truck, the van. We go to

> load this heater into the vehicle, and something happens where he loses his side of the heater. I've still got my right hand and left hand on the heater itself. Right hand is on the strap, and I feel a jerking and pulling motion as he loses his side, a lot of weight on my right-hand side."

Petitioner testified he felt a great deal of pain in the right shoulder and "a sudden snap and popping feeling, not very much mobility in it." He promptly notified Carrie Hosa, Respondent's office manager. However, he did not seek treatment, thinking "it was just something that was going to be workable through." As he continued to work, Petitioner noticed loss of strength and range of motion. Petitioner denied prior injuries or problems with the right shoulder. He also denied subsequent right shoulder injuries.

Petitioner further testified that on September 24, 2014, he saw his primary care physician, Dr. Thomas McGowan, for a severe acute illness. He did not mention a problem with his right shoulder because he was very ill. On October 20, 2014, Petitioner saw Dr. McGowan's physician's assistant about his right shoulder and was referred to Dr. David Beigler at the Illinois Bone & Joint Institute. Ultimately, Dr. Beigler operated on the right shoulder. Petitioner last saw Dr. Beigler on June 4, 2015, at which time Dr. Beigler released him to return to work full duty.

On cross-examination, Petitioner acknowledged sustaining a work-related injury to the right knee in 2011 and treating for it right away at the Illinois Bone & Joint Institute. Petitioner stated he treated for the knee injury right away because Respondent transported him to a hospital. Petitioner acknowledged finishing his shift on May 28, 2014, qualifying that he did not help with the second heater. The first time he complained to a medical provider about his right shoulder was on October 20, 2014. Petitioner did not file an application for adjustment of claim until June of 2015. Petitioner admitted that he used to be an avid weightlifter.

The medical records in evidence show that on September 24, 2014, Petitioner presented at Dr. McGowan's office with flu-like symptoms and was prescribed an antibiotic. There is no mention of right shoulder pain. On October 20, 2014, Dr. McGowan's physician's assistant noted the following history and complaints: "Pain at R AC joint x 3 months; not getting any better. *** Thinks he tweaked it 3 months ago; flares up intermittently (fluctuating in intensity). *** 0 tearing/popping sensation felt at time of possible injury. Shoulder seems to pop in and out of place. Unsure if he had swelling at the time. Takes ibuprofen here & there. Denies constant ache. Feels weaker than L side. *** Can't sleep on [right] side – too painful. *** Works as a plumber." X-rays of the right shoulder showed "[m]ild widening of the AC joint may be sequela of prior trauma."

On November 25, 2014, Petitioner consulted Dr. Beigler, who noted the following history and complaints: "[The patient] recounts an injury to his right shoulder on May 28, 2014. He was taking a *** 75 gallon water heater out of a truck. He was holding it underhand, and it slipped and he tried to catch it and at that point, his right shoulder jerked. He had some pain and

discomfort at that time. He thinks he might have heard a pop, but he was able to work through the pain that day. Gradually over the next couple of days, his right shoulder got increasingly more painful. He did not seek any treatment for this initially. He just limited his activities with his right shoulder, put himself on light duty work. Over the course of the next several months, he continued to struggle. He eventually ended up seeing his primary care doctor in October." X-rays taken in the office showed some osteolysis of the distal clavicle. Dr. Beigler also suspected a labral tear and ordered an MRI arthrogram. The MRI arthrogram, performed December 2, 2014, showed: a partial thickness undersurface tear of the infraspinatus; labral tearing; and "[d]egenerative change at the acromioclavicular joint. Marked marrow hyperintensity in both sides of the joint raises the possibility of a more acute superimposed injury. Alternately, irregularity at the distal clavicle is suspicious for distal clavicle osteolysis such as may be seen with repetitive microtrauma (e.g., weightlifting)."

On December 22, 2014, Dr. Beigler performed an arthroscopic repair of a SLAP tear and nearly complete infraspinatus anterior tear. Petitioner's postoperative recovery was uneventful and he made very good progress in physical therapy. On June 4, 2015, Dr. Beigler declared Petitioner at maximum medical improvement and released him to return to work full duty.

On April 29, 2016, Dr. Troy Karlsson, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner gave a history consistent with his testimony. Dr. Karlsson diagnosed a labral tear and near full-thickness rotator cuff tear. Regarding accident/causation, Dr. Karlsson stated: "Both of these diagnoses can be caused by an acute trauma or by a degenerative process. With a sudden acute trauma, there will be significant pain, which usually will cause one to seek treatment early on. It is significant that this examinee did not seek treatment with his primary care physician until nearly 5 months after the alleged date of injury. In fact he saw his primary care doctor a month before that, and made no mention of shoulder pain. In the original note of October 20, 2014, when shoulder complaints were given, there is a mention that he tweaked it 3 months earlier. There was no mention of a work injury. This tweaking 3 months earlier also, would not fit with a work injury 5 months earlier. As such, I think it is more likely that not that this is on a degenerative basis rather than due to any trauma or lifting accident on May 28, 2014."

The Arbitrator found that Petitioner proved accident and causal connection. Respondent argues that Petitioner is not credible. Respondent submits Petitioner injured his right shoulder while weightlifting or sustained degeneration/microtrauma as a result of weightlifting. Respondent underscores the five-month gap in treatment between the date of accident and the first complaints in the medical records relative to the right shoulder. Respondent also notes the initial history Petitioner gave to Dr. McGowan's physician's assistant points to an injury in July of 2014.

The Commission finds that Respondent's argument has merit. Having carefully considered the entire record, the Commission finds that Petitioner failed to meet his burden of

proof on the issues of accident and causal connection. Accordingly, the Commission denies the claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 29, 2016, is hereby reversed and Petitioner's claim is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid 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.

JUN 20 2017

DATED:
o-04/27/2017
SM/sk
44

Stephen Mathis

Deborah Simpson

DISSENT

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JENSEN, CHRISTOPHER B
Employee/Petitioner

Case# **15WC020758**

BRATSCHI PLUMBING INC
Employer/Respondent

17IWCC0375

On 8/29/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0152 LINN CAMPE & RIZZO LTD
JACK M LINN
215 N MARTIN L KING JR AVE
WAUKEGAN, IL 60085

0507 RUSIN & MACIOROWSKI LTD
KISA P STHANKIYA
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)SS.

COUNTY OF Lake)

17IWCC0375

☐ Injured 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

Christopher B. Jensen
Employee/Petitioner

v.

Bratschi Plumbing Co., Inc.
Employer/Respondent

Case # **15** WC **20758**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Waukegan, Illinois**, on **July 22, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 28, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 **$42,401.29**; the average weekly wage was **$815.41**.

On the date of accident, Petitioner was **25** 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 **$8,816.60** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,816.60**.

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 $543.61 for 19 and 6/7 weeks, from December 22, 2014 through May 10, 2015, as provided in Section 8(b) of the Act. Respondent is entitled to credit in the amount of $8,816.60 for temporary total disability benefits paid.

Respondent shall pay Petitioner permanent partial disability benefits of $489.25 for a further period of 68.75 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the 13.75% loss of use of the person as a whole.

Respondent shall pay to Petitioner reasonable and necessary medical expenses of $150.00, as provided in Section 8(a) of the Act, subject to the fee schedule of Section 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

8/29/16
Date

AUG 29 2016

 17IWCC0375

FINDINGS OF FACT:

Petitioner, a 25 year old apprentice plumber, began his employment with Bratschi Plumbing Co., Inc. in 2009. As part of his duties he regularly lifted plumbing works in excess of 100 pounds during installation, removal, and repair, and performed maintenance on plumbing systems. Petitioner testified that he received a GED or high school equivalent diploma. Petitioner testified that he is right hand dominant.

Petitioner testified that on May 28, 2014, he injured his right shoulder while lifting a 75 gallon water heater, weighing in excess of 100 pounds, off a truck with a co-worker. Petitioner provided that the co-worker lost his grip on the water heater, causing the entire weight to shift onto Petitioner, specifically onto his right arm, jerking his right shoulder. Petitioner indicated he felt a pull and immediate pain in his right shoulder. Petitioner also provided that he gave notice of the incident to his supervisor, Carrie Hoza, that same day.

Petitioner testified that he did not seek immediate medical attention indicating he "thought he could work through it." Petitioner testified that as he continued to work, he noticed continual worsening symptoms. He wanted to work and hoped he could fight through the pain. He testified that he had never had any right shoulder problems or injuries before May 28, 2014, and that although he continued to experience increasing right shoulder problems following the work injury, he had not re-injured his right shoulder after the date of the accident. He further testified that he had never seen a doctor for right shoulder complaints prior to this work injury.

Petitioner testified that in September 2014, he woke up with a fever of 102 degrees, experiencing flu like symptoms and chills. Petitioner testified that his mother called his primary care doctor, Dr. Thomas McGowan, and set up a visit on an emergency basis, stating that her son was extremely sick and could "hardly walk." This phone call from Petitioner's mother is reflected in Petitioner's Exhibit 3. Petitioner was able to see Dr. McGowan on that date on an emergency basis, and Dr. McGowan prescribed Omnicef for the aforementioned illness related symptoms (PX 3)

Petitioner continued working. He stated that on October 20, 2014, the pain had gotten to the point he "had enough of trying to deal with the pain." Petitioner presented to Dr. McGowan on October 20, 2014 with a history of right shoulder pain. Petitioner reported that he worked as a plumber and thought "he tweaked it 3 months ago." Dr. McGowan noted that Petitioner was experiencing ongoing right shoulder pain, fluctuating in intensity, worse when lifting overhead or extending his arm. X-rays were ordered demonstrating "mild widening of the AC joint may be sequel of prior trauma." Dr. McGowan rendered a provisional diagnosis of right labral tear and referred Petitioner to an orthopedist, Dr. David Beigler. (PX 3)

Petitioner came under the care of Dr. Beigler on November 25, 2014. He provided Dr. Beigler with a history of the work accident of May 28, 2014. Dr. Beigler's records note "an injury to his right shoulder on May 28, 2014. He was taking a 75 gallon water heater out of a truck. He was holding it underhand, it slipped, and he tried to catch it, and at that point, his right shoulder jerked. He had some pain and discomfort at that time… He did not seek any treatment for this initially. He just limited his activities with his right shoulder, put himself on light duty work. Over the course of the next several months, he continued to struggle. He eventually ended up seeing his primary care doctor in October." Dr. Beigler noted Petitioner reported he was experiencing significant right shoulder pain on a daily basis, pain with any overhead activity, and that work was causing him significant pain. He had experienced no improvement over the last six months, and had no medical history of right shoulder problems. (PX 4)

Dr. Beigler ordered x-rays which demonstrated some osteolysis of the distal clavicle. Dr. Beigler assessed distal clavicle osteolysis and possible labral tear. The doctor noted that although the x-rays demonstrated some osteolysis at the distal clavicle, the amount of pain, discomfort and guarding on examination indicate he might have additional pathology as well. As a result the doctor ordered a right shoulder MR Arthrogram, which took place on December 2, 2014. The MR Arthrogram report details a partial-thickness undersurface tear of infraspinatus at the level of the tendon insertion involving 50-75% of the tendon thickness and extending for 10mm, along with extensive tearing of the anterosuperior labrum which was detached and nondisplaced from approximately the 11 to the 4 o'clock position. Also noted was degenerative change at the acromioclavicular joint. It was noted that alternately, irregularities at the distal clavicle was suspicious of distal clavicle osteolysis such as may be seen with repetitive microtrauma such as weightlifting. (PX 4)

Following the MR Arthrogram, Petitioner again saw Dr. Beigler on December 8, 2014. Dr. Beigler reviewed the MR Arthrogram indicating same demonstrated a significant labral tear and a small partial thickness tear of the infraspinatus. Dr. Beigler stated that given that Petitioner's symptoms and reported injury extend back to the end of May 2014, nonsurgical treatment would unlikely provide significant relief. The doctor prescribed surgery. (PX 4)

Petitioner underwent arthroscopic repair of the right shoulder labral and rotator cuff tears on December 22, 2014 with Dr. Beigler. The postoperative diagnosis was 1.) labral tear from 11 o'clock to 4 o'clock and 2.) nearly complete anterior infraspinatus tear. (PX 4) Petitioner testified that he was taken off work the date of the surgery.

Petitioner returned to Dr. Beigler on January 6, 2015. Dr. Beigler referred Petitioner for a course of physical therapy at IBJI Gurnee, and according to Petitioner he was to remain off work. (PX 4)

Petitioner followed-up with Dr. Beigler on February 5, 2015. Dr. Beigler noted Petitioner's active range of motion in his right shoulder was somewhat limited. He advised Petitioner to continue with physical therapy, follow up in a month. On March 19, 2015, Dr. Beigler described a "catching pain" Petitioner was experiencing as he progressed through 100 degrees of forward abduction and flexion. The doctor noted Petitioner was progressing satisfactorily but he felt Petitioner was not yet able to work. (PX 4)

Petitioner next saw Dr. Beigler on May 7, 2015. Dr. Beigler noted Petitioner was still experiencing some pain, and a less than full range of motion. Petitioner had finished with therapy. He allowed Petitioner to "return to unrestricted work other than over the next couple weeks as he gets back into the swing of things… overhead lifting will be limited to 50 pounds."(PX 4) Petitioner testified that he returned to work on May 11, 2015.

Petitioner last saw Dr. Beigler on June 4, 2015. Dr. Beigler noted that although Petitioner had been working full time with no restrictions, he did get sore particularly at the end of the day. Dr. Beigler advised continued unrestricted work and to follow up as needed. (PX 4)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Troy Karlsson on April 29, 2016. Dr. Karlsson noted Petitioner gave a history of lifting a water heater that weight in excess of 100 pounds with a coworker on May 28, 2014, which slipped out of the co-worker's hands and ended with Petitioner's end of the water heater jerking down, causing a pull in his right shoulder, which he reported to his supervisors when it occurred. Dr. Karlsson noted Petitioner complained of on and off pain, problems with overhead use, range of motion deficits, difficulty sleeping, and the inability to throw a baseball or football. He further noted Petitioner continued to take Advil for the ongoing pain. Dr. Karlsson noted his examination revealed no asymmetry to the musculature around his shoulders. With exception of external rotation, Petitioner had range of motion loss in all planes. Petitioner's right upper arm girth was larger than his left arm. Petitioner's distal clavicle was tender to touch. Dr. Karlsson reviewed Petitioner's medical records and noted Petitioner had

not treated until five months after his work injury. Dr. Karlsson assessed right shoulder labral tear and near full-thickness rotator cuff tear. He concluded that Petitioner's diagnosis could occur by acute trauma or the degenerative process. He indicated that with acute trauma there would be significant immediate pain which would cause one to seek treatment early on. He opined that it was more likely than not that Petitioner's condition occurred on a degenerative basis rather than due to trauma or a lifting accident on May 28, 2014. He believed Petitioner was at MMI and in need of no further medical treatment. He believed Petitioner's medical treatment had been reasonable but unrelated to his May 28, 2014 work injury. (RX 2)

Dr. Karlsson also performed a AMA Impairment Rating. In a separate report, Dr. Karlsson noted Petitioner's rotator cuff tear was "best classified…as a full-thickness tear of the rotator cuff." Dr. Karlsson further noted that Petitioner "does have pain and symptoms with strenuous activity. He does use medications to control symptoms…there are some losses of motion." Dr. Karlsson indicated Petitioner had a 5% Impairment of the upper extremity. (RX 2)

Petitioner testified as to the current complaints he has referable to his shoulder, including pain, weakness, soreness, and stiffness in his right shoulder. Petitioner testified that the pain and weakness is exacerbated when lifting overhead or extending his right arm. He further testified that he avoids throwing baseballs and soft-balls. Also, he no longer participates in basketball. Petitioner testified that he no longer has full range of motion in his right shoulder, and often has difficulty sleeping through the night as he wakes up from pain when he rolls onto his right side. He further testified that he regularly takes over the counter medication to control the ongoing pain in his right shoulder.

With respect to (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Petitioner testified that while in the employ of Respondent on May 28, 2014, he injured his right shoulder while lifting a 75 gallon water heater weighing in excess of 100 pounds off of a truck with a co-worker. The co-worker lost his grip on the water heater, causing the entire weight to shift onto Petitioner, specifically onto his right arm, jerking his right shoulder. Petitioner felt a pull and immediate pain in his right shoulder.

Based on Petitioner's unrebutted testimony, the Arbitrator finds that Petitioner sustained an accidental injury that arose out of and in the course of his employment on May 28, 2014.

The Arbitrator notes that Petitioner's testimony is consistent with the November 25, 2014 note of Dr. Beigler as well as the history provided to Respondent's Section 12 examiner, Dr. Karlsson

With respect to (E.) Was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

Petitioner testified that on the date of the accident, May 28, 2014, he notified his supervisor Carrie Hoza of the accident.

Based on unrebutted, uncontroverted, and credible testimony of Petitioner, the Arbitrator finds that Petitioner provided timely notice of the May 28, 2014 accident.

With respect to (F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

Petitioner testified that he had never had any right shoulder problems or injuries before May 28, 2014. On May 28, 2014, he injured his right shoulder while lifting a 75 gallon water heater, weighing in excess of 100 pounds, off a truck with a co-worker. Petitioner provided that the co-worker lost his grip on the water heater, causing the entire weight to shift onto Petitioner, specifically onto his right arm, jerking his right shoulder. Petitioner indicated he felt a pull and immediate pain in his right shoulder.

The central issue regarding causal relationship stems from the gap in Petitioner seeking treatment. The Arbitrator finds Petitioner's testimony credible that he had never had any right shoulder problems or injuries before May 28, 2014. Petitioner stated that he did not seek immediate medical attention thinking "…he could work through it." He wanted to work and hoped he could fight through the pain. As he continued to work, he noticed continual worsening symptoms.

Finally, on October 20, 2014, the pain had gotten to the point wherein he "had enough of trying to deal with the pain" and sought medical attention with Dr. McGowan, his primary care physician. Dr. McGowan rendered a provisional diagnosis of right labral tear and referred Petitioner to an orthopedist, Dr. David Beigler. The Arbitrator is persuaded by Petitioner's testimony that he did not seek immediate medical attention indicating he "thought he could work through it." Petitioner testified that as he continued to work, he noticed continual worsening symptoms. He wanted to work and hoped he could fight through the pain.

On November 25, 2014, Petitioner provided Dr. Beigler with a history of the work accident of May 28, 2014. Dr. Beigler's records note "an injury to his right shoulder on May 28, 2014. He was taking a 75 gallon water heater out of a truck. He was holding it underhand, it slipped, and he tried to catch it, and at that point, his right shoulder jerked. He had some pain and discomfort at that time… He did not seek any treatment for this initially. He just limited his activities with his right shoulder and put himself on light duty work. Over the course of the next several months, he continued to struggle. He eventually ended up seeing his primary care doctor in October." Dr. Beigler noted Petitioner reported he was experiencing significant right shoulder pain on a daily basis, pain with any overhead activity, and that work was causing him significant pain. He had experienced no improvement over the last six months, and had no medical history of right shoulder problems.

Dr. Beigler ordered a right shoulder MR Arthrogram which the doctor indicated same demonstrated a significant labral tear and a small partial thickness tear of the infraspinatus. Dr. Beigler stated that given that Petitioner's symptoms and reported injury extend back to the end of May 2014, nonsurgical treatment would unlikely provide significant relief. The doctor prescribed surgery.

Based on the above, relying on Petitioner's credible testimony, the consistent histories provided and Dr. Beigler's reference that Petitioner's symptoms and reported injury extend back to the end of May 2014, the Arbitrator finds that Petitioner's right shoulder condition of ill-being is causally related to the accident sustained on May28, 2014.

With respect to (K.) What temporary benefits are in dispute, the Arbitrator finds as follows:

Petitioner was temporarily and totally disabled from December 22, 2014 through May 10, 2015. This is based on the credible testimony of Petitioner and the medical reports of Dr. Beigler.

The Arbitrator finds Respondent liable to pay Petitioner temporary total disability benefits of $543.61 for 19 and 6/7 weeks from December 22, 2014 through May 10, 2015, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $8,816.60 for temporary total disability benefits previously paid.

With respect to Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Petitioner submitted outstanding medical expenses totaling $150.00 representing charges for Petitioner's October 20, 2014 visit to Dr. McGowan.

Having found the requisite causal relationship, the Arbitrator finds Respondent liable to pay the outstanding medical bill of $150.00, as provided in Section 8(a) and subject to the fee schedule of Section 8.2 of the Act.

Pursuant to the parties stipulation, Respondent has paid $30,939.44 in medical expenses.

With respect to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "Guides to the Evaluation of Permanent Impairment"; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

With regards to subsection (i) of Section 8.1(b), the Arbitrator notes that Respondent's Section 12 examiner, Dr. Karlsson, provided a 5% impairment of the upper extremity, or 3% impairment rating of the whole person. The Arbitrator notes that when performing this impairment rating Dr. Karlsson specified that the "clinical studies" of Petitioner's right shoulder injury were "not utilized" when making the grading modifications. The Arbitrator further notes that impairment rating does not equate to permanent partial disability under the Act. The Arbitrator gives some weight to this factor.

With regard to subsection (ii) of Section 8.1(b), the Arbitrator notes that the record reveals Petitioner was employed as an apprentice plumber by Respondent. He was released to return to his normal work duties by May 7, 2015 without restrictions. Petitioner testified that his jobs duties are physical in nature. He also testified that he has been performing his regular work duties since returning to work after his full duty release. The Arbitrator gives weight to this factor.

With regard to subsection (iii) of Section 8.1(b), the Arbitrator notes that Petitioner was 25 years old at the time of the accident. Because Petitioner is a young individual and his permanent partial disability will last considerably longer than an older individual, the Arbitrator gives additional weight to this factor.

With regard to subsection (iv) of Section 8.1(b), the Arbitrator notes that Petitioner returned to full duty work for Respondent with no loss of earning capacity. His earnings have increased since the work injury and he testified he was set to become a journeyman plumber one month after the trial with a 30% wage increase. Because of the evidence produced at trial shows that Petitioner has not sustained any impairment of his future earning capacity, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of Section 8.1(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner sustained an extensive labral tear and near full thickness rotator cuff tear to his right shoulder as a result of the work accident of May 28, 2014. Petitioner underwent corrective surgery on December 22, 2014. Thereafter, Petitioner underwent physical therapy from January 2015 until May 2015 when he was released to unrestricted work. Petitioner testified as to the current complaints he has referable to his injured right shoulder, including pain, weakness, soreness, and stiffness in his right shoulder. Petitioner testified that his participation in sports activities is limited. He avoids throwing baseballs and soft-balls. Also he no longer participates in basketball. Petitioner also testified that he no longer has a full range of motion in his right shoulder, and often has difficulty sleeping through the night as he wakes up from pain when he rolls onto his right side. He further testified that he regularly takes over the counter medication to control the ongoing pain in his right shoulder. Dr. Karlsson, Respondent's Section 12 examiner, noted in his April 29, 2016 report that Petitioner complained of ongoing on and off pain, problems with overhead use, range of motion deficits, difficulty sleeping, and the inability to throw a baseball or football. He further noted Petitioner continued to take Advil for the ongoing pain. On examination, Dr. Karlsson noted there was no asymmetry to the musculature around his shoulders. With exception of external rotation, Petitioner had range of motion loss in all planes. Petitioner's right upper arm girth was larger than his left arm. Petitioner's distal clavicle was tender to touch. In Dr. Karlsson's Section 12 addendum, he noted Petitioner's rotator cuff tear was "best classified…as a full-thickness tear of the rotator cuff." Dr. Karlsson further noted that Petitioner "does have pain and symptoms with strenuous activity. He does use medications to control symptoms…there are some losses of motion." Because the evidence of disability is corroborated by the treating medical records, the Arbitrator gives weight to this factor.

Based on the above, the Arbitrator finds that Petitioner is permanently disabled to the extent 13.75% under Section 8(d)2 of the Act.

With respect to (N.) Is Respondent due any credit, the Arbitrator finds as follows:

The parties stipulated that Respondent has paid $30,939.44 towards reasonable and necessary medical expenses.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cedric Morris,

Petitioner,

vs.

NO: 15 WC 26599

17IWCC0378

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the sole issue of nature and extent of 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.

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:
(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

i. In this case, neither party submitted an AMA impairment rating. The Commission gives no weight to this factor.

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

ii. Petitioner was a construction laborer for the City of Chicago and had been so for 18 years at the time of his March 14, 2015 accident. He testified he returned to work in his usual and customary position with no restrictions. On April 15, 2016, Dr. Slack allowed Petitioner to return to work full duty effective April 20, 2016. The Commission places great weight on this mitigating factor.

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

iii. Petitioner was 55 years old at the time of the March 14, 2015 accident. The Commission places some weight on this aggravating factor.

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

iv. There is no evidence that Petitioner's future earning capacity has diminished as a result of this injury. The Commission places some weight on this mitigating factor.

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

v. The medical records indicate Petitioner treated for a L4-L5 disc protrusion and lumbar radiculopathy. He received conservative treatment consisting of physical therapy, home exercises and prescribed medications. No injections or surgery was recommended. Dr. Slack's last report of April 15, 2016 indicated Petitioner's lumbar radiculopathy had completely resolved. Petitioner reported he had some low back stiffness in the morning which improved with activity. Dr. Slack refilled medications of Ibuprofen and Flexeril in case Petitioner had a flare-up with returning to work. Petitioner was to be seen as needed. Petitioner

testified he currently experiences low back pain while bending and lifting on the job. At home he has to rake a little bit, then take a break and sit down before he can move on. He takes Flexeril three times a day and Ibuprofen twice a day. He has not treated with Dr. Slack or any other physician for his low back since April 15, 2006. The Commission gives no weight to this factor as there is no evidence of permanent disability corroborated by the medical records.

The determination of permanent partial disability is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, *820 ILCS 305/8.1b* (West 2013) and considering the relevance and weight of all these factors, the Commission modifies the Arbitrator's Decision finding that Petitioner is permanently disabled to the extent of 7.5% person as a whole. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $735.37 per week for a period of 37.50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 7.5%.

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

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

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the Act. The party commencing 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: JUN 22 2017
LEC/maw
o06/06/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MORRIS, CEDRIC
Employee/Petitioner

Case# **15WC026599**

17IWCC0378

CITY OF CHICAGO
Employer/Respondent

On 12/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

0010 CITY OF CHICAGO
HOLLY ANDERSON
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

17IWCC0378

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

Cedric Morris
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **26599**

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 **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 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 **5/14/2015**, 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 **5/14/2015** injury, Petitioner earned **$78,692.38**; the average weekly wage was **$1,513.32**.

On the date of **5/14/2015** accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$48,716.90** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$48,716.90**.

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

ORDER

This Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 62.5 weeks, because the injuries sustained caused a loss of 12.5% man as a whole, as provided in section 8 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

12-02-16
Date

DEC 5 - 2016

Cedric Morris vs. City of Chicago
15 WC 26599

FINDINGS OF FACT

On May 14, 2015, Petitioner Cedric Morris was working as a Laborer for Respondent, the City of Chicago, when he suffered an injury that arouse out of and in the course of his employment. Petitioner testified that he was lifting a vault cover when he felt a pop and pain in her back. He was 55 years of age on this date. He claims injury to his lumbar back.

Petitioner reported the incident on May 14, 2015, and was seen at Mercy Works on May 15, 2015. (Px 1). He noted a burning sensation radiating to both legs with a little numbness and tingling. Petitioner reported he previously injured his lower back in 2000 while lifting a vault cover. He was diagnosed with low back sprain and strain. He continued to treat at Mercy Works on May 18, 2015, June 2, 2015, and June 19, 2015, and began physical therapy. Petitioner underwent an MRI on June 27, 2015, which found "lower lumbar degenerative disc and facet changes most significant at L4-L5. At L4-L5, the traversing left L5 nerve root and both exiting L4 nerve roots appear compressed." (Px 1). Petitioner returned to see Dr. Diadula at Mercy Works on June 30, 2015, and he diagnosed Petitioner with Left L5 nerve root and bilateral L4 nerve root compression.

Petitioner began seeing Dr. Charles Slack on July 29, 2015. Dr. Slack diagnosed Petitioner with lumbar derangement with L4-L5 disc protrusion with radiculopathy and recommended physical therapy. (Px 2).

Petitioner returned for a follow up visit with Dr. Slack on October 22, 2015. He reported he had been working with physical therapy on increasing his exercise program and had a flare up

of pain. In the November 19, 2015, discharge report from physical therapy, Petitioner reported, "I had no radicular pain down my legs, I feel like I can do almost anything now in my daily life." (Px 2).

On November 23, 2015, Petitioner reported to Dr. Slack that he was not having any radiating leg pain. He had been continuing physical therapy and still had discomfort in his back and fatigue in his legs with some of the exercises. Dr. Slack noted, "At this point in time, I will have the patient work on an increasing strengthening exercise program now in a gym setting…I would recheck him in about five weeks to determine at that point his ability to return to work full duty. If he would develop any increased leg symptoms, he then may need an epidural; however, at this point in time, it appears that he should continue to improve and not require the shot." (Px 2).

Petitioner continued to treat with Dr. Slack on January 21, 2016, and March 9, 2016, and Dr. Slack noted improvement in Petitioner's low back derangement and recommended increasing his exercise program. On April 15, 2016, Dr. Slack released Petitioner to work full duty. Dr. Slack noted that Petitioner "gets some stiffness in his lower back in the morning, but this gets better with activity." He also reported that Petitioner was only taking an occasional ibuprofen or Flexeril and that no other specific treatment is necessary. (Px 2). Petitioner testified that he wanted to avoid shots and surgery to his back.

Petitioner testified that he was off work from May 18, 2015, through April 19, 2016, and that he returned to his usual and customary employment as a laborer on April 20, 2016. He testified that bending and activities like raking leaves bothers his low back. Petitioner testified that he previously injured his low back in 2000 and was off work for seven months. He also

testified to taking the medications Flexeril three times a day and ibuprofen two times a day. He has no doctor appointments scheduled for his back, and he has not seen his doctor for his back since April 2016.

CONCLUSIONS OF LAW

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

In the case at hand there is no dispute that Petitioner sustained accidental injuries that arose out of his employment on May 14, 2015. The dispute is whether Petitioner's current condition of ill-being is causally connected to this incident.

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury. The testimony of Petitioner and the medical records support the causal relationship, and there is no evidence of a subsequent injury to interrupt causality.

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

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). This includes the nature and extent of Petitioner's injury.

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

> (a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the

injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

In the current case, neither party submitted an AMA impairment rating. Thus, the Arbitrator further considers the remaining factors of 8.1b in this decision. Petitioner was a laborer for the City of Chicago. He returned to work in his usual and customary position with no restrictions. The Arbitrator places great weight on this factor. Petitioner was 55 years old at the time of the incident, thus some weight is given to this factor. Petitioner returned to the same position and did not sustain a loss of earning capacity, so the Arbitrator gives no weight to this factor. The medical records indicate that Petitioner was treating for an L4-L5 disk protrusion and lumbar radiculopathy. He went through conservative treatment consisting of physical therapy and home exercises. He progressed well with physical therapy, therefore, no injections or surgery was recommended, and he was released to work full duty. The medical reports reflect that his lumbar radiculopathy has completely resolved, but that he has some stiffness in the morning that improves with activity. Petitioner has not seen a doctor for his back since April 2016. Therefore, the Arbitrator gives some weight to this factor.

The Arbitrator finds that as a result of the injury sustained on the above date, Petitioner is to have and receive from the respondent 62.5 weeks at a weekly rate of $735.37, which represents a loss of 12.5% man as a whole.

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

Gualberto Olac,

Petitioner,

vs.

NO: 15 WC 29265

S.G. Exterior Construction, Inc.,

17IWCC0384

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, penalties, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 5, 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.

17IWCC0384

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 $22,900.00. 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: JUN 26 2017
TJT:yl
o 5/16/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

OLAC, GUALBERTO
Employee/Petitioner

Case# **15WC029265**

S G EXTERIOR CONSTRUCTION INC
Employer/Respondent

17IWCC0384

On 4/5/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.38% 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:

4564 ARGIONIS & ASSOCIATES LLC
LOUKAS KALLIANTASIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0507 RUSIN & MACIOROWSKI LTD
DAVID KALIMUTHU
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

17IWCC0384

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)

17IWCC0384

Gualberto Olac
Employee/Petitioner

v.

S.G. Exterior Construction, Inc.
Employer/Respondent

Case # 15 WC 29265

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria S. Bocanegra**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **1/21/16**. 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 **causal connection, medical, TTD and penalties. Future medical care and benefits. Future TTD.**

17IWCC0384

FINDINGS

On the date of accident, **7/10/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$31,200.00**; the average weekly wage was **$600.00**.

On the date of accident, Petitioner was **29** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$10,800.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$10,800.00**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay to Petitioner temporary total disability benefits of **$400.00/week** for **28 weeks**, commencing **7/10/15** through **1/21/16**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$10,800.00** for temporary total disability benefits that have been paid.

Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$22,399.06**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the medical treatment recommendations made by Dr. Baylis and Dr. Rubenstein.

Respondent shall pay to Petitioner penalties of **$1,120.00**, as provided in Section 16 of the Act; **$5,600.00**, as provided in Section 19(k) of the Act; and **$4,770.00**, as provided in Section 19(l) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

4-5-2016
Date

APR 5 - 2016

17IWCC0384

FINDINGS OF FACT

Gualberto Olac ("Petitioner") testified via Spanish interpreter/translator Lourdes Soto-Smith, that in July 2015, he was employed by S.G. Exterior Construction ("Respondent") to do construction work and had been so employed since April 2013. Petitioner testified that part of his job duties included knocking down ceilings, gathering debris, taking material up high and roof work. He climbed ladders to clean gutters and perform roofing work.

Petitioner testified and it was undisputed that on 7/10/15, Petitioner sustained an accident arising out of and in the course of his employment with Respondent with he fell off of a ladder, sustaining injuries to the left knee and lower back. Specifically, Petitioner testified that on 7/10/15, he reported to work at approximately 9:00 am. On said date, Petitioner's duties included cleaning out the gutters of the residence located at the work site. In order to clean out the gutters, Petitioner testified that he used a ladder with a height of approximately 13 to 14 feet. Petitioner testified that while cleaning the gutters, he began to descend the ladder to get water. At this time, he testified that either the ladder slipped or he slipped and he fell to the ground. Petitioner stated that he was approximately 12 to 13 feet off the ground at the time he fell. Petitioner said he performed these duties up to the moment he fell.

Petitioner testified that he landed on his left foot first, collapsed on his left leg and fell backwards. Petitioner testified that his fall occurred very quickly. Petitioner stated that he felt immediate pain in the leg and back upon contact with the ground. He said the immediate pain was very intense, especially in his left knee. He reported the incident to the Respondent, who was on the work-site at the time of injury and asked his employer to call an ambulance. An ambulance came and transported Petitioner to Advocate Christ.

Ambulance services arrived and noted Petitioner had fallen 13 feet off of a ladder while working. Px1. He complained of left knee and lower back pain. Petitioner was positive of loss of consciousness. He rated his pain rated 8 out of 10 and swelling in both areas were noted. Glasgow coma scale was 15 out of 15 and paramedics noted that Petitioner was alert and oriented and that his pupils were equal size and reactive to light. Paramedics administered morphine on scene to treat Petitioner's pain. Petitioner was transported via ambulance to Advocate Christ Medical Center.

At Advocate Christ Medical Center, trauma to the hip, leg and back were noted after a fall from a roof. Doctors noted a 30 second loss of consciousness reported to them by EMS. Px1. Petitioner testified he complained of left knee pain and back pain. The treating physician noted significant swelling in Petitioner's left knee and lumbar spine tenderness. Radiological testing, including x-ray examination and CT scans, revealed a comminuted and depressed lateral tibial plateau fracture and a diagnosis for same was made. A 1.8mm depression and blood was noted at the fracture site. CT scans of Petitioner lower back revealed small posterior disc protrusions at L4-L5 and L4-S1. He was diagnosed with lumbar spine tenderness. Toxicology tests were negative. Treating physicians and nurses noted on multiple occasions that Petitioner was alert and oriented, and that his pupils were equal size and reactive to light. It was noted Petitioner understood simple English and was able to respond. He was unable to rate his pain but had "pain post stair negotiation." Petitioner was given a knee immobilizer and crutches.

Petitioner was given weight bearing restrictions with non-weight bearing to the left lower extremity and ordered to use crutches. He was ordered to follow up as needed with emergency and to continue medications. He was referred to Dr. William Baylis to rule out development of compartment syndrome and to re-evaluate for possible open reduction and fixation. Px1.

Petitioner testified that he is a native Spanish speaker and does not speak English. He said he had a difficult time communicating with the medical providers and that no interpreter was provided during treatment. He testified he did not have an understanding of the results because his native language is Spanish but he felt something was wrong in the knee. Advocate's "Certification of Interpretation" was left blank and unsigned. Px1.

On 7/11/15, Petitioner saw Dr. Baylis. Px1. The history of accident was noted. The doctor wrote that Petitioner had no hip, heel, neck or back pain. He complained only of pain in the left lateral knee. He had no history of similar problems in the past. The doctor reviewed the x-rays of the knee and confirmed the tibial plateau fracture. He reviewed the CT of the back and noted a L5 pars defect and some degenerative disc disease at C5-6 but no pain to those areas at that time. The plan was for non-weight bearing, therapy, pain control, DVT prophylaxis, knee immobilizer and CT scan of the left knee. He was returned to work with crutches. Petitioner testified that doctors did not state whether he could work but that they told him he could not walk. Petitioner testified that at that time, he felt weakness in the knee and a lot of pain in the knee and that it did not feel stable.

On 7/30/15, Petitioner followed up with Dr. Baylis at Parkview Orthopaedic Group. Px3. Petitioner testified that he complained of left knee pain, weakness, and instability. Petitioner testified that he had difficulty communicating with Dr. Baylis because of the language barrier. On exam, the doctor noted Petitioner was compliant with immobilizer and non-weight bearing. Knee motion was minimally reduced, there was no effusion, no gross instability and mild pain. The extensor mechanism was intact. New x-rays showed excellent alignment of the tibial plateau fracture without significant depression. Petitioner was placed in a hinged knee brace with strict non-weight bearing, crutches and active motion. He was continued off of work. Follow up was ordered. A copy of the medical note was faxed to "Karen Osbourne/Amtrust."

On 8/13/15, Petitioner once again followed up with Dr. Baylis. Px3. Petitioner testified that he continued to experience pain, weakness and instability in his left knee during this time. X-rays showed healing tibial plateau fracture. Dr. Baylis kept Petitioner off work and ordered him to remain non-weight bearing. A copy of the medical note was faxed to "Karen Osbourne/Amtrust."

On 8/27/15, Petitioner followed up with Dr. Baylis for a final time. Px3. Petitioner testified that he continued to experience pain, weakness, and instability in his left knee during this time. Exam showed full motion of the knee, no pain over the lateral tibial plateau and some soreness to the patella. The extensor mechanism was intact. New x-rays showed continued healing fracture at 7 weeks without any displacement. The plan was for partial weight bearing, continued crutch and knee immobilizer use, therapy for quads and hamstring strengthening. Petitioner was continued off of work. A copy of the medical note was faxed to "Karen Osbourne/Amtrust." The doctor certified that the recommended treatment was medically necessary.

Petitioner testified that he recalled treatment was recommended. Petitioner testified that he has not undergone any physical therapy. Petitioner testified that he contacted his attorney and asked if he could seek a second opinion. Petitioner testified that he wanted a second opinion because he continued to feel pain, weakness, and instability in his left knee.

On 9/25/15, Petitioner saw Dr. Scott Rubenstein of Illinois Bone and Joint Institute. Px5. Petitioner testified that there was an interpreter to help translate during his appointment. Petitioner testified that he complained of pain, stiffness and weakness in his knee. Dr. Rubenstein noted that Petitioner fell from a ladder while at work, landing on his left knee. Petitioner reported stiffness and weakness in his left knee. On exam, Dr. Rubenstein noted lateral joint line tenderness and a positive McMurray's test. X-ray examination revealed a

tibial plateau fracture mostly healed with a possibility of a superimposed meniscal tear. Based on the physical and radiological examinations, Dr. Rubenstein suspected a meniscal tear and recommended an MRI. Dr. Rubenstein kept Petitioner off of work and ordered the MRI. Dr. Rubenstein noted that "certainly [a] tibial plateau fracture or meniscus tear can be caused by similar injuries and he could have both." Dr. Rubenstein noted that if the MRI revealed a meniscal tear, then an arthroscopy would be necessary. If no tear was appreciated, Petitioner would still require physical therapy to rehabilitate the left knee. Petitioner testified he has yet to obtain the MRI and would do so if approved.

On 9/30/15, Petitioner's counsel filed his request for hearing under 19(b)/8(a) and petition for fees and penalties. Px7. In the documents, Petitioner alleged his counsel attempted to confer with Pharo Ezebuiro by telephone on numerous occasions regarding the disputed matters and alleged ongoing medical treatment pursuant to Section 8(a). In his petition for fees and penalties, Petitioner alleged that he remained off of work per doctor orders, that he forwarded his Application for Adjustment of Claim and medical records, in part, showing that he suffered injuries. He further alleged that on 9/11/15, Respondent's insurance adjuster, Pharo Ezebuiro, informed Petitioner's counsel that temporary total disability benefits (TTD) would be started. As of the date of the filing of these documents, Petitioner alleged he had not yet been paid any temporary total disability. The 9/30/15 petition and accompanying documents were noticed to counsel for Respondent.

On 10/14/15, Respondent, through its counsel, filed its response to Petitioner's request for immediate hearing under 19(b)/8(a) and its response to Petitioner's petition for fees and penalties. Rx3. Respondent denied all issues. In its response to the petition for penalties and fees, Respondent alleged as follows:

> *"According to the medical records currently in Respondent's possession, Petitioner admitted to his treating physicians that he smokes marijuana daily. Petitioner also reported that he smoked marijuana on the date of his alleged accident, July 10, 2015."*

Respondent implied it had an intoxication defense. Respondent admitted it had recently subpoenaed medical records of Advocate Christ and that it intended to determine whether toxicology tests were performed. Respondent asserted it acted reasonably in relying on these medical records in asserting its defense. Rx3.

On 11/5/15, Petitioner's counsel wrote to Respondent's counsel asking for agreement of payment of back TTD owed from 7/10/15 through 11/6/15, to continued payment of TTD and to payment of medical bills. In exchange, Petitioner's counsel agreed not to proceed on his 19b. Px7. On 11/6/15, Respondent's counsel wrote "We will bring him current using that stipulated rate pending receipt of any wage records." *Id.* On 11/6/15, Petitioner's counsel responded asking for clarification regarding the receipt of wage records. Petitioner's counsel disclosed Petitioner was paid in cash and asked for copies of any wage records in Respondent's possession. *Id.* That same date, Respondent's counsel reassured Petitioner's counsel that "As stated, we are bringing Petitioner current on TTD benefit and authorizing medical. Please see that he attends his upcoming IME. Notice is on its way."

On 12/3/15, Petitioner, through his counsel, re-filed his 19(b)/8(a) petition and petition for fees and penalties. Px7. Petitioner alleged much of the same basis for his seeking benefits, penalties and fees. Petitioner added, however, that his original 9/30/15 19(b) filing had been set for hearing on 11/9/15. Prior scheduled 11/9/15 hearing date, Petitioner asserted that Respondent's counsel contacted him via phone on 11/7/15 in part to agree that in lieu of proceeding to the 11/9/15 hearing, Respondent to pay back TTD, ongoing TTD and to authorize treatment. Petitioner's counsel asserted no benefits were paid and calls to Respondent's counsel were unreturned. The 12/3/15 petition and accompanying documents were noticed to counsel for Respondent.

On 12/21/15, Petitioner underwent a Section 12 examination administered by Dr. Kevin Walsh at the request of Respondent. Rx1. Petitioner testified that Dr. Walsh met with him for five minutes and that he was barely examined. Dr. Walsh summarized and reviewed medical records, including various imaging study reports, from EMS, emergency care and Dr. Baylis. On exam, Dr. Walsh noted no effusion of the left knee, full extension, full flexion, negative McMurray's and negative Apley grind test. Petitioner related he could not perform heel toe walk. Exam of the spine showed full range of motion, negative straight leg raise, no palpable trigger points and no muscle spasm. Petitioner admitted to Dr. Walsh he no longer had back pain. in the doctor's opinion, Petitioner had an objectively normal exam. The doctor felt the fracture was healed, that Petitioner was not in need of further medical treatment and could return to work full duty. The report was addressed to David Kalimuthu, counsel for Respondent.

Petitioner testified that he currently feels pain, weakness and instability in his left knee. Petitioner also testified that, while the majority of his back pain resolved, he still feels minor lower back pain from time to time. Petitioner testified that he lives in a third-floor apartment and when he walks up 3 flights of stairs, he feels pain as if he is going to fall down. When he goes down stairs, he does so slowly. Petitioner testified that his knee feels weak and unstable when he walks or climbs stairs.

Petitioner testified that he did not have any pain or issues with his left knee or lower back prior to the accident and that he did not suffer an additional injury to his left knee or lower back subsequent to the accident. Petitioner admitted that an undated document shows his signature as having received $700.00 in cash. Rx2. Petitioner testified he received a check from Respondent after seeing Dr. Walsh and after that he received no other checks. He further testified there are bills outstanding related to his injuries as he is receiving them.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator finds Petitioner's testimony to be credible and forthright on the issues presented at trial. Specifically, he was candid and honest in his work history, ability to work, accident, ability to speak and understand English and in this medical treatment history.

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

The Arbitrator finds that the Petitioner has proven by a preponderance of the evidence that his current condition of ill-being as it relates to his knee and low back is causally related to his undisputed work injury of which occurred on 7/10/15.

Petitioner's credible testimony was that he injured himself while attempting to descend a work ladder. He estimated he fell approximately 13 feet. Petitioner said he felt immediate pain in the knee and low back. Prior to and subsequent to this injury, Petitioner credibly testified he did not have any issues with either the left knee or his low back. Petitioner's history of accident, mechanism and complaints are corroborated in the EMS records, in the records of Advocate Christ, the records of Dr. Baylis, the records of Dr. Rubenstein and the records of Respondent's doctor, Dr. Walsh. The Arbitrator notes that some of Petitioner's medical treatment records document the injuries as work-related. As a result of these injuries, records show Petitioner was diagnosed with a left knee tibial plateau fracture and a low back injury. Petitioner treated for the left knee injury with medications, work restriction, knee immobilization and knee brace. Petitioner received minimal treatment, if any,

for the low back. Dr. Baylis recommended physical therapy for the left knee, which appears to not have been completed as of the date of trial. Petitioner sought a second medical opinion for the left knee through the aid of his legal counsel.

To that end, Petitioner came under the care of Dr. Rubenstein, who acknowledged the tibial plateau fracture but suspected a meniscal tear and ordered an MRI to rule out same. Dr. Rubenstein did not rule out the need for physical therapy to address the left tibial plateau fracture, which had also still not been completed at the time of Dr. Rubenstein's examination. Subsequently, Petitioner was sent for a Section 12 exam.

Respondent asserts Petitioner's current condition of ill-being is not causally related to the work injury based upon Dr. Walsh's opinions. Dr. Walsh concluded that while Petitioner suffered a minimal low back injury and a left knee tibial plateau fracture, Petitioner had reached maximum medical improvement and was no longer in need of further care. Dr. Walsh based his opinions on his review of the medical records provided to him and his examination of Petitioner. Dr. Walsh noted that Petitioner's fracture was healed and that Petitioner freely admitted he no longer had low back pain. The Arbitrator notes inconsistencies in the doctor's report. On page 3 of his report, Dr. Walsh noted that Petitioner is positive for back pain but on page 5, Dr. Walsh wrote that Petitioner admitted he had no back pain. Petitioner testified that Dr. Walsh examined him for five minutes.

The Arbitrator is not persuaded by Dr. Walsh's opinions in this matter. Dr. Walsh did not appear to review any of the actual films of any x-rays relative to Petitioner's left knee and instead relied on documents alone. Dr. Walsh did not appear to perform new x-rays in his office at the time of his examination of Petitioner. Further, Dr. Walsh's findings on exam are at odds with Drs. Baylis' and Rubenstein's findings on exam. Dr. Walsh's findings are also at odds with Petitioner's credible testimony that through out his treatment and at the time of his exam with Dr. Walsh, he continued to experience left knee symptoms of pain, weakenss and instability. The Arbitrator assigns less weight to the opinions of Dr. Walsh on this issue.

The Arbitrator finds the medical opinions of Dr. Baylis and Dr. Rubenstein more credible on the issue of whether Petitioner's condition of ill-being persisted at the time of the their most recent exams. Dr. Rubenstein opined that "certainly [a] tibial plateau fracture or meniscus tear can be caused by similar injuries and he could have both." This is consistent with Petitioner's fall, which was approximately 12 to 13 feet and which caused him to land with the full force of his weight onto his left leg and knee and then collapsed backwards onto his back. Dr. Rubenstein performed McMurray's testing, which was positive. The Arbitrator does not find Dr. Rubenstein's opinions at odds with Dr. Baylis; Dr. Baylis was following Petitioner only for the tibial plateau fracture and Dr. Baylis never performed McMurray's testing. The evidence demonstrates that Petitioner's condition of ill-being is causally related to his work accident based upon a chain of events theory.

The Arbitrator also finds that Respondent's purported defense of intoxication is wholly unsupported and insufficient to break any causal connection between Petitioner's accident and resultant injuries. The Arbitrator notes that Petitioner's toxicology results were negative at the emergency room immediately following the accident. The Arbitrator finds Petitioner was not intoxicated or otherwise impaired at before, at the time of or after his work accident.

ISSUE (J), (O) Were 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 incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that Petitioner has proven by a preponderance of the evidence that the medical services provided to him were reasonable and necessary. Further, the Arbitrator concludes that

Respondent has not yet paid all appropriate charges for same. At trial, Petitioner testified there were outstanding bills he believed were related to his work accident based upon the fact that he had been receiving such bills. Petitioner submitted the following bills as unpaid:

Px2	Advocate Christ	$19,625.00
Px4	Parkview	$2,521.06
Px6	IBJI/Rubenstein	$253.00
TOTAL		**$22,399.06**

17IWCC0384

The foregoing bills submitted at trial correspond to the appropriate conservative medical treatment received by Petitioner for his work-related injuries. Accordingly, Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$22,399.06**, as provided in Sections 8(a) and 8.2 of the Act.

ISSUE (K), (O) ***Is the Petitioner entitled to any prospective medical treatment?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that Petitioner has proven by a preponderance of the evidence that the he is entitled to prospective medical treatment. Having adopted the opinions of Dr. Baylis and Rubenstein over those of Dr. Walsh, the Arbitrator finds that Petitioner's left knee condition has not yet stabilized and that he has not otherwise reached maximum medical improvement. Dr. Baylis and Rubenstein has recommended physical therapy for the left knee to address remaining symptoms and deficiencies as the result of the tibial plateau fracture. Dr. Rubenstein has recommended an MRI to rule out meniscal tear. The Arbitrator finds these recommendations supported by Petitioner's complaints and otherwise supported by the record. Therefore, Respondent shall authorize and pay for the medical treatment recommendations made by Dr. Baylis and Dr. Rubenstein.

ISSUE (L), (O) ***What temporary benefits are in dispute?***
ISSUE (N) ***Is Respondent due any credit?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that Petitioner has proven by a preponderance of the evidence that the he is entitled to temporary total disability benefits. At trial, Petitioner alleged entitlement to TTD from 7/10/15 through 1/21/16. These dates reflect the date of the accident through the date of arbitration. Emergency room records show Petitioner was ordered to non-weight bearing and to use of crutches. He could not recall whether he was issued work restrictions but recalled he was told he could not or should not walk. The Arbitrator finds that although Advocate Christ may not have issued work restrictions per se, the restrictions that were issued show that Petitioner could not have worked in light of the duties he testified he would have been required to perform as a roofer. Medical records show that after the emergency room care, Petitioner was taken off of work as a result of his work injuries by either Dr. Baylis or Dr. Rubenstein. The Arbitrator declines to adopt Dr. Walsh's conclusion that Petitioner is capable of full duty work. Respondent submitted a document purporting to show that Petitioner received $700.00 in cash from Respondent employer. Rx2. The document is undated and does not indicate what the $700.00 was for (i.e. work, TTD, etc.). Respondent claimed a credit for this amount but it was not clarified at trial what that amount was supposed to represent. Ax1. Petitioner disputes Respondent is entitled to this credit. Ax1. The Arbitrator finds this document unreliable and insufficient to prove Respondent is entitled to a credit in this amount for any TTD due and owing.

Respondent alleged it paid $11,085.71 toward TTD. Ax1. Petitioner disputed this figure and alleged that Respondent, as of the date of trial, paid $10,800.00 for TTD through 12/16/15. Ax1. Respondent failed to introduce any evidence that it paid the $11,085.71. Therefore, Respondent shall pay to Petitioner temporary total disability benefits of **$400.00/week** for **28 weeks**, commencing **7/10/15** through **1/21/16**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$10,800.00** for temporary total disability benefits that have been paid.

ISSUE (M) Should penalties or fees be imposed upon Respondent?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein and relies on same in concluding that penalties and fees should be imposed upon Respondent pursuant to Section 19(k), Section 19(l) and Section 16 of the Act.

On the issue of penalties and fees, the Arbitrator makes the following findings: there is evidence in the record to suggest that Respondent was almost immediately aware Petitioner was taken off of work as a result of the accident. First, Petitioner testified that the owner's wife took him to most of his appointments. Second, Dr. Baylis' records show that the doctor's office faxed copies of the office visit notes to "Karen Osbourne/Amtrust." The Arbitrator notes it is the same company listed as the Respondent's insurance or service company. Ax1.

On 9/30/15, Petitioner filed his first 19(b) petition and petition for fees and penalties. Px7. In support of the petition for penalties and fees, Petitioner alleged that the insurance carrier's adjuster with whom his counsel had been in communications with at that time, averred temporary total disability payment would issue. In response, Respondent filed its response on 10/14/15, Respondent asserted it had medical records in its possession that would allegedly support the defense of intoxication. Rx3. These records were not appended to its response to the petition for penalties and fees in support of its allegation.

Following the filing of this response, Petitioner offered to withdraw his request for hearing in exchange for the payment of TTD, among other things. In response, rather than assert its intoxication defense, Respondent averred in two separate electronic mail communications that payment of TTD would be forthcoming. No reason was stated for the delay up to that point of why TTD payments had not issued previously. The Arbitrator also notes that based on the language of the communications exchanged between the parties in November 2015, it is evident the parties had discussed the payment of TTD and the wage rate to be used at some point prior to the written communications. Following the e-mail correspondence, Respondent once again in a phone conversation represented that TTD payments would be forthcoming. Apparently no intoxication defense was asserted in this communication.

In December 2015, Petitioner re-filed his petition for immediate hearing under Section 19(b)/8(a) and petition for penalties and fees. Px7. The Arbitrator notes that Respondent failed to file any response to Petitioner's latest petition. Respondent did not assert any defense to the allegations made by Petitioner. Despite its alleged prior intoxication defense, Respondent issued payment of TTD in the amount of $10,800.00 on 12/16/15. Ax1. Respondent introduced no contrary evidence on the payment of TTD or the date in which it was eventually paid.

The Arbitrator finds Respondent's intoxication defense is without factual or legal support and was put forth merely to file a response in an attempt to excuse its delay. As such, Respondent's defense is frivolous and for delay. As mentioned previously, Respondent did not append any such record in support of its response to the petition for penalties, did not forward or share the alleged records with Dr. Walsh, did not assert this defense in

any of the communications between the parties, did not assert the defense at all in response to the second 19(b)/8(a) petition, did not assert this defense at trial and did not introduce any evidence at trial in support of this. Px7, Rx3, Ax1. Having found Respondent's alleged intoxication defense without merit and one otherwise abandoned, the Arbitrator finds that Respondent has engaged in unreasonable delay in the payment of TTD benefits. The failure to pay such compensation in accordance with Section 8(b) shall be considered unreasonable delay. Consequently, pursuant to Section 19(k) Respondent is hereby ordered to pay 50% of the total TTD awarded herein or $5,600.00. The Arbitrator declines to award Section 19(k) penalties for Respondent's alleged failure to pay medical bills as Petitioner presented no evidence it demanded such payments from Respondent at any time or that Respondent otherwise had notice of any of the outstanding balances.

Regarding Section 19(l) penalties, the Arbitrator relies on the same findings made above and notes that Petitioner made proper demand for the payment of TTD benefits. Respondent failed to set forth in writing any reasonable basis for delay, the Arbitrator noting the intoxication defense meritless. In this case, the Respondent has without good and just cause, failed, neglected, refused or unreasonably delayed the payment of TTD benefits. Pursuant to Section 19(l), Respondent shall pay $4,770.00, representing $30.00 per day that each day TTD benefits have been so withheld or refused, for 159 days, which includes dates 7/10/15 through 12/16/15, the date in which payment was finally made. Ax1. The Arbitrator declines to award 19(l) penalties on the basis of non-payment of medical bills for the same reasons stated above.

Having found Respondent guilty of unreasonable delay in the payment of TTD and having found Respondent put forth a frivolous defense merely for the purpose of delay, Respondent shall pay to Petitioner penalties of $1,120.00 (20% x $5,600.00) pursuant to Section 16 of the Act. In summary, Respondent shall pay to Petitioner penalties of **$1,120.00**, as provided in Section 16 of the Act; **$5,600.00**, as provided in Section 19(k) of the Act; and **$4,770.00**, as provided in Section 19(l) of the Act.

Signature of Arbitrator

4-5-2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ 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

Jason Gaither,

Petitioner,

17IWCC0380

vs.

NO: 15 WC 38563

Cassens Transport Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

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 $4,800.00. 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: JUN 22 2017
KWL/vf
O-4/24/17
42

Michael J. Brennan

Thomas J. Tyrrell

DISSENT

I respectfully dissent from the decision of the majority. I would reverse the Arbitrator's decision. The Petitioner was a traveling employee, the test determining whether a traveling employee's injury arises out of and in the course of his employment involves two distinct considerations; 1) the reasonableness of the conduct in which he was engaged at the time of his injury and 2) whether that conduct might have been anticipated or foreseen by the employer. *Howell Tractor & Equip. Co., v. Indus. Commission*, 78 Ill.2d 567 (1980). Traveling employees will not be compensated for injuries when their conduct is willful and wanton rather than merely negligent. *Mitchell v. State Police*, 12 IWCC 700 (2012). A thorough review of the record clearly shows that Respondent's drivers are to be licensed CDL holders. I find it clear and compelling and am persuaded that on the date and time of the accident the Petitioner was fully aware that his license to operate a commercial vehicle was suspended. The fact remains that Petitioner chose to operate the Respondent's truck outside the boundaries of the law. Even considering Petitioner's thought that he could obtain license reinstatement at a future court proceeding does not bring Petitioner's actions into the arena of reasonable or foreseeable. As such the resulting accident was not foreseeable. Withholding information from the Respondent regarding prior legal action on your CDL is willful and the act of driving in disregard of your legal ability to do so is wanton. I would reverse this decision and deny compensation.

Kevin W. Lamborn

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

17IWCC0380

GAITHER, JASON
Employee/Petitioner

Case# 15WC038563

CASSENS TRANSPORT COMPANY
Employer/Respondent

On 5/26/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO LTD
DONN P LaHAIE
1 E WACKER DR 39TH FL
CHICAGO, IL 60601

2396 KNAPP OHL & GREEN
L DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

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)

17IWCC0380

Jason Gaither
Employee/Petitioner

v.

Cassens Transport Company
Employer/Respondent

Case # 15 WC 38563

An *Application for Adjustment 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 **February 10, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. 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. X Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other _____

17IWCC0380

FINDINGS

On the date of accident **October 31, 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 **$57.054.04;** the average weekly wage was **$1,097.20**

On the date of accident, Petitioner was **43** years of age, **married** with **2** dependent children.

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

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

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

ORDER

Medical benefits

Respondent shall authorize and pay for the MRIs of petitioner's cervical spine, left knee and both shoulders, as well as evaluation and treatment by a neurologist as ordered by Med Works in accordance with the provisions of §8 and §8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits at the rate of **$731.47** per week for **6-3/7 weeks**, commencing **11/01/2015 through 12/15/2015.**

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

05/25/2016
Date

IC ArbDec19(b) p. 2

MAY 26 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jason Gaither	)	17IWCC0380
Petitioner,	)	
vs.	)	**No. 15 WC 38563**
Cassens Transport Company	)	
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 February 10, 2016. The parties agree that on October 13, 2015 the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that Petitioner's average weekly wage calculated pursuant to §10 was $1,097.20.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of his employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
3. Whether respondent is liable for the unpaid medical bills
4. Whether petitioner is entitled to payment for prospective medical treatment.
5. Whether petitioner is due TTD.
6. Whether penalties and fees should be imposed upon respondent.

STATEMENT OF FACTS

As of October 31, 2015 petitioner had been employed by respondent as a car hauler for 9-1/2 years. The job requires a CDL licensure. As a car hauler, petitioner picks up vehicles and delivers them to dealerships. He is a union teamster; member of Local 710.

Petitioner testified he reported to work on October 30, 2015, loaded his truck, proceeded to deliver units to two or three areas in Milwaukee and then was to return to Elwood. On October 31, 2015, while on his way back to Elwood, on I-55, just passed I-80, petitioner heard a pop and felt the vehicle pull the right. Petitioner overcompensated and steered to the left. A few seconds later a bunch of metal started flying up in the truck, which he later determined was the guardrail. He felt a sense of weightlessness and then a sudden stop. Petitioner believed he was traveling at the rate of 60 to 63 miles per hours.

Petitioner felt immediate pain in his left knee and had tingling in his left fingertips. His right and left shoulder hurt, as well as his neck. He testified he felt as though he had taken a blunt trauma to the head. His left ankle was slightly sore. He noticed a fire on the passenger

side dash, and both doors were jammed shut. He was able to exit the vehicle by rolling down the window; he then crawled up a hill.

Sometime after the accident, State Trooper Brandy arrived. Petitioner requested medical attention. He denied telling Trooper Brandy that there was another vehicle involved. Petitioner was taken by ambulance to St. Joe's Hospital. He was examined in the emergency room and was released.

On November 4, 2015 he went to Med Works, where he was seen by Dr. Xia. Dr. Xia kept him off work. He was referred by Dr. Xia to Silver Cross emergency room. Dr. Xia also referred petitioner for an MRI, which he had not yet obtained.

Petitioner's regular physician is Dr. Vlad Badescu. Petitioner saw Dr. Badescu after the accident for medical treatment unrelated to the accident; specifically, for blood pressure and basic things. Petitioner had been prescribed Adderall by Dr. Badescu, which he had taken on the day of the accident. Petitioner had taken one Adderall at approximately 8 o'clock and also on October 31, 2015 at 1 or 1:30.

Respondent terminated petitioner on or about December 4, 2015 because of the accident. As a result of the accident petitioner received citations from the State Police, including driving on a suspended license, no proof of insurance, illegal lane change and no CDL. Petitioner claimed he had a valid CDL. Petitioner testified he went to court and all charges from the accident were dismissed.

Petitioner said his physical condition had not improved. He has headaches on and off with different severity. His left knee hampers his ability to walk. He has problems with movement and rotation of his right shoulder.

On cross examination petitioner admitted he received a ticket in Will County in June, 2015 which he had not reported to the respondent. On July 14, 2015 an ex parte judgement was entered against petitioner for which petitioner filed a motion to vacate on August 8, 2015. In July, 2015, while in Wisconsin, petitioner was issued a citation for operating a motor vehicle without a valid license. Petitioner claimed his CDL had been suspended due to a medical card issue. Petitioner testified he was currently making payments for that conviction.

After the accident, petitioner denied he told the State Trooper or the purported witness that an SUV cut him off.

Petitioner confirmed he has been taking Adderall for five years. Petitioner could not recall if he told the DOT medical examiner that he was taking Adderall. Petitioner admitted Adderall was a form of amphetamine, which he was taking for his attention deficit disorder.

After the occurrence, petitioner completed a written statement for respondent. Petitioner did not know why he did not put all tickets he received on the written statement. (See RX.1-30)

Petitioner denied he had an accident between August 25, 2015 and August 26, 2015, which was the reason for his termination in September, 2015.

Petitioner admitted he had an accident in May, 2015. Petitioner testified he was driving for respondent in Racine Wisconsin when a barrel came off a truck in front of petitioner and bumped the front of his truck.

At the time of the accident on October 31, 2015, petitioner claimed he heard a noise, the vehicle pulled to the right and he over-corrected to the left even though the guard rails he hit were on the right side of the road. Petitioner claimed he was in the right lane and when he overcorrected to the left he continued in the right lane.

Dr. Badescu had been prescribing Adderall for about a year. Before that, he was seeing a psychiatrist in Joliet who prescribed the Adderall.

Petitioner testified that when he advised Dr. Badescu on December 21, 2015 that he was doing well it was in regard to the treatment with the Adderall.

Petitioner denied being associated with Iron Clad Vapor Shop. He agreed he appeared at the January 25, 2016 town hall meeting in New Lenox to talk about the Iron Clad Vapor Shop.

Petitioner confirmed he was required by respondent to report a license suspension to respondent within 24 hours. (See RX.1-6)

Petitioner could not recall if he ever plead guilty to a crime.

Tom Zitt testified in behalf of the respondent. He is respondent's Aurora terminal manager. Petitioner worked out of respondent's Aurora terminal. Zitt confirmed petitioner was hired in 2006. Zitt testified respondent discharged petitioner in 2006 as petitioner had a major chargeable accident. After an appeal or grievance was filed, it was changed from discharge to a disciplinary suspension.

Zitt testified that in 2010, petitioner had another major car damage incident. Petitioner elected to take retraining in lieu of discharge. In June, 2015, petitioner was found medically disqualified. Respondent had received a call from DOT Medical Review officer that there was an issue with petitioner's medical test. He was re-tested and passed the test.

Zitt testified that in September, 2015, respondent discharged petitioner due to major cargo damage, which was a damaged vehicle on a load petitioner had delivered. Due to the 40-day time period in which respondent could act on a charge, the incident could have happened within 30 days of the discharge.

Zitt testified that between August 14, 2015 and August 15, 2015 the day shift driver reported the truck which he shared with petitioner appeared to have gone off the road as it was covered in dirt. It was impacted all the way up to the air bags and in and around the fuel tank. Petitioner was discharged for failing to report the incident.

Zitt testified that on September 3, 2015 petitioner received another discharge notice which was due to day-shift driver of petitioner's vehicle had reported a lot of damage to the truck. After a grievance was filed, the NATA panel, which decides grievances that cannot be resolved at the local lever, petitioner was reinstated with time off served, no benefits and no back pay.

Zitt testified petitioner was discharged for major chargeable [October 31, 2015] accident and for dishonesty due to the discrepancies between the police report and petitioner's report, and the discrepancies between a witness statement received by respondent, the police report and petitioner's report to respondent of the October 31, 2015.

Zitt testified that if he had received the driving record of petitioner before October 31, 2015, petitioner would have been taken off the truck; as having an unlicensed driver could jeopardize respondent's authority or to operate with the federal government. Therefore, according to Zitt, petitioner was not furthering respondent's business.

Zitt testified that petitioner had contacted him by phone on July 4, 2015 to advise he was cited for operating a commercial vehicle without a license. Petitioner had been pulled over due to a noise, was cited and put out of service as petitioner was not able to drive the truck. Petitioner advised Zitt there was an issue with his license. Zitt had to send another driver up to Wisconsin to pick up respondent's truck.

Zitt testified as to the meaning of the GPS tracking pictures on of petitioner's truck (RX.7). Zitt testified the GPS pictures showed petitioner was driving in the right lane, then almost on the right shoulder, then drifting to the left lane and then into the right lane again and then goes off the road coming to a rest against the guardrail; all without any abrupt movements.

Petitioner introduced the records of Med Work. (PX.1)

These records indicate petitioner was first seen at Med Works on November 4, 2015. Petitioner provided a history of being involved in the work accident of October 31, 2015 wherein the truck went off the road, he hit an abatement (sic) and he crawled out the window before the truck exploded into flames. He had complaints of neck pain, bilateral shoulder pain, pain to the back, his left arm his left knee and his left ankle. He denied he had injured any of these body parts in the past. Because petitioner was disoriented and the doctor did not have access to the records from St. Joseph Hospital from the night of the accident, he was immediately referred to Silver Cross Emergency Room. The diagnosis was post-concussive headache status post head injury, blunt head trauma, altered mental status and paresthesia to the left arm and left leg. He was kept of work. (PX.1)

Petitioner returned to Med Work on November 5, 2015. Petitioner reported the CT scan obtained at Silver Cross was negative. The diagnosis was cervical strain, left upper extremity radiculopathy, left knee contusion with abrasion, bilateral elbow contusion and left shoulder strain. He was kept off work. (PX.1)

Petitioner returned to Med Works on November 10, 2015. The diagnosis was post-concussion headache status post blunt head trauma, bilateral shoulder pain, left knee strain and neck strain. An MRI was ordered for the cervical spine and left knee and both shoulders. Physical therapy was prescribed. He was kept off work.

Petitioner was seen again at Med Works on November 17, 2015. Diagnosis remained the same; the MRI was pending. Physical therapy was continued and petitioner was kept off work. Petitioner returned to Med Works on November 24, 2015 and referred to a neurologist. He remained off work. He was seen on December 1, 2015 and his condition remained the same. He was kept off work. He was scheduled to return to the clinic two weeks after the December 1, 2015 visit. (PX.1)

Petitioner introduced the records of Dr. Vlad Badescu of Family Medical Clinic from December 21, 2015. Petitioner went to Dr. Badescu to discuss depression and anxiety which had been ongoing for two months. Although petitioner gave a history to Dr. Badescu of the work accident and injury, according to the records, Dr. Badescu did not provide any treatment of these injuries. Dr. Badescu's assessment was ADHD, anxiety and obesity. (PX.2)

Petitioner introduced the Troy Fire Protection District records from the day of the accident. The paramedics reported petitioner complained of leg pain, as well as left knee and left arm pain, mid thoracic pain. He was found to have abrasions to his left elbow and left knee, with superficial lacerations to his right leg and left hand. He was not sure if he lost consciousness. He was transported to Presence St. Joseph Medical Center. (PX.3)

The records of Silver Cross Hospital from November 4, 2015. Petitioner's CT scan of the cervical spine and brain were negative. (PX.4)

Petitioner's Exhibit 4 also included (inexplicably) petitioner's Secretary of State driver's records dated January 14, 2016. (PX.4)

Petitioner's Exhibit 4 also included the emergency room records of Presence Saint Joseph Medical Center from October 31, 2015. Petitioner complained of right quadrant pain, disorientation, bilateral knee pain, left ankle pain, and midline C-spine tenderness. CT of the spine and brain were negative as well as X-rays of the left ankle, right knee, left knee, chest, and Abdomen CT.(PX.4)

Petitioner introduced a copy of a court order from January 27, 2016 dismissing three traffic cases. (PX.5)

Respondent offered select portions of petitioner's employment records with respondent (RX.1). These records include petitioner's discharge on October 9, 2006 because of a major chargeable accident, which was then reduced to a two-week suspension after grievance filed (RX. pp.8-9). The records include petitioner's discharge on August 23, 2010 for a major cargo damage and an indication petitioner elected to take retraining in lieu of discharge (RX.1, pp. 10-11).

On the March 15, 2015 Medical Examination Report, which is to determine petitioner's commercial driving fitness, petitioner failed to list nervous or psychiatric disorder or medication he was taking (RX.1, p.12). He was certified for two years (RX.1, p.14).

On June 11, 2015, petitioner was terminated as he was medically unqualified (RX.1, p.18). As of June 29, 2015, petitioner was reported as active (RX.1, p.22). On July10, 2015, it was noted that petitioner's license was valid (RX.1, p.23). On July 23, 2015 petitioner was put on indefinite sick leave (RX.1, p.24).

On September 2, 2015, petitioner was terminated due to major cargo damage and on September 3, 2015, petitioner was found to have failed to report an accident that had occurred between August 14, 2015 and August 15, 2015 (RX.1, pp.25-26). On October 5, 2015, petitioner was reported active (RX.1, p.28).

On November 4, 2015 petitioner provided a written report of the October 31, 2015 accident. According to the report, petitioner heard a loud noise under the cab, felt a hard pull to the right and made impact with a guard rail. He reported an impact to his head that dazed him. He realized the tractor was on fire and escaped out the driver's window. He reported he was ticketed for improper lane usage. (RX.1, p.30)

The records also include petitioner's driver's record from November 6, 2015 (RX.1, p.32 & RX.5).

On December 4, 2015, respondent discharged petitioner due to a major chargeable accident and dishonesty (RX.1, p.35).

Respondent introduced the complete records of Dr. Vlad Badescu. According to these records, petitioner was first seen by Dr. Badescu on June 11, 2015. The records show petitioner was on Adderall, which was previously prescribed by a psychiatrist for ADHD. The records also indicate petitioner has PTSD. He was seen by Dr. Badescu on October 14, 2015, He received Adderall prescriptions on November 13, 2015 and December 9, 2015. He was also seen on December 21, 2015. (RX.2)

Respondent introduced the Federal Motor Carrier Safety Administration regulations which indicated drivers would be disqualified for a CDL if using an amphetamine. The driver can be certified even if he takes the medication if the prescribing doctor can write that it is safe to be a commercial driver while taking the medication. (RX.3)

Respondent introduced the Criminal Courts record from Ozaukee County, Wisconsin. The records confirm petitioner plead guilty on October 19, 2015 to operating a commercial vehicle without a valid license on July 4, 2015. (RX.4)

Respondent introduced the Will/Grundy EMS System telemetry run sheet. The sheet reflects petitioner reported he was on Adderall. He had complaints of back pain, left arm, left leg, right leg and abdomen pain. He was not sure if he lost consciousness. (RX.6)

Trooper Matthew Brandy, with the Illinois State Police, testified for respondent via deposition on January 26, 2016 (RX.9). Trooper Brandy arrived on the scene of petitioner's accident right behind the fire truck (RX.9, p.8). Trooper Brandy reported petitioner told him he was driving in the right lane when a dark-colored SUV came over into his lane and he moved over to give the SUV more room, when he heard a pop noise and metal went flying into the air and he went off the road (RX.9, p.8). Trooper Brandy also spoke with the witness who was behind petitioner's vehicle (RX.9, p.9). The witness did not see another vehicle, he only saw petitioner's vehicle go off the road (RX.9, p.9). Trooper Brandy issued petitioner a citation for improper lane usage, invalid CDL and no proof of insurance (RX.9, p.11).

Respondent introduced a record from the Clerk of the Circuit Court of Will County for Case 2015 TR 047509 and2015 TR 047510 (RX.11).

Respondent introduced the qualifications of Drivers and longer combination vehicle (LCV) drivers by the Federal Motor Carrier Safety Administration (RX.12).

Respondent introduced the calculations of petitioner's weekly wage of $1,097.20 (RX.13).

Respondent introduced the Herald News article dated January 26, 2016 reporting on the New Lenox Village Board meeting at which time adding vaping to the no-smoke law was discussed (RX.14). In addition, respondent offered the minutes of the New Lenox Board of Trustees meeting of January 25, 2016 relative to the no-smoking law as it related to Vapor Products (RX.15).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

Respondent contends that because petitioner was not a CDL licensed driver on October 31, 2015 this took him out of the course of his employment with respondent at the time of the accident. Petitioner testified that even though he was cited for not having a valid CDL, he was able to clear up the issues and charges for the citations issued on October 31, 2015 were dismissed. (See PX.5). Petitioner admitted there were previous issues with his CDL for which he was cited on July 4, 2015. He was able to clear up the medical issue with the CDL and his license was reinstated.

Respondent also implied petitioner would not have been issued a CDL license as he was taking Adderall for his ADHD and failed to disclose this on his medical examination report (RX.1-12), and thus not in the course of his employment at the time of the accident due to the lack of a CDL. According to the Federal Motor Carrier Safety Administration regulations, petitioner would have been disqualified to receive a CDL license as he was using amphetamines. However, these regulations would allow petitioner to overcome this issue by obtaining a report from his doctor confirming petitioner was safe to drive while on this medication.

The evidence does not conclusive support respondent's theory that petitioner was not in the course of his employment as he was purportedly driving without a valid CDL license at the time of his accident. There is evidence petitioner was cited for not having a valid CDL at various times, including at the time of the accident. However, there was further evidence that suggests petitioner was able to clear up any issues with his CDL license and the charges were dropped. Furthermore, respondent was aware petitioner was cited for not having a valid license in July, 2015 in Wisconsin and yet put him back into respondent's truck having determined he did have a valid CDL license. (See RX. 1, p. 28)

Whether there was a phantom vehicle that caused petitioner to move to the right or the whether the vehicle to jerk to the right after the petitioner heard a loud noise under the cab, the fact remains, petitioner was driving respondent's car hauler at the time of the accident on a public highway and thus petitioner was exposed to a risk greater than that of the general public. There is no evidence petitioner deliberately drove off the road. There is no evidence that the Adderall caused petitioner to run off the road.

For all of these reasons, the Arbitrator finds petitioner was injured in an accident that arose out of and in the course of his employment with respondent on October 31, 2015.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

Petitioner does not claim any unpaid medical bills.

K. In support of the Arbitrator's decision in regard to prospective medical care, the Arbitrator finds the following:

The Arbitrator, having determined petitioner's accident arose out of and in the course of his employment with respondent, awards the costs for the MRIs ordered by Med Works of his cervical spine, left knee and both shoulders, as well as treatment by a neurologist in accordance with the provisions of §8 and §8.2 of the Act.

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

The medical evidence supports petitioner's claim for temporary total disability from the date of accident until two weeks after his last visit at Med Works on December 1, 2015, or until December 15, 2015. There is no evidence petitioner received any treatment after the date of December 1, 2015 for the work injuries, or was ordered off work by any other doctor after December 15, 2015. Although petitioner saw his own doctor, Dr. Badescu, on December 21, 2015, Dr. Badescu did not provide treatment of petitioner's work injury and gave no indication of ongoing disability. Therefore, the Arbitrator awards temporary total disability from November 1, 2015 through December 15, 2015.

The Arbitrator makes this award despite the implication petitioner may have been working at a vapor shop known as Iron Clad Vapor Shop. The evidence respondent introduced

only indicates petitioner may be a part owner of the vapor shop, which is something petitioner denies. It does not prove petitioner was actually working at the vapor shop.

M. In support of the Arbitrator's decision with regard to penalties and fees, the Arbitrator finds the following:

Although the evidence is sufficient to support petitioner's claim, there were enough issues raised by respondent to justify denial of benefits. Therefore, the Arbitrator denies petitioner's claim for penalties and attorneys' fees.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TEMEKA PRICE,

Petitioner,

vs. NO: 15 WC 39674

PACE,

Respondent.

17IWCC0376

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 accident, causal connection, prospective medical, and temporary total disability (TTD), and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Petitioner, Temeka Price, sustained a work-related accident on November 23, 2015 that arose out of and in the course of her employment, and that her condition is causally related to said accident.

The Commission finds that Petitioner is entitled to TTD benefits from November 24, 2015 through January 15, 2016, representing 7-3/7 weeks, and prospective medical treatment related to her fractured left ankle. 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).

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

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The Commission makes the following findings:

1. Petitioner filed an Application for Adjustment of Claim on December 21, 2015, alleging "multiple injuries at work" on November 23, 2015.

2. Temeka Price was employed as a bus driver for Pace. On November 23, 2015, Price began driving a new bus route. She took her bus out of service at a bus stop, located in front of Fuddrucker's parking lot, to take her 15 minute break. She left the bus to go use the restroom. Fuddrucker's was closed as it was 8:05 a.m. Price, therefore, started to walk across the restaurant's parking lot to the Holiday Inn hotel located on the other side of the lot. T.11. She slipped on the ice in Fuddrucker's parking lot. *Id.*

3. Price testified that she only had a 15 minute break, so she walked through the parking lot to the hotel. She had made about 50 stops during the first 4 hours of her shift. T.15. This was her first restroom break of the shift. *Id.* On cross-examination, Price stated that it is Pace's policy that she can take her bus out of service and use the restroom. T.28. She was never instructed to use a specific bathroom or advised to not walk through a parking lot. T.25.

4. Respondent's exhibit 1 shows an aerial view of Fuddrucker's parking lot. Petitioner placed an "x" where she fell. Price noted there was a sidewalk and one direction led to a curb. She did not see the sidewalk that led directly to the hotel. T.13.

5. Price testified that she had previously used the Fuddrucker's restroom when it was open. T.30. She had never used the Holiday Inn's restroom, however. *Id.* She was not sure where the hotel entrance was located. T.31. She also did not know if the sidewalk would lead to the hotel. T.24.

6. On re-cross examination, Price stated that she can get written up if she is late on her route. T.51. However, if she calls into the station, she likely could avoid administrative punishment for exceeding her 15 minute break. T.52.

7. Price testified that she felt pain in her left ankle when she fell. She stated that the passengers had to help her up so she could call the garage. An ambulance was called and she was transported to Good Samaritan Hospital. T.17.

8. Per the US Healthworks of Illinois Bellwood Medical Center report dated December 4, 2015, Price was diagnosed with a comminuted fracture of the left fibula. She was to wear a boot at all times and was to be non-weight bearing. She was to undergo surgery on December 8, 2015. PX.2.

9. Price testified that surgery was scheduled in December 2015, but was cancelled as her claim was denied. She had not had the surgery as of the date of the hearing. T.19. She currently wears an orthopedic boot and will occasional use crutches. T.20. She is trying to get surgery through her group health insurance. *Id.* She has not received any benefits and has not returned to work since the accident. T.21. It was her opinion that she cannot drive a bus with a broken ankle.

Our Supreme Court recently addressed the issue of a travelling employee in *Venture-Newberg-Perini v. Ill. Workers' Comp. Comm'n*, 2013 IL 115728. In *Venture-Newberg*, the Supreme Court stated "The general rule is that an injury incurred by an employee in going to or returning from the place of employment does not arise out of or in the course of the employment and, hence, is not compensable." *Commonwealth Edison Co. v. Industrial Comm'n*, 86 Ill. 2d 534, 537, 428 N.E.2d 165, 56 Ill. Dec. 846 (1981).

The Supreme Court noted, however, that "[a]n exception applies, however, when the employee is a "traveling employee." "[C]ourts generally regard employees whose duties require them to travel away from their employer's premises (traveling employees) differently from other employees when considering whether an injury arose out of and in the course of employment." *Wright v. Industrial Comm'n*, 62 Ill. 2d 65, 68, 338 N.E.2d 379 (1975); *Hoffman v. Industrial Comm'n*, 109 Ill. 2d 194, 199, 486 N.E.2d 889, 93 Ill. Dec. 356 (1985).

The Supreme Court further explained that "[i]f a traveling employee is injured, the court then considers whether the employee's activity was compensable." *Wright*, 62 Ill. 2d at 69. "This court has found that injuries arising from three categories of acts are compensable: (1) acts the employer instructs the employee to perform; (2) acts which the employee has a common law or statutory duty to perform while performing duties for his employer; (3) acts which the employee might be reasonably expected to perform incident to his assigned duties."

Furthermore, "[c]onsidering the third category, this court has found that traveling employees may be compensated for injuries incurred while performing an act they were not specifically instructed to perform. The act, however, must have arisen out of and in the course of his employment. To make this determination, the court considers the reasonableness of the act and whether it might have reasonably been foreseen by the employer."

The Commission finds that Price, without question, was a travelling employee. As a bus driver, Price was required to be away from the employer's premises for an extended period of time. Price sustained injury during one of her scheduled breaks during her bus route. The Commission finds that the activity of using the restroom during her shift was an act that was reasonably expected to be performed incidental to her assigned duties.

The act of a bus driver having to use the restroom during her route was reasonably foreseeable by the Respondent. Further, Price's decision to walk through the parking lot was reasonable. The Commission finds Respondent's argument that Price's decision to walk through the parking lot instead of using the sidewalk constituted an unnecessary personal risk is without merit. The Respondent offered an aerial photo of the parking lot and the adjacent sidewalk. Respondent argues that the she should have used the sidewalk to get to the hotel. However,

having reviewed the aerial photo, the sidewalk represented a longer distance to the hotel. Her decision to take the straight route through a parking lot to the hotel was reasonable, especially given she was on a timed 15 minute break.

The Respondent argues this case is similar to *Dodson v. Indus. Comm'n*, 308 Ill. App. 3d 572. They argue that in *Dodson*, the employee had taken a customary and direct route across a sloping grassy path rather than using stairs and a sidewalk. The employee's fall, resulting from ice, was deemed the result of a voluntary act outside the scope of her employment. They also argue that this case is similar to *Hatfill v. Industrial Comm's*, 202 Ill. App. 3d 547. In *Hatfill*, benefits were denied for an employee who jumped across a watery ditch in a parking lot rather than using the walkway. The Commission notes that both *Dodson* and *Hatfill* are factually distinguishable from the case at hand. Most importantly, the petitioners in *Dodson* and *Hatfill* were not travelling employees and, therefore, the travelling employee exception, as stated above, did not apply in those cases.

Therefore, the Commission finds that the act of using the restroom during her shift was reasonably foreseeable by the employer, and the act of taking the direct route to the hotel through the parking lot was reasonable, especially in light of the fact that she was on a 15 minute break. Accordingly, her injury arose out of and in the course of her employment.

The Petitioner argued that her injury was compensable under the personal comfort doctrine. Having found that Price was a travelling employee and that her injury arose out of and in the course of her employment, the personal comfort doctrine is not applicable. However, the Commission notes that this case would also have been compensable under the personal comfort doctrine.

Per the personal comfort doctrine: "Employees who, within the time and space limits of their employment, engage in acts which minister to personal comfort do not thereby leave the course of employment, unless the * * * method chosen is so unusual and unreasonable that the conduct cannot be considered an incident of the employment."

The Illinois Supreme Court has added:

> If the employee voluntarily and in an unexpected manner exposes himself to a risk outside any reasonable exercise of his duties, the resultant injury will not be deemed to have occurred within the course of the employment. The employer may, nevertheless, still be held liable for injuries resulting from an unreasonable and unnecessary risk if the employer has knowledge of or has acquiesced in the practice or custom, *Eagle Discount Supermarket,* 82 Ill. 2d at 340.

There is no evidence that using the parking lot to go to the hotel was unusual or unreasonable. Rather, it was wholly reasonable for her to take the shortest route to the hotel, which was straight through the parking lot given she only had a 15 minute break. The testimony

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also establishes that the Respondent had knowledge that its employee's would take their bus out of service to use a public restroom during their shift while away from the Respondent's premises.

The Commission further finds that Price's current condition of ill-being is causally related to her November 23, 2015 accident. She is entitled to TTD benefits from November 24, 2015 through January 15, 2016, representing 7-3/7 weeks of TTD. Petitioner is entitled to all reasonable and necessary medical expenses, and prospective medical care including surgical repair of her comminuted fracture of the left fibula.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 25, 2016 is hereby reversed for the reasons stated above.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $331.03 per week for a period of 7-3/7 weeks, November 24, 2015 through January 15, 2016, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JUN 22 2017

Michael J. Brennan

MJB/tdm
O: 4-24-17
052

Thomas J. Tyrrell

Dissent

I respectfully dissent from the decision of the majority. I would affirm Arbitrator Hegarty's thorough and well-reasoned decision in its entirety and without modification.

Kevin W. Lamborn

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

PRICE, TEMEKA
Employee/Petitioner

Case# **15WC039674**

PACE
Employer/Respondent

17IWCC0376

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:

2004 SCHACTER, JEROME & ASSOC LTD
RICHARD DOMASH
9933 N LAWLER SUITE 100
SKOKIE, IL 60077

1505 SLAVIN & SLAVIN
PATRICK SHIFLEY
100 N LASALLE ST 25TH FL
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TEMEKA PRICE
Employee/Petitioner

v.

PACE
Employer/Respondent

Case # **15** WC **39674**

Consolidated cases: _____

17IWCC0376

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Geneva, Illinois**, on **1/15/2016**. 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 **Number of Dependents**

17IWCC0376

FINDINGS

On the date of accident, **11/23/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,834.34**; the average weekly wage was **$496.55**.

On the date of accident, Petitioner was **39** years of age, ***single*** with **4** dependent children.

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

Respondent shall be given a credit of **$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 the accident did not arise out of work, and was not causally connected to said employment, 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.

Jessica A. Hegarty

Signature of Arbitrator

4/21/16
Date

ICArbDec19(b)

APR 25 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TEMEKA PRICE, Petitioner,	)	
v.	)	**15 WC 39674** Geneva
PACE, Respondent,	)	**17IWCC0376**

Addendum to the Decision of the Arbitrator

This matter was heard on January 15, 2016 in Geneva, Illinois, pursuant to sections 19(b) and 8(a) of the Illinois Workers' Compensation Act. The primary issue in dispute is whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent.

Findings of Fact

Petitioner testified that she has been employed as a bus driver for Respondent since January 7, 2013. Petitioner testified that on November 23, 2015 she was operating one of Respondent's buses on route 313, her first time driving this route. Petitioner began her shift at 4:23 a.m. Route 313 required Petitioner to drive from a Pace facility to Lake and Austin, then to the Elmhurst train station, and then to the intersection of Branding Lane and Finley Road, in Downers Grove. Petitioner completed her run to this point at approximately 8:40 a.m. when her schedule permitted a 15 minute break. Petitioner allowed the bus passengers to disembark and placed the bus in an "Out of Service" status.

At the intersection where Petitioner had parked the bus is a Fuddruckers restaurant. The Petitioner testified that she was familiar with the Fuddruckers restaurant, and that it was not open at this time of day. Petitioner, who needed use a restroom, left her bus, walking north towards a Holiday Inn Express that was visible from across the Fuddruckers parking lot, approximately 100 yards away. Petitioner admitted that she chose to cut through the parking lot because it was a shorter route than taking the sidewalk. Petitioner was unfamiliar with the area. She testified she did not know if access to the hotel was possible from the east. She testified she did not know if there were any open doors on the side of the hotel facing the Fuddruckers parking lot.

The Petitioner made it approximately 20 feet from the bus before slipping on ice in the parking lot. Petitioner fell on her behind and her left leg went over to the left. After the fall, Petitioner could not get up unassisted. Passengers from the bus assisted her up and brought her back to the bus.

The Petitioner then called the Respondent's garage and an ambulance was sent to take her to Good Samaritan Hospital where an x-ray was taken of her left ankle.

Petitioner testified that it is the policy of the Respondent that bus operators may stop their buses along the routes and leave to take a washroom break. These breaks can be taken whenever the operator needs, but the operators are required to call in and report the break.

Petitioner testified that she had a 15 minute break between the two legs of her bus route. Petitioner further testified that if she had needed more time, she could have called and reported that she needed a break.

Petitioner had discussed the route with other drivers, and they had told her that the washroom in the hotel at the Holiday Inn was available for her to use.

Petitioner's Medical Treatment

In their opening statements the counsel for both parties stated that the dispute in this matter centered on the compensability of the Petitioner's accident. Counsel for the Respondent stated the Respondent's defense that the accident did not arise out of and in the course of the employment. For that reason, little medical evidence was introduced.

On November 23, 2015, Petitioner was seen at Advocate Good Samaritan Hospital. (Px 3 – 5). The Petitioner was discharged after treatment for a left ankle injury, and was placed off work. (Px 3) On November 23, 2015, Petitioner was treated at Advocate Occupational Health. The Petitioner was placed off work until she could be cleared by occupational health. (Px 1)

On December 4, 2015, Petitioner was seen at U.S. Healthworks. Petitioner's x-ray were noted to reveal a comminuted fracture of the left fibula. The Petitioner was placed off work, and a surgery was scheduled for December 8, 2015. (Px 2)

Respondent introduced demonstrative exhibits showing the scene of the slip and fall. (Rx 1) Petitioner testified that these accurately depicted the area in which she fell, but testified that there was no snow on the ground on November 23, 2015. For the purposes of this decision, all exhibits will be oriented with the exhibit sticker in the bottom right corner.

Respondent's Exhibit 1.1 shows an overhead view of the area, taken from Google Maps. North is up, east is to the right. The exhibit shows Branding Lane where it intersects Finley Road in the bottom left corner. Three Pace bus stops are notated with a blue bus icon. North of Branding Lane is a parking lot. The west half of that lot includes a white roofed building labeled as a Fuddruckers, the east portion is an empty parking lot bordered by a sidewalk and grassy median on the south and west. North of the Fuddruckers parking lot is an embankment and a darker parking lot surrounding a brown roofed building labeled as a Holiday Inn Express.

The Petitioner marked an "x" on the exhibit in the approximate position of her fall. That mark was made in the Fuddruckers parking lot, north of Branding Lane, and slightly to the north-east of a blue bus icon. Traveling from the bus icon to that spot would require crossing the grassy portions of the southern median, the sidewalk in the southern median, traversing a curb, and stepping into the parking lot.

Conclusions of Law

To obtain compensation under the Act, a claimant must show, by a preponderance of the evidence, that he or she suffered a disabling injury that arose out of and in the course of the claimant's employment. 820 ILCS 305/2. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. *Baggett v. Industrial Comm'n*, 201 Ill.2d 187, 194, 266 Ill.Dec. 836, 775 N.E.2d 908 (2002).

There are three categories of risk an employee may be exposed to: (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. *Illinois Inst. of Tech. Research Inst. v. Indus. Comm'n*, 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 806 (1st Dist. 2000). An injury does not arise out of the employment where an employee voluntarily exposes themselves to an unnecessary personal danger solely for their own convenience. *Dodson v. Indus. Comm'n*, 308 Ill. App. 3d 572, 720 N.E.2d 275, 277 (5th Dist. 1999).

C. Whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent

In *Dodson v. Indus. Comm'n*, 308 Ill. App. 3d 572, 720 N.E.2d 275, 277 (5th Dist. 1999), the employee had taken a customary and direct route across a sloping grassy path rather than using stairs and a sidewalk. The employee's fall, resulting from ice, was deemed the result of a voluntary act outside the scope of her employment. On analysis, the Fifth District determined that the employee had been within the course of her employment, but denied that the accident "arose out of" that employment. As there was an unobstructed sidewalk available, the employee's shortcut across the wet and icy slope was a voluntary decision which unnecessarily exposed her to a danger entirely separate from her employment. Testimony regarding other employee's habitual use of the same slope, and the employer's acquiescence to that use, was deemed irrelevant. *Dodson* at 577 citing *Orsini v. Industrial Comm'n*, 117 Ill.2d at 47, 109 Ill.Dec. 166, 509 N.E.2d 1005 (1987).

In the instant matter, the Petitioner testified that there was a sidewalk around the perimeter of the parking lot. She testified that the sidewalk was in use by some passengers from her bus. Although Petitioner was in the course of her duties when she took a washroom break, she made a choice to take a shortcut through a parking lot rather than use the sidewalk. Consistent with the above precedent, Petitioner's choice was personal in nature and not designed to serve the interests of her employer. As such, her risk did not arise out of her employment.

Because Petitioner failed to establish that her accident arose out of and in the course of her employment with Respondent, the Arbitrator finds that Petitioner's present condition of ill-being is not causally related to the injury. Accordingly, all benefits claimed by Petitioner 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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS J. SPANOS,

Petitioner,

vs. NO: 16 WC 19519

CITY OF HIGHLAND PARK,

Respondent.

ORDER

This matter comes before Commissioner Michael J. Brennan on Respondent's Notice of Motion and Order to Amend the Settlement Contract, filed on April 18, 2017, and the subsequent Stipulation of the Parties, filed on April 28, 2017.

Procedurally, the parties entered into a Settlement Contract Lump Sum Petition and Order ("Settlement Contract") that was approved by Arbitrator Stephen Friedman on March 23, 2017. Subsequently, the parties filed the above-referenced Stipulation on April 28, 2017.

Per the Stipulation, the parties request that the Commission enter an Order clarifying the previously approved Settlement Contract to conform with the intent of the parties. Specifically:

1) At the time of settlement, the Settlement Contract included payment of $1,126.95, from Respondent to Petitioner, towards satisfaction of certain outstanding medical bills as specified in the Settlement Contract; and,

2) That since the Settlement Contract was entered and approved, Respondent elected to satisfy their obligation by directly paying the medical providers on their outstanding bills.

By the Stipulation, the parties agree that the total amount of the Settlement should be

reduced by $1,126.95 to reflect Respondent's payment of the medical bills, and they request modification of the Settlement Contract to accurately reflect the terms of their Agreement.

The Commission finds that it has jurisdiction over this matter, as Respondent timely filed its petition for review pursuant to Section 19(b) of the Act. Although, technically, Respondent's petition is in the form of a Notice of Motion and Order, it is proper under the law. In *Shafer v. Ill. Workers' Comp. Comm'n*, our Appellate Court noted:

> Section 19(b) of the Act, which governs petitions for review filed in the Commission, does not prescribe any specific requirements regarding the form of petitions for review. It merely requires that petitions for review be filed within 30 days and that they 'contain a statement of the petitioning party's specific exceptions to the decision of the arbitrator.' 2011 IL App (4th) 100505WC.

Our Supreme Court has also long established that a settlement contract approved by the Commission has the same legal effect as an award entered by the Commission. *Millennium Knickerbocker Hotel v. Ill. Workers' Comp. Comm'n*, 2017 IL App (1st) 161027WC.

The Commission has reviewed said Petition and finds it has authority to modify the terms of the settlement to correctly reflect the parties' agreed-upon terms as set forth above.

Therefore, it is the Order of the Commission:

1) That the Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Stephen Friedman on March 23, 2017, is hereby reduced by $1,126.95 to reflect Respondent's payment of the medical bills;

2) That the heretofore approved Settlement Contract Lump Sum Petition and Order, as was approved by Arbitrator Stephen Friedman on March 23, 2017, remains in full force and effect, and shall be read in concert with this Order and the stipulations of the parties as recited herein; and,

3) The referenced Settlement Contract together with Respondent's Notice of Motion and Order to Amend the Settlement Contract and the parties' signed stipulation are attached to and made a part of this Order.

DATED: JUN 27 2017
MJB/pm
6/27/17

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed.
Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

Thomas J. Spanos
Employee/Petitioner

v.

Case #: **16 WC 19519**

City of Highland Park
Employer/Respondent

TO: **John J. Rizzo**
Linn, Campe & Rizzo, Ltd.
215 N. Martin Luther King Jr. Ave.
Waukegan, IL 60085

On **5/12/17**, at **9:00 a.m.** or as soon thereafter as possible, I shall appear before the **Commissioner Brennan**, or any arbitrator or commissioner appearing in his place at the **Lake County Courthouse, Waukegan**, Illinois, and present the attached motion for:

_____ Change of venue (#3072)	____ Fees under Section 16 (#1600)	___ Reinstatement of case (#3074)
_____ Consolidation of cases (#3071) 16 WC 19519	____ Fees under Section 16a (#1645)	___ Request for hearing (#R33)
	____ Hearing under Sect. 19(b) (#1902)	___ Withdrawal of attorney (#3073)
_____	____ Penalties under Sect. 19(k) (#1911)	X Other (explain)
_____ Dismissal of attorney (#3052)	____ Penalties under Sect. 19(l) (#1912)	**Amendment of Settlement Contracts**
_____ Dismissal of review (#3085)		

Signature Petitioner ___ Respondent X

Jared P. Vasiliauskas #75
Attorney's name and IC code # (please print)1

POWER & CRONIN, LTD.
Name of law firm, if applicable

900 Commerce Drive – Suite 300
Street address

Oak Brook IL 60523
City State Zip code

(630) 571-2001 Daniel.Artman@powercronin.com
Telephone number Email address

ORDER

The motion is set for hearing on _____

_____
Signature of arbitrator or commissioner

_____
Date

ORDER

The motion is ___ Granted ___ Withdrawn ___ Continued to _____
___ Denied ___ Dismissed ___ Set for trial (date certain) on _____

_____
Signature of arbitrator or commissioner

_____
Date

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

THOMAS J. SPANOS,	)	
	)	Case Number (s) 16 WC 19519
Petitioner,	)	
	)	
v.	)	
	)	
CITY OF HIGHLAND PARK,	)	
	)	
Respondent.	)	

MOTION TO AMEND SETTLEMENT CONTRACTS

NOW COMES the Respondent, City of Highland Park, by and through its attorneys, POWER & CRONIN, LTD., and states that the Settlement Contracts in the above-referenced case should be Amended, and in support thereof, states as follows:

1. On March 23, 2017, Arbitrator Erbacci approved Settlement Contracts in this case.
2. The Settlement Contracts contained terms where the Petitioner would pay specific medical bills directly with funding provided by the Respondent (See Attached Exhibit A).
3. After approval of the Settlement Contracts, the Parties learned that the Respondent had paid the medical providers directly, and that there were no outstanding medical bills.
4. There is no need for the additional funding stated in the original Settlement Contracts as the Petitioner's medical bills were paid.
5. In order to accurately reflect the Agreement of the Parties, the Settlement Contracts should be Amended to remove the payment of funding for medical bills, which are already paid (See Exhibit B).

6. The Amendment of the Settlement Contracts is permitted under the Illinois Workers' Compensation Act and is necessary to accurately reflect the Agreement of the Parties.

WHEREFORE, Respondent, City of Highland Park, respectfully requests that this Honorable Workers' Compensation Commission approve Amended Settlement Contracts in this case which accurately reflect the Parties settlement terms.

Respectfully submitted,

City of Highland Park

By: _____
One of Its Attorneys

Jared P. Vasiliauskas
Power & Cronin, Ltd.
900 Commerce Drive – Suite 300
Oak Brook, IL 60523
(630) 571-2001
Attorney Number: 75

EXHIBIT

tabbies A

ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act X Occupational Diseases Act ____ Fatal case? No X Yes ____ Date of Death? ____

Thomas J. Spanos
Employee/Petitioner

Case # 16 WC 19519

v.

City of Highland Park
Employer/Respondent

Setting Waukegan - Erbacci

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Thomas J. Spanos	7351 N. Oleander	Chicago	IL	60631
Employee's name	Street address	City	State	Zip code
City of Highland Park	1707 St. Johns Ave.	Highland Park	IL	60035
Employer's name	Street address	City	State	Zip code

State Employee? Yes ☐ No ☒ Male ☒ Female ☐ Married ☒ Single ☐

Dependents under age 18 2 Birthdate 4/3/1975 Average weekly wage $ 1,712.85

Date of accident 03/04/2016

How did the accident occur? Restraining a resisting suspect.

What part of the body was affected? Right arm/elbow

What is the nature of the injury? Lateral Epicondylitis

The employer was notified of the accident orally X In writing ____ Return-to-work date 3/8/2016

Location of accident Highland Park Did the employee return to his or her regular job? Yes X No ____

If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

TEMPORARY TOTAL DISABILITY BENEFITS Compensation was paid for 0 weeks at the rate of $ 1,141.90 /week

The employee was temporarily totally disabled from N/A through N/A

MEDICAL EXPENSES: The employer has ____ has not X paid all medical expenses. List unpaid bills in the space below.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner $ N/A as compensation for the permanent disability caused by the injury.
An arbitrator or commissioner of the Commission previously made an award on this case on N/A / / regarding TTD N/A Permanent disability N/A Medical Expenses N/A Other N/A.

TERMS OF SETTLEMENT: Attach a recent medical report signed by a physician who examined or treated the employee.
Respondent to pay and Petitioner to accept **$15,457.25** in full and final settlement of any and all claims under the Workers' Compensation Act and/or Occupational Disease Act or otherwise for accidental injuries allegedly incurred as described hereinbefore as occurring on or about **03/04/2016** and including any and all results, developments, sequalae, fatal or non-fatal, resulting or allegedly resulting from such accidental injuries. Issues exist between the parties as to whether the Petitioner has incurred injuries to the degree alleged and whether or not such injuries are compensable, and this settlement is made to amicably settle these issues. The settlement includes liability for temporary total compensation and all medical, surgical and hospital expenses incurred or to be incurred or allegedly resulting from the said accidental injuries for all of which the Petitioner expressly assumes responsibility. Review under Section 19(h) and 8(a) is expressly waived by the parties hereto. This settlement does not release or extinguish any Section 5 (b) rights that Respondent may have. The settlement represents: 7.5% loss of use of Petitioner's right arm or 18.975 weeks of compensation at a rate of $755.22 and payment of the following medical bills; Illinois Bone & Joint Institute – Dr. Hoepfner $83.00; Atletico $149.15; and Illinois Bone & Joint Physical Therapy $894.80. It is the Petitioner's responsibility to pay the bills directly to the providers.

Total amount of settlement	$ 15,457.25
Deduction: Attorney's fees	$ 3091.45
Deduction: Medical reports and X-rays	$ 136.58
Deduction: Other (explain)	$
Amount employee will receive	$ 12,229.22

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.* I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

Signature of petitioner | Thomas J. Spanos, Name of petitioner (please print) | Petitioner | Telephone number | Date

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

Signature of attorney | Date

Mr. John J. Rizzo
Attorney's name and IC code # (please print)

LINN, CAMPE & RIZZO, LTD.
Firm name

215 N. Martin Luther King Jr. Ave.
Street address

Waukegan | IL | 60085
City | State | Zip code

847-249-4600
Telephone number | E-mail address

FEIN #

RESPONDENT'S ATTORNEY. I attest that any fee petitions * on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney or agency | 3/6/17 Date

Mr. Daniel J. Artman | #75
Attorney's name and IC code # or agent (please print)

POWER & CRONIN, LTD.
Firm name

900 Commerce Drive - Suite 300
Street address

Oak Brook | IL | 60523
City | State | Zip code

(630) 571-2001 | Daniel.Artman@powercronin.com
Telephone number | E-mail Address

CCMSI
Name of respondent's insurance or service company (please print)

ORDER OF ARBITRATOR OR COMMISSIONER:
Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case.

pursuant to Section 9 of the Workers' Compensation and Workers' Occupational Diseases Acts

MAR 23 2017

By: Stephen Mathis, Arbitrator

*** - (served on Respondent's counsel prior to Respondent's signature date)**

EXHIBIT B

AMENDED
ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Amended

Workers' Compensation Act X Occupational Diseases Act ____ Fatal case? No X Yes ____ Date of Death? ____

Thomas J. Spanos Case # **16 WC 19519**
Employee/Petitioner

v.

City of Highland Park Setting **Waukegan - Erbacci**
Employer/Respondent

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Thomas J. Spanos	**7351 N. Oleander**	**Chicago**	**IL**	**60631**
Employee's name	Street address	City	State	Zip code

City of Highland Park	**1707 St. Johns Ave.**	**Highland Park**	**IL**	**60035**
Employer's name	Street address	City	State	Zip code

State Employee? Yes ☐ No ☒ Male ☒ Female ☐ Married ☒ Single ☐

Dependents under age 18 **2** Birthdate **4/3/1975** Average weekly wage $ **1,712.85**

Date of accident **03/04/2016**

How did the accident occur? **Restraining a resisting suspect**

What part of the body was affected? **Right arm/elbow**

What is the nature of the injury? **Lateral Epicondylitis**

The employer was notified of the accident orally **X** In writing ____ Return-to-work date **3/8/2016**

Location of accident **Highland Park** Did the employee return to his or her regular job? Yes **X** No ____

If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

TEMPORARY TOTAL DISABILITY BENEFITS Compensation was paid for **0** weeks at the rate of $ **1,141.90** /week

The employee was temporarily totally disabled from **N/A** through **N/A**

MEDICAL EXPENSES: The employer has ____ has not **X** paid all medical expenses. List unpaid bills in the space below.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner $ **N/A** as compensation for the permanent disability caused by the injury.
An arbitrator or commissioner of the Commission previously made an award on this case on **N/A** / / regarding
TTD **N/A** Permanent disability **N/A** Medical Expenses **N/A** Other **N/A**.

TERMS OF SETTLEMENT: Attach a recent medical report signed by a physician who examined or treated the employee.
Respondent to pay and Petitioner to accept **$ 14330.30** in full and final settlement of any and all claims under the Workers' Compensation Act and/or Occupational Disease Act or otherwise for accidental injuries allegedly incurred as described hereinbefore as occurring on or about **03/04/2016** and including any and all results, developments, sequalae, fatal or non-fatal, resulting or allegedly resulting from such accidental injuries. Issues exist between the parties as to whether the Petitioner has incurred injuries to the degree alleged and whether or not such injuries are compensable, and this settlement is made to amicably settle these issues. The settlement includes liability for temporary total compensation and all medical, surgical and hospital expenses incurred or to be incurred or allegedly resulting from the said accidental injuries for all of which the Petitioner expressly assumes responsibility. Review under Section 19(h) and 8(a) is expressly waived by the parties hereto. This settlement does not release or extinguish any Section 5 (b) rights that Respondent may have. The settlement represents: 7.5% loss of use of Petitioner's right arm or 18.975 weeks of compensation at a rate of $755.22.

Total amount of settlement	$ 14330.30
Deduction: Attorney's fees	$
Deduction: Medical reports and X-rays	$
Deduction: Other (explain)	$
Amount employee will receive	$

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.* I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

Signature of petitioner	Name of petitioner (please print)	Telephone number	Date
	Thomas J. Spanos	Petitioner	

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

Signature of attorney — Date

Mr. John J. Rizzo
Attorney's name and IC code # (please print)

LINN, CAMPE & RIZZO, LTD.
Firm name

215 N. Martin Luther King Jr. Ave.
Street address

Waukegan — IL — 60085
City — State — Zip code

847-249-4600
Telephone number — E-mail address

FEIN #

RESPONDENT'S ATTORNEY. I attest that any fee petitions * on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney or agency — Date: 4/17/17

Mr. Daniel J. Artman — #75
Attorney's name and IC code # or agent (please print)

POWER & CRONIN, LTD.
Firm name

900 Commerce Drive - Suite 300
Street address

Oak Brook — IL — 60523
City — State — Zip code

(630) 571-2001 — Daniel.Artman@powercronin.com
Telephone number — E-mail Address

CCMSI
Name of respondent's insurance or service company (please print)

ORDER OF ARBITRATOR OR COMMISSIONER:
Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case.

*** - (served on Respondent's counsel prior to Respondent's signature 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

William Frazier

Petitioner,

vs.

No. 16 WC 01176

B&F Construction,

17IWCC0389

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 prospective medical care, 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 error in the Arbitrator's Decision to reflect that the analysis of mechanical stress elements applied to petitioner's left hip in the motor vehicle accident was attributable to Dr. Fetter rather than Dr. Sherman. There is no issue that Petitioner did have pre-existing arthritic changes in his left hip. Prior to the work accident, petitioner's symptoms were only episodically troublesome whereas now petitioner experiences constant pain. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2017, is hereby corrected as stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, 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: JUN 26 2017
o-4-27-17
SM/msb
44

Stephen Mathis

David L. Gore

Deborah Simpson

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

FRAZIER, WILLIAM
Employee/Petitioner

Case# **16WC001176**

B & F CONSTRUCTION CODE SERVICES
Employer/Respondent

17IWCC0389

On 11/1/2016, 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 0.50% 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:

5238 COLLISON & O'CONNOR LTD
MURIEL COLLISON
19 S LASALLE ST SUITE 1400
CHICAGO, IL 60603

0445 RODDY LAW LTD
PAUL SCHUMACHER
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

17IWCC0389

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

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

WILLIAM FRAZIER
Employee/Petitioner

v.

B & F CONSTRUCTION CODE SERVICES
Employer/Respondent

Case # 16 WC 1176

Consolidated cases: _____

Venue: Elgin

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Wheaton (Elgin)**, on **9/28/16**. 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, **11/12/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$37,980.80**; the average weekly wage was **$734.40**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

- The Arbitrator finds that Petitioner suffered an accident, which arose out of and in the course of the employment.
- The Arbitrator finds that Petitioner's need for a hip replacement is causally related to the accident of November 12, 2015.
- The Arbitrator awards medical in the amount of $1,250.00 to Midwest Bone & Joint since the treatment for this bill was reasonable, necessary and causally related. The charges from Midwest Bone & Joint shall be paid pursuant to the Fee Schedule.
- The Arbitrator awards prospective medical care (hip replacement) as prescribed by Dr. Palmer as well as necessary and related follow-up care.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Signature of Arbitrator

10/26/16
Date

ICArbDec19(b)

NOV 1 - 2016

17IWCC0389

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

WILLIAM FRAZIER,	)	
	)	
Petitioner,	)	
	)	
v.	)	**16 WC 1176**
	)	
B & F CONSTRUCTION CODE SERVICES,	)	
	)	
	)	
Respondent.	)	

STATEMENT OF FACTS

It is undisputed that on November 12, 2015, the Petitioner was injured in a rear end collision while performing work related duties for the Respondent as a property maintenance inspector. (Arb. 1). On that date, Petitioner was waiting at a stop light in a company car when he heard screeching tires and saw an oncoming car in the rear view mirror. At the moment of impact, Petitioner's body was lifted to the right and Petitioner's head struck the roof of the vehicle. Petitioner began noticing tightness in his back and tenderness to his neck within 5 to 10 minutes of the motor vehicle accident.

Petitioner presented to Physician's Immediate Care on the accident date with a history of constant shooting pain in his left lower back following a car accident. Complaints of neck, headache, left groin and possible left knee pain were also noted. On exam, tenderness in the lower back and cervical para spinous muscles was documented. Petitioner was diagnosed with low back and cervical pain, prescribed analgesic medication and released back to work without restriction.

Petitioner testified that he reported to work the following day, November 13, 2015, with persistent pain in his neck, back, shoulder blade and groin.

On November 17, 2015, Petitioner was re-evaluated at Physician's Immediate Care where he reported increasing left hip pain radiating into the left groin and inner thigh. Examination revealed reduced range of left hip motion causing limping and mild lumbar tenderness. Petitioner was diagnosed with a lumbar sprain and trochanteric bursitis of the left hip for which physical therapy and continued use of Naproxen was recommended.

The Petitioner began physical therapy on November 24, 2015 at which time his complaints of hip pain and difficulty bending and rotating his left hip were noted. The physical therapy notes episodic buckling occurring when Petitioner walked due to sharp stabbing pain in his left hip.

A left hip MRI was performed on December 22, 2015 which noted:

1. The patient has an element of dysplasia of the femoral head/neck junction with a distal graft deformity which is known to cause CAM-type femoral acetabular impingement and premature hip osteoarthritis.

2. There is advanced degenerative disease in the left hip and mild to moderate degenerative change in the right hip.

3. There is a small left hip joint effusion.

4. A small cyst along the superolateral acetabular margin on the right may represent a dissecting paralabral cyst and suggests that there may be an underlying right hip labral tear.

5. The changes described are chronic. The possibility of an acute exacerbation of the abnormalities due to trauma cannot be excluded; however, the significant abnormalities are chronic and degenerative in nature.

The Petitioner completed physical therapy and followed-up with Physician's Immediate Care two more times before being referred to Shawn Palmer, D.O. regarding his persistent left hip complaints.

On January 15, 2016, Dr. Palmer noted a history of left hip and groin pain following a motor vehicle accident on November 12, 2015. Petitioner reported difficulty with sleeping, putting on shoes and socks and getting in and out of a car. On examination, Dr. Palmer documented an antalgic Trendelenburg gait to the left and restricted range of motion of the left hip. Petitioner reported dancing pain free at his daughter's wedding the month prior. An injection was administered to Petitioner's left hip. The doctor recommended Petitioner continue conservative treatment as long as his symptoms allow. (PX C).

On February 16, 2016, Petitioner was again seen by Dr. Palmer who noted the prior injection only relieved his symptoms for about 3 days. Petitioner reported being "miserable". He further reported continuing to work as a building inspector but the pain was making the work challenging. Dr. Palmer noted Petitioner's difficulty getting up and out of a chair, pain with prolonged walking and difficulty sleeping due to pain. Dr. Palmer viewed the video of Petitioner jumping up and down and dancing at his daughter's wedding. The doctor noted Petitioner was an excellent candidate for left anterior total hip arthroplasty. (Id.).

At the request of the respondent, the Petitioner was examined and evaluated, pursuant to Section 12 by, Dr. Fetter, who concluded that Petitioner's prescription for a hip replacement was not causally related to this motor vehicle accident. Dr. Fetter opined that the Petitioner's MRI study of the hip showed significant degenerative processes and that Petitioner's prescription for the aforementioned surgery was related to Petitioner's degenerative processes since the motor vehicle accident caused a cervical and possible lumbar strain.

At the request of Petitioner's counsel, the Petitioner was examined by Dr. Sherman, who concurred with the prescription for a hip replacement surgery which he causally connected to the work injury. Dr. Sherman reviewed Petitioner's medical records, including Respondent's Section 12 examination by Dr. Fetter and a video of Petitioner dancing at his daughter's wedding three weeks prior to the accident. The doctor also performed a physical examination and ultimately opined that Petitioner had preexisting arthritis of the left hip that was

asymptomatic prior to the work related accident. According to Dr. Fetter, the mechanical stress on the left hips from the force of the rear end collision, whereby Petitioner planted his left leg on the floor board of a car, caused a twisting axial load to the left hip resulting in an exacerbation of his arthritis to the point where it became symptomatic. Dr. Sherman additionally opined, Petitioner's current state of painful arthritis was due to the forces that occurred at the time of this automobile accident, resulting in the need for hip replacement surgery.

Petitioner testified he is currently in pain and wants to proceed with the hip replacement surgery prescribed by Dr. Palmer.

FINDINGS AND DECISION OF THE ARBITRATOR

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

The only record prior to the accident at issue that mentions Petitioner's hip is the Centegra Physician Care record dated 6/12/15 in which Petitioner indicated an incident two years prior where he had fallen onto a four foot wall and heard a pop in his left hip (PX E Pg. 12). Petitioner testified this fall resulted in back pain and pain that radiated from his groin to his leg. Petitioner testified that the MRI performed on 12/22/15 was the first MRI done in his lifetime on his left hip.

Petitioner did have groin pain on several occasions prior to this accident. Petitioner testified and the records indicate he had a hernia which was accompanied with groin pain and was diagnosed with a groin strain. Additionally Petitioner indicated when he had a back injury there was pain to the groin. The Centegra records detail Petitioner's prior complaints of groin pain but there is no mention of his left hip prior to the accident. (PX E &F)

The medical records in evidence contain histories that are consistent with Petitioner's testimony at the hearing. The history given to both Section 12 examining physicians was also consistent with his testimony.

Petitioner's treating physician Dr. Palmer noted:

> "It is my impression that this gentleman was under no prior care before his Work Comp claim. He was apparently dancing pain-free at his daughter's wedding the month prior. He states that he does not have any prior history of treatment or discomfort to the hip. He states that this has all cascaded since his claim of injury. I have no evidence to the contrary. I would state that this is an acute exacerbation of an underlying degenerative condition in his left hip." (PX C Pg. 5)

The Arbitrator notes that Petitioner was sent to Physician's Immediate Care by the Respondent and was referred from Physician's Immediate Care to Dr. Palmer.

Petitioner was also evaluated by Dr. Sherman who opined to a reasonable degree of medical and surgical certainty that Petitioner's work related accident caused an exacerbation of his arthritis to the point where it became symptomatic resulting in the need for hip replacement surgery. (PX D)

Petitioner testified he did not experience any difficulty performing his job prior to this injury. Respondent presented no evidence to the contrary.

Petitioner testified he was dancing at his daughter wedding a mere three weeks prior to this accident. Dr. Sherman saw the video and Dr. Palmer was told about the dancing from the Petitioner. The video clearly shows Petitioner was pain free and able to dance and jump and celebrate. All things Petitioner testified he has difficulty doing now. Petitioner testified and it is consistent with the history in the records that he has difficulty walking, sleeping, sitting, climbing in and out of cars and performing everyday tasks without pain. Respondent presented no evidence to refute this.

The Arbitrator places less weight on the opinions of Dr. Fetter noting that Petitioner was working pain free and had no prior treatment or complaints regarding his left hip prior to the accident. Petitioner testified he was not involved in any other accidents. Petitioner showed the Arbitrator how his legs were positioned and where his weight was allocated at the time of impact. His description of his body placement was also the description given to Dr. Sherman and is consistent with his mechanism of injury. Petitioner also testified that Dr. Fetter spent 15 minutes examining him and did not view the video of him dancing three weeks prior at his daughter's wedding. Additionally, there is no indication that Dr. Fetter reviewed Petitioner's physical therapy records or the records from Centegra.

Although Petitioner has worked consistently following the accident, the Arbitrator notes Petitioner's testimony that he was the only source of income for his family and remaining off work was not an option. Petitioner testified he had to rest and put heat on his hip for 15-20 minutes per day after work and continues to take over the counter medication to manage his discomfort.

The Arbitrator finds that based upon Petitioner's testimony, as well as, the credible medical records and the findings of Dr. Palmer and Dr. Sherman, that the Petitioner's degenerative asymptomatic left hip condition was aggravated by the car accident on 11/12/15.

Is Petitioner entitled to any prospective medical?

The Arbitrator finds that Petitioner's current need for a hip replacement is causally related to this accident and awards the prospective medical including the hip replacement surgery and any necessary and related post-surgical care.

Medical Bills

The Arbitrator awards the medical bill from Midwest Bone & Joint in the amount of $1,250.00 pursuant to the Fee Schedule.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIA RODRIQUEZ,

Petitioner,

17IWCC0397

vs.

NO: 16 WC 004991

EDIBLE CUTS,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petititoner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical treatment and expenses, and temporary total disability and being advised of the facts and law, reverses 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 Decision of the Arbitrator, filed with the Commission on July 18, 2016, denied all benefits sought by Petitioner on the basis that Petitioner failed to prove that she sustained an accident on January 26, 2016, that arose out of and in the course of her employment with Respondent. Specifically, it was found that the evidence Petitioner presented was insufficient to establish that her work duties were repetitive or caused injury to her right hand. The Commission disagrees with the contention that Petitioner's work duties did not cause injury to her right hand.

Petitioner claims to have sustained the injury to her right hand on January 26, 2016, and presented to the Arbitrator medical records evidencing that she sought medical care for right hand on that day. The medical records from St. Anthony's Medical Center indicate that she presented to its emergency room on January 26, 2016, with complaints of 10/10 pain that radiated outward from her right wrist into both her fingertips and her forearm and attributed this

17IWCC0397

pain from the "snap" that she felt in her right wrist while peeling fruit. The examination of Petitioner's right wrist, as indicated by the emergency room record, found it to be moderately swollen and exhibited both diminished range of motion and strength. Petitioner was diagnosed as having pain in the right wrist. Petitioner's history concerning the onset of her symptoms coupled with the objective findings concerning Petitioner's right wrist convince the Commission that Petitioner sustained an accident while performing her usual work activities on January 29, 2016.

The Commission finds that Petitioner sustained a work-related accident on January 29, 2016. Accordingly, the Commission addresses whether the current condition of Petitioner's right wrist can be attributed to the January 29, 2016, accident. Although there was no specific testimony at trial relative to the current condition of Petitioner's right wrist elicited during the June 29, 2016, Arbitration Hearing, the transcript of the proceedings demonstrates that Petitioner wants to undergo further testing and surgery upon her right wrist. The Commission infers this testimony to mean that her right wrist remains symptomatic with this inference supported by the medical records from Petitioner's most recent examination of her right wrist.

Dr. Gary Kronen, on May 5, 2016, found Petitioner's right wrist to be significantly swollen and tender to palpation and reiterated his diagnosis of DeQuevain's tendinitis and intersection syndrome, the same diagnosis he made when he initially saw Petitioner on February 22, 2016. The May 5, 2016, findings were consistent with Dr. Kronen's examination findings from February 29, 2016, save Dr. Kronen's finding of the level of tenderness to be more significant on May 5, 2016, than he did on January 29, 2016. The Commission concludes Petitioner's expressed willingness to undergo further testing and surgery, as she testified to on June 29, 2014, is causally related to the right wrist pain and dysfunction that her May 5, 2016, and January 29, 2016, examinations elicited.

By way of treatment recommendations, Dr. Kronen suggested surgical releases upon the first and second dorsal compartments and an extensory tenosynovectomy. Dr. Michael Vender, Respondent's examining physician, did not explicitly take issue with the propriety of the proposed surgery to address the diagnosed DeQuevain's tendinitis and intersection syndrome. But, he raised concerns regarding the appropriateness of the treatment, given his examination of the Petitioner and his concern that Petitioner exhibited a lack of localized pain and symptom magnification. Because of its findings relative to accident, the Commission believes it is unnecessary for Petitioner to undergo a rheumatological evaluation, as suggested by Dr. Vender. Accordingly, the Commission finds the surgical intervention as recommended by Dr. Kronen to be reasonable and necessary to further treat Petitioner.

The Commission finds Petitioner was temporarily and totally disabled from February 23, 2016, through June 29, 2016, as Petitioner's ability to work was premised upon her ability to work in a room-temperature environment and Respondent's failed to accommodate this restriction.

The Commission further finds Petitioner's course of medical treatment to be reasonable and necessary. She initially treated for her injury at St. Anthony's Medical Center before seeking treatment from Dr. Kronen. The Commission's finding as to reasonableness and necessity is corroborated by Respondent's Section 12 examiner, Dr. Vender.

17IWCC0397

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $319.00 per week for a period of 18-1/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act. This award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the prospective medical treatment prescribed by Dr. Kronon.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1008.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,900.00. 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: JUN 27 2017
KWL/mav
O: 05/16/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

17IWCC0397

RODRIQUEZ, MARIA
Employee/Petitioner

Case# **16WC004991**

EDIBLE CUTS
Employer/Respondent

On 7/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0700 GREGORIO & MARCO
SEAN C STEC
TWO N LASALLE ST SUITE 1650
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
JASON P ALLAIN
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

☐	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

17IWCC0397

MARIA RODRIGUEZ
Employee/Petitioner

Case #16 WC 4991

V.

EDIBLE CUTS
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 June 29, 2016. After reviewing all of the issues, the stipulations of the parties and the evidence, it is hereby found and ordered as follows:

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On January 26, 2016, 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.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $21,446.50; the average weekly wage was $446.80.
- At the time of injury, the petitioner was 31 years of age, single with three children under 18.
- The parties agreed that the respondent paid $1,868.43 in temporary total disability benefits.

ORDER:

- All claims for benefits are denied and the claim is dismissed.

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

STATEMENT OF INTEREST RATE: If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

July 11, 2016

Date

JUL 18 2016

FINDINGS OF FACTS:

The petitioner, a right-handed laborer, testified that she peels, scoops, cuts and weighs melons and pineapples and places the fruit into a cart for packaging for approximately seven hours a day with occasional overtime. On January 26, 2016, the petitioner sought care at Saint Anthony Hospital and reported chopping and feeling a snap in her right wrist and then 10/10 wrist pain in the radial and ulnar aspects. She complained that she has been unable to move her wrist since then. The petitioner also reported peeling fruit and feeling really hot in her wrist area and then really cold. Dr. Rao noted that she was able to move her fingers, that she denied any numbness or tingling in her fingers and that she guarded her wrist and was unwilling to move her wrist. The doctor's physical exam revealed moderate swelling of her wrist and tenderness to palpation of the dorsal ulnar, dorsal radial, radial styloid and ulnar styloid of her right wrist. Right wrist ROM and strength were decreased. Tinel signs and Phalen's tests were negative. X-rays of her right wrist were unremarkable. A wrist splint, medication and left-handed work only were prescribed. At a follow-up with Dr. Gustas at Saint Anthony Hospital on January 29th, the petitioner reported continuing symptoms but no traumatic injury to her right hand. The petitioner's physical examination was essentially unchanged except for no swelling of her right wrist. Dr. Gustas noted a poor effort with active range of motion, subjective findings that significantly outweighed the objective findings, positive Waddell's hypersensitivity with minimal stimuli and irreproducible palpable tenderness. A right wrist MRI on February 6th revealed only small distal radioulnar and radiocarpal joint effusions. The petitioner reported unchanged symptoms on February

10th, but had only tenderness to palpation of her mid dorsal wrist. Dr. Gustas noted a full range of motion in the wrist with poor effort.

The petitioner saw Dr. Kronen at MidAmerica Orthopaedics on February 22, 2016, who noted a limited range of motion, significant tenderness overlying the 2nd dorsal compartment and at 5 cm above her wrist and a positive Finkelstein and crepitus overlying the first dorsal compartment to palpation. Dr. Kronen's impressions were de Quervain's tendinitis and intersectional syndrome. Dr. Kronen gave the petitioner a cortisone injection into her 1st and 2nd dorsal compartment and recommended left-hand work only. The petitioner reported no relief of her symptoms on February 29th and Dr. Kronen recommended a release of her right 1st and 2nd dorsal compartments.

At the request of the respondent, Dr. Vender evaluated the petitioner on April 5, 2016. Dr. Vender noted that there was no swelling or deformity on physical examination, that her wrist flexion was very self-limiting and that there were multiple areas of tenderness to palpation about her wrist area. Dr. Vender opined that, although the petitioner exhibited tenderness in the areas associated with de Quervian's and intersection syndrome, the multiple areas of tenderness and diffuse tenderness reduced the reliability and a definitive site for a de Quervian's diagnosis. Dr. Vender opined that the petitioner's work duties would not lead to any significant trauma to the hand or wrist, specifically not de Quervain's disease and/or intersection syndrome. On May 5, 2016, Dr. Kronen opined that the petitioner's tendinitis was due to a substantial amount of ulnar and radial deviation with rotation of the wrist, repetitively, to perform her activities of scooping melon seeds, etc. He reiterated that surgery was warranted and recommended left-handed work.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident on January 26, 2016, arising out of and in the course of her employment with the respondent. The petitioner denied a traumatic injury to her right hand and relies on a repetitive injury pursuant to the opinion of Dr. Kronen that her duties of scooping melon seeds, etc., require a substantial amount of ulnar and radial deviation with rotation of her wrist. At her initial medical care, the petitioner told Dr. Rao that she was chopping and felt a snap in her right wrist and radial and ulnar pain. However, she also reported peeling fruit and feeling really hot in her wrist area and then really cold. The evidence is not clear as to the specific activity the petitioner was doing at the time her right wrist symptoms began. In addition, there are at least six different work tasks described by the petitioner and indicated in the treating records. Yet, there is no evidence of the duration and frequency of the different tasks or the effort, exertion or movement involved for the tasks. Also, on February 10, 2016, Dr. Gustas noted a full range of motion in the petitioner's wrist with poor effort and only tenderness in her mid dorsal wrist.

Dr. Kronen's opinion that the petitioner's job requires a significant amount of repetitive activity is conjecture and has no weight. The evidence is not sufficient to establish that the petitioner's work duties were repetitive or caused an injury to her right hand. All claims for benefits are denied and the claim is dismissed.

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

Michael Sanchez,

Petitioner,

vs. NO: 16WC 7544

Freightcar,

Respondent.

17IWCC0413

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, causal connection, temporary total disability and denial of emergency petition to reopen proofs, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 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.

17IWCC0413

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 $13,300.00. 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: JUN 28 2017
MJB/bm
o-6/20/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

SANCHEZ, MARIO
Employee/Petitioner

Case# **16WC007544**

FREIGHT CAR SERVICES
Employer/Respondent

17IWCC0413

On 10/28/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.47% 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:

1937 TUGGLE SCHIRO & LICHTENBERGER
NICHOLAS M SCHIRO
510 N VERMILION ST
DANVILLE, IL 61832

1872 SPIEGEL & CAHILL PC
MARTIN T SPIEGEL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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
# CORRECTED ARBITRATION DECISION
19(b)

MARIO SANCHEZ
Employee/Petitioner

v.

FREIGHT CAR SERVICES
Employer/Respondent

Case # 16 WC 07544

Consolidated cases: _____

17IWCC0413

An *Application for Adjustment 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 23, 2016 and June 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 _____

17IWCC0413

FINDINGS

On the date of accident, **8/14/15**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$45,709.04**; the average weekly wage was **$879.02**.

On the date of accident, Petitioner was **36** 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 **$6,697.27** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$6,697.27**.

ORDER

Respondent shall pay temporary total disability benefits from in the amount of $ 586.o2 peer week from 8/15/15 to 11/12/15 and 2/2/16 to 6/28/16 representing 34 weeks, as provided in Section 8(a) of the Act.
The respondent shall be given a credit of $6,697.27 for a total credit of $6,697.27.

Respondent shall pay reasonable and necessary medical expenses if any remain unpaid as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall approve and pay for the surgery including but not limited to hardware removal, an ulnar nerve transposition as recommended by Dr. Merrill as well as all reasonable and necessary follow up care subject to the Medical Fee Schedule.

The Arbitrator awards no penalties or attorney fees.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

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

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

Edwd Lee

Signature of Arbitrator

10/20/16
Date

ICArbDec19(b)

OCT 28 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

(Petitioner's Testimony)

Petitioner worked for Respondent approximately 10 years. He assembled rail car steel wheels. His position involved heavy work. He was involved in an accident on 8-14-15 (Trans. pg. 9, lines 5-17). He was assembling the wheels and was using a hoist to pick up a heavy item when the hoist hook caught his left elbow (Trans. pg. 10, line 2 to pg. 11, line 8). He never injured the left elbow before that date (Trans. pg. 11, lines 9-12). He felt intense pain in the elbow after the accident (Trans. pg. 11, lines 5-7). He was taken to Presence United Samaritans initially and then transferred by ambulance to Carle Hospital in Urbana (Trans. pg. 12, lines 7-17). He underwent surgery (Trans. pg. 12, lines 18-20). He subsequently underwent physical therapy (Trans. pg. 13, lines 6-8).

After physical therapy he was still having symptoms. He was sent back to work full duty on 11-12-15 (Trans. pg. 13, lines 9-20). He returned back to work for a few days and noticed when he used the sledgehammer he again was feeling the problem in his arm and then the pain returned. He did his job despite pain (Trans. pg. 14, line 1 to pg. 15, line 8). He did not feel safe going back to work. He returned to the doctor and told him that upon returning to work he had aggravated his symptoms (Trans. pg. 15, lines 9-15). His doctor put him back on light duty (Trans. pg. 15, lines 16-19). Respondent did not allow Petitioner to return to work light duty (Trans. pg. 16, lines 5-15).

On November 10, 2015 the doctor said he could go back to work with no limitations (Trans. pg. 17, lines 5-13). Subsequently, Petitioner tried to go back to work and that is when he suffered aggravation pains. He went back to the doctor on February 2, 2016 and that's when the doctor imposed restrictions again. He recommended more physical therapy and scheduled a two month follow-up (Trans. pg. 17, line 14 to pg. 18, line 9). Petitioner returned to Respondent with the light duty slip and asked for work and did not get light duty work (Trans. pg. 19, lines 1-11).

Petitioner has been in physical therapy. He is right hand dominant (Trans. pg. 19, lines 12-16).

Petitioner incurred medical bills (Trans. pg. 19, lines 17-19).

Petitioner did not receive any check from the worker's compensation carrier after Respondent refused to allow him to return to light duty. He hasn't received any money since approximately 2-2-16 (Trans. pg. 20, lines 14-20).

Petitioner has not suffered any accidents since 8-14-15 (Trans. pg. 21, lines 1-3).

Respondent sent Petitioner for an independent medical examination to Dr. Merrell in Indianapolis who recommended surgery. The appointment was on May 12, 2016. Petitioner desires surgery because sometimes he feels a sharp pain inside the elbow. He feels the nails [screws] (Trans. pg. 21, line 9 to pg. 22, line 16).

The surgery was for removal of the hardware. Dr. Merrell thought the screws were sticking in Petitioner's tendons and muscles causing the pain (Trans. pg. 23, lines 1-10).

Petitioner notices that his hand is not as strong and it loses energy. His finger will not close correctly. He cannot make a fist without pressing his fingers closed. His pinky and second finger don't work correctly. They are numb (Trans. pg. 23, line 11 to pg. 24, line 7).

Petitioner takes Tylenol and Ibuprofen for his pain. He takes one every 2 hours or every 3 hours for Tylenol. He takes two in the morning and two pills every 2 or 3 hours depending on how bad his hand hurts. He takes 10 Tylenol tablets a day (Trans. pg. 24, lines 8-20).

Petitioner's pain is constant. He feels pain inside his bones all the time. His pain is worse when he stretches the arm because the nails [screws] cause a stabbing sensation (Trans. pg. 25, lines 1-19). He still does not have full use yet (Trans. pg. 26, lines 2-3).

(CROSS EXAMINATION)

Dr. Low told Petitioner on November 10, 2015 his arm was fine and that he could go to work full duty. At that time Petitioner was still experiencing pain in his hand. He told Petitioner to return if needed (Trans. pg. 26, line 12 to pg. 27, line 13).

Petitioner went back to work and was doing his usual job duties after being released by Dr. Low up until February 2, 2016 (Trans. pg. 27, lines 14-20).

Petitioner recalls Deanna Johnson advising him of a plant shut down. When he gave the work restrictions to her that is when he believes he was advised of the plant shutdown. This occurred on or about February 2, 2016 (Trans. pg. 28, line 19 to pg. 29, line 11).

Petitioner knew prior to February 2, 2016 that the plant was planning on shutting down. He was told before Christmas (Trans. pg. 30, line 18 to pg. 31, line 12).

Petitioner returned to Dr. Low right about the time the plant was going to close down (Trans. pg. 31, lines 13-18). When he saw Dr. Low on February 2, 2016, Petitioner told him when he started working he said he got hurt. He told the company and his sister. He told Dr. Low his left arm was doing well until about a week prior and that he was doing his job (Trans. pg. 31, line 20 to pg. 33, line 18). He started using the sledgehammer before January 2016 (Trans. pg. 34, lines 14-19).

Dr. Low sent Petitioner back to work full duty after the November 2015 visit. Petitioner tried to do his job (Trans. pg. 45, lines 1-8). At the end of January 2016 Petitioner was asked to use a heavy hammer to assemble a brake. Great pressure was required and during the process he felt very acute pain in his elbow at that time. That was when Respondent decided to send him back to Dr. Low (Trans. pg. 45, line 14 to pg. 46, line 3).

Petitioner had gone back to Deanna, the supervisor, and reported the pain in his elbow after hammering. She obtained the new appointment with Dr. Low for February 2, 2016 (Trans. pg. 46, lines 4-15). On that date Dr. Low gave Petitioner light duty. Petitioner took the light duty slip back to Deanna and she said that she could not hold him as a worker. They needed someone that could do that job because he could not work with his arm or elbow. He was not employable and she sent him to the unemployment office (Trans. pg. 46, line 16, to pg. 47, line 8).

Petitioner identified Petitioner's Exhibit 15 as his last pay stub from Respondent (Trans. pg. 47, lines 9-14).

Petitioner worked one week with the hammer before he returned to the doctor. He started hammering the last week of January (Trans. pg. 47, line 15 to pg. 48, line 6).

Petitioner was currently in physical therapy for his elbow. Petitioner's Exhibits 12 and 14 show his physical therapy schedule (Trans. pg. 48, lines 7-16).

On November 10, 2015 Dr. Low released Petitioner to return to work at full duty and set no further appointments (Trans. pg. 49, lines 3-8). He went back to work full duty 2 weeks after that appointment. He continued to work full duty from that time until February 2, 2016. During that time he worked full duty, 40 hours per week (Trans. pg. 49, lines 12 to pg. 50, line 5).

Petitioner did not see any other doctor after Dr. Low on November 10, 2015 (Trans. pg. 50, lines 13-16).

Petitioner went back to see Dr. Low on February 2, 2016 because his elbow was hurting (Trans. pg. 51, line 18 to pg. 52, line 1). The company made the appointment for him. Petitioner did not ask the company to make the appointment for him (Trans. pg. 52, lines 2-10). At that time Petitioner was aware of layoffs (Trans. pg. 53, lines 5-11).

When Petitioner went back to see Dr. Low on February 2nd he told him he had been doing well until about a week prior. He was feeling a little better because he did not have any work causing him to force his arm for anything. Petitioner maintained that he told Dr. Low about the use of this sledgehammer (Trans. pg. 53, line 18 to pg. 54, line 9).

Petitioner has not been back to see Dr. Low since February 2016 (Trans. pg. 54, lines 10-12).

Petitioner started taking physical therapy about 2 weeks from the layoff notice. The first time he went to physical therapy was April 11, 2016 (Trans. pg. 54, line 16 to pg. 55, line 5).

When Petitioner saw Dr. Merrell he explained to him he had a fear of needles (Trans. pg. 55, line 18 to pg. 56, line 5). Petitioner did not get a nerve test from Dr. Merrell. Dr. Merrell told him that his elbow might benefit from surgery (Trans. pg. 56, lines 6 - 14).

Petitioner denied Dr. Merrell telling him that before any surgery could be done he would have to have a nerve test that would involve putting needles into his arm (Trans. pg. 56, lines 15-19).

Petitioner denied telling Dr. Merrell that he didn't want to have surgery. He told him that he wanted to think about it (Trans. pg. 56, line 20 to pg. 57, line 3). Dr. Merrell told Petitioner he could return to work at full duty (Trans. pg. 57, lines 4-6).

Dr. Low has not recommended additional surgery for the elbow (Trans. pg. 57, lines 7-12).

Petitioner is very interested in having the surgery and the nerve test (Trans. pg. 57, lines 13-19).

Dr. Merrell told Petitioner to think about the surgery (Trans. pg. 58, lines 2-5).

Petitioner has not been recalled to work by Respondent (Trans. pg. 58, lines 6-8).

Petitioner described the difficulties he had when he went back to work full duty from that time to February 2, 2016 including swelling and weakness and pain. He rated his pain at 9 on a scale of 0-10 (Trans. pg. 59, lines 3-13). He felt dizzy and weak; he had no power whatsoever in his arm and he was only allowed to push the remote control with the right hand (Trans. pg. 60, lines 2-8).

Documentary Evidence

Petitioner was seen at the Carle Clinic hours after the accident. The history revealed that Petitioner was a direct transfer from a Danville hospital and placed under the care of Dr. Low. He was at work earlier that day and a piece of equipment slammed into his left elbow creating an injury to his left elbow. X-rays confirmed a left open elbow fracture. A physical examination revealed significant swelling and mild bruising about the medial aspect of the left elbow. There was a small puncture-like laceration measuring just over 1 cm in length with a slight bend to it. He was diagnosed with a left open elbow fracture involving the medial epicondyle. He was admitted and scheduled for surgery the next morning (PX 1, pgs. 5-6).

Dr. Low performed an open reduction internal fixation of the left open medial condyle distal humerus fracture and irrigation and debridement of left open distal humerus medial condyle fracture on August 15, 2015. He also performed an excisional debridement because the doctor debrided some hematoma and a small amount of devitalized appearing muscle, but there was no gross contamination (PX 1, pg. 9). Dr. Low commented during surgery that Petitioner had significant muscle trauma on the medial side of his elbow and there was significant hematoma that was removed carefully. Pins, locking and nonlocking screws as well as medial distal humerus plate were used to stabilize the fracture (PX 1, pg. 10).

In follow-up on August 31, 2015 Dr. Low noted that the Petitioner had a slight ulnar sensory neuropraxia from the injury as well. He had been compliant with weight bearing instructions and came in for first post-operative wound check. A physical exam revealed well healed surgical incision with sutures ready for removal. He had full motor function of his left upper extremity including the ulnar nerve distribution. However, he did have slightly decreased sensation in the ulnar nerve distribution. Range of motion was quite uncomfortable. The doctor recommended therapy to improve getting his elbow range of motion back. A four week follow up was scheduled at which time the patient would be advanced to weight bearing. (PX1, Pg.18).

In follow up on September 28, 2015 Dr. Low noted the patient still had discomfort much less than previously and he had been working with therapy to regain elbow range of motion. He had a lot of motion back but still not full. He was still experiencing pain with motion occasionally because there were some times he experienced snapping in his elbow with elbow motion but overall he was happy with the outcome of surgery so far. A physical exam showed some improvement but the patient still had pain at the limits of his motion. X-rays showed a stable position with stable internal fixation, no signs of hardware failure or loosening and good healing. Dr. Low recommended the patient advance to weight bearing as tolerated and let pain be the guide. Dr. Low did not want the Petitioner doing any heavy lifting. He did not think he was ready to go back to work yet. A six week follow up was scheduled. (PX1, Pgs. 20-21).

In follow-up on November 10, 2015 the patient gave a history that his pain was much better controlled and with the assistance of physical therapy he had basically regained all of his elbow range of motion and was eager to go back to work. A physical exam showed a well healed surgical incision with no signs of infection. There was minimal tenderness to palpation over the medial epicondyle and his motor function in his ulnar nerve distribution was completely normal. His sensory function continued to improve. It was not yet 100% normal, but as significantly improved. He had regained full elbow range of motion in flexion, extension, pronation and supination. X-rays did not reveal any abnormality. Dr. Low noted that the patient was 3 months status post open reduction with internal fixation of the left distal humerus medial epicondyle. He noted this was a workers' compensation related injury and that patient did have some sensory ulnar nerve neuropraxia that was continuing to improve. Patient had done really well getting all range of motion back in the elbow. Dr. Low thought the patient was ready to go back to work since x-rays looked good and pain was fairly well controlled. Dr. Low indicated the patient could advance to weight bearing as tolerated. He could do motion as tolerated and weight bearing as tolerated. There were no limitations imposed as Dr. Low felt that he had basically reached maximum medical improvement and could return on an as needed basis (PX1, Pgs. 22-23).

Petitioner underwent physical therapy at the Carle Clinic beginning September 15, 2015. He underwent 14 visits of occupational therapy and finished on November 3, 2015. The therapist noted that the patient was progressing well. All goals had been met. Petitioner had reached maximum medical benefit from therapy at that time. Patient had demonstrated increased left elbow range of motion and demonstrated increased left grip strength and reported decreased pain (PX 1, Pg. 92).

The Petitioner returned to Dr. Low on February 2, 2016 and gave a history that he was doing quite well until about a week prior when at work he started picking up heavier objects such as large car parts and experienced increased pain at the medial aspect of his elbow. He related that any time he picked up anything heavy he experienced a lot of pain about his elbow. He had tenderness to the area currently as well. He felt that his arm maybe was not ready to begin lifting such heavy objects. A physical exam revealed a well healed surgical incision of the left upper extremity with no signs of infection. There was tenderness to palpation over the medical epicondyle and he was neurovascularly intact throughout the left upper extremity. There was a painful range of motion. It was from full extension to approximately 100% of flexion. He noted that at maximal flexion the patient felt a sensation as if he was pulling apart his surgical incision. Updated x-rays did not show any abnormality. Dr. Low felt the fracture was healed in stable alignment with no interval changes seen on x-ray. Dr. Low felt that the Petitioner may have aggravated the soft tissue about his elbow and perhaps caused significant inflammation of the scar tissue from the surgery around the area when he began lifting up extremely heavy objects at work. Because of this Dr. Low felt that the Petitioner needed to rest the elbow and treat his pain with anti-inflammatory medicines and for the next two months to do light duty. He wanted a return in two months at which time physical therapy would be ordered to work on strengthening as long as the pain was much better. Because of the Petitioner's labor intensive job the doctor wanted to make sure that the strength in his arm was full before he went back to full duty. There was a long discussion about physical therapy and the patient was concerned that he really couldn't do physical therapy until his pain was better and the doctor thought this was logical. Physical therapy was therefore held up until a two month follow up could determine if the pain was better (PX1, Pgs. 109 – 110).

Dr. Low issued a light duty slip dated February 2, 2016 (PX2, Pg. 119).

Petitioner's Exhibit 6 is an attendance warning dated 11 days after Petitioner's accident indicating that Petitioner was given a warning for being absent for 1 day 4 days after the accident, a half day 5 days after the accident, 1 day 6 days after the accident, a half a day 7 days after the accident and a full day 10 days and 11 days after the accident. Accordingly, Respondent gave Petitioner an attendance warning for not meeting his attendance responsibilities most of which occurred after the subject accident (PX6).

Petitioner entered into evidence Exhibit 7 which is a notice of expected lay off. For Mr. Sanchez his expected last day of work was going to be February 16, 2016 and this appeared to be acknowledged by Petitioner on February 23, 2016.

Petitioner admitted into evidence Exhibit 12 consisting of his physical therapy appointments. Physical therapy started April 15, 2016 and lasted through May 5, 2016 (PX12).

Dr. Merrell examined the Petitioner at Respondent's request on May 12, 2016. Dr. Merrell reviewed x-rays and found a well healed medial epicondylar fracture with intact hardware in appropriate position. He noted the joint was well lined up and there was minimal arthritic changes. There were a few small bone chips and calcifications in the area of the plating which were not considered likely significant. Dr. Merrell opined within a reasonable degree of medical certainty that the Petitioner had a residual ulnar neuropathy from the initial trauma and some medial elbow pain partially related to a plate which by necessity sat in a relatively subcutaneous position. The ulnar neuropathy diagnosis was a clinical diagnosis and the medial elbow diagnosis and medial elbow tenderness the same although also supported by imaging. Dr. Merrell believed both of the diagnosis were

clearly related to the incident in question. Dr. Merrell thought hardware removal may decrease the area of the sensitivity in the affected area and at the same time obtain an ulnar nerve transposition if necessary. Given the function that the Petitioner had in his elbow Dr. Merrell thought it was possible for him to return to work in an unrestricted manner. However, if he felt that it was unsafe then a functional capacity evaluation was necessary to determine what would be safe to do. Dr. Merrell did not see any major structural issues that would prevent a full return to work. If the Petitioner was not interested in the surgery then he was deemed at maximum medical improvement. He rated 4% impairment of the left upper extremity due to the decreased interosseous strength and ulnar nerve sensation (PX10).

Petitioner entered into evidence Exhibit 13, the COBRA election form. This shows Petitioner was laid off on February 16, 2016 (PX13).

Petitioner entered evidence Exhibit 15, his last earning statement from Respondent with pay period ending January 24, 2016 (PX15).

Petitioner entered into evidence Exhibit 17 consisting of correspondence between the attorneys from both parties. Correspondence as early as March 21, 2016 shows Petitioner's attorney advising Respondent's attorney of notice of hearing and request for penalties for non-payment of TTD (PX17).

Petitioner put into evidence Exhibit 18 consisting of correspondence between Petitioner and the workers' compensation carrier. On March 24, 2016 the workers' compensation carrier acknowledged that if the Petitioner was taken off work or was losing wages in relation to this injury he should notify her so a determination could be made for wage loss (PX18, Letter dated March 24, 2016 from Michelle Kriovoshein). And finally, Exhibit 18 shows a letter dated March 1, 2016 from Petitioner's attorney to Ms. Kriovoshein enclosing the most recent off work slip dated February 2, 2016 and demanding temporary total disability benefits (PX18, letter dated March 1, 2016 to Ms. Kriovoshein).

Respondent entered into evidence a letter dated December 9, 2015 indicating that employees of Freight Car should expect a lay off commencing February 12, 2016 for approximately 14 days.

The Petitioner submitted billing statements into evidence as Exhibits 3, 4, 8 and 9. The parties stipulated that the Respondent would be liable for these medical bills if they were reasonable, related and outstanding.

With respect to issue (F) whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following findings of fact and conclusions of law:

The Petitioner testified that he had no prior injuries or treatment to his left arm or elbow before his accident of August 14, 2015. The Petitioner was treated the same day of the accident and was diagnosed with a left open elbow fracture and other abnormalities confirmed by x-ray. He was taken into surgery early the next morning where Dr. Low performed an open reduction and internal fixation of the left elbow. The Petitioner's treating medical records consistently show a history of a traumatic incident at work followed by consistent complaints of pain. The Respondent's IME, Dr. Merrell, actually provided a clear cut causation statement when he stated that the Petitioner has a residual ulnar neuropathy from the initial trauma and some medial elbow pain partially related to a plate which by necessity was located in the relatively subcutaneous position. Furthermore Dr. Merrell went on to state that "I think given the history here both of these diagnoses are clearly related to the incident in question." Based on Petitioner's credible testimony, no subsequent or intervening accidents occurred to break the initial causation chain. Although Respondent argues that a subsequent intervening accident occurred, their own argument fails because their own IME, indicated that the Petitioner's current condition of ill-being is related to the incident in question. The Arbitrator finds that Petitioner's use of a sledgehammer and

other activities after initially returning to work do not represent an intervening accident sufficient to break the chain of causal connection. Petitioner is found very credible. Any minor inconsistencies in facts are attributable to a language barrier. Petitioner is a Mexican American and did not speak or understand English easily. An interpreter was used many times. Accordingly, the Arbitrator hereby finds that the current condition of ill-being with respect to the Petitioner's left arm, elbow, hand and wrist as well as the need for light duty restrictions associated with the injury are causally related to the accident of August 14, 2015.

With respect to issue (J) whether the medical services that were provided to the Petitioner were reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator hereby finds:

As detailed above, the Arbitrator has found that Petitioner's left arm, elbow, hand and wrist condition of ill-being is related to his August 14, 2015 work accident. The parties have stipulated that Respondent is liable for all reasonable, related and outstanding medical bills. The Arbitrator hereby orders the Respondent to pay reasonable and necessary medical expenses if found to be outstanding as provided in Section 8(a) and 8.2 of the Act. The Arbitrator finds that all medical care provided to Petitioner to date has been reasonable and necessary to alleviate the effects of the August 14, 2015 accident.

The Arbitrator finds that Petitioner is entitled to prospective medical care. Dr. Merrell has proposed hardware removal and possible ulnar transposition. Petitioner desires to have such procedure. Respondent is ordered to approve and pay for the surgery proposed by Dr. Merrell subject to the Medical Fee Schedule.

With respect to issue (L), what temporary total disability benefits are in dispute, the Arbitrator hereby finds:

The Respondent disputed liability for temporary total disability compensation after November 12, 2015. Respondent argues that Petitioner was at MMI and could return to full duty work based on Dr. Low's evaluation that took place on November 12, 2015. Petitioner maintains that he was not at maximum medical improvement on February 2, 2016 when he returned to Dr. Low and Dr. Low imposed light duty restrictions.

On February 2, 2016 Dr. Low saw the patient due to increased pain at the medial aspect of his elbow. He was doing quite well up to that point but started performing heavier jobs including lifting heavier objects and using a sledgehammer and noticed increased pain in the elbow. X-rays showed there was no new trauma and the hardware was in stable position and there was good alignment. Dr. Low felt that the Petitioner may have aggravated his soft tissue about his elbow and perhaps caused significant inflammation of the scar tissue from the surgery around the area when he began lifting up extremely heavy objects at work. Dr. Low thought Petitioner just needed to rest the elbow and treat his pain with anti-inflammatory medicines and for two months work in a light duty capacity. He considered how labor intensive the Petitioner's job was and wanted to make sure that he had strengthening work done in his arm before he returned to full duty. Dr. Low's statements indicate not a new injury but an aggravation of a pre-existing condition. Placing him back on light duty work seemed logical.

No other medical opinions were provided indicating Petitioner could or might be able to perform more than light duty work until Dr. Merrell's appointment on May 12, 2016. Dr. Merrell thought that it would be possible for the Petitioner to return to work in an unrestricted manner. However, if the Petitioner did not feel that it was safe then a functional capacity evaluation would be needed to determine what the Petitioner would be safe to do. Dr. Merrell didn't see any major structural issues that would prevent the Petitioner from returning to work.

The Arbitrator finds Dr. Low's opinion more credible than Dr. Merrell's. Dr. Low was the treating surgeon and was much more familiar with the Petitioner's post-surgical course of care and treatment and rate of recovery. He was even more familiar with the internal derangements that he observed during surgery. It is not clear whether Dr. Merrell thought that the Petitioner was really able to do unrestricted work. First, Dr. Merrell only thought that it would be possible for him. Second, if the Petitioner didn't feel safe doing the job then a functional capacity evaluation was recommended. The reason for a functional capacity evaluation would be to determine the Petitioner's limitations on his left arm and elbow. Petitioner testified credibly that he did not feel safe doing his regular job. Accordingly, based on all the evidence and the testimony in the case, the Arbitrator finds that the Petitioner was temporarily totally disabled beginning August 15, 2015 to November 12, 2015 and February 2, 2016 through the date of hearing, June 28, 2016 and continuing until such time as the Petitioner reaches maximum medical improvement or is otherwise returned to work. Accordingly, Respondent shall pay Petitioner temporary total disability benefits of $586.02 per week for 34 weeks, commencing 8/15/15 to 11/12/15 and 2/2/16 to 6/28/16, as provided in Section 8(a) of the Act. However, Respondent is entitled to a credit of $6,697.27.

With respect to issue (M) whether penalties and attorney's fees should be imposed upon the Respondent, the Arbitrator hereby finds:

The Arbitrator finds that there were legitimate issues concerning whether or not Petitioner was temporarily totally disabled and accordingly finds Respondent was not vexatious by not paying TTD. Therefore the Arbitrator awards no 19(l) or (k) penalties or attorney fees.

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

Kenneth Outhouse,
Petitioner,

vs.

NO: 16 WC 24548

Dugger Pool,
Respondent,

17IWCC0403

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, 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 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.

The party commencing 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: JUN 27 2017
o060817
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

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

OUTHOUSE, KENNETH
Employee/Petitioner

Case# **16WC024548**

DUGGER POOL
Employer/Respondent

17IWCC0403

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:

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

0522 THOMAS MAMER & HAUGHEY LLP
KENNETH REIFSTECK
30 MAIN ST SUITE 500
CHAMPAIGN, IL 61820

17IWCC0403

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)

Kenneth Outhouse
Employee/Petitioner

v.

Dugger Pool
Employer/Respondent

Case # 16 WC 24548

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 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 _____

17IWCC0403

FINDINGS

On the date of accident, **June 28, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$36,975.12**; the average weekly wage was **$711.06**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **0** dependent children.

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

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. Bruce-Sullivan

Signature of Arbitrator

11/2/16

Date

ICArbDec19(b)

NOV 7 – 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Case # 16 WC 24548

Consolidated cases: N/A

Kenneth Outhouse
Employee/Petitioner

v.

Dugger Pool
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is 55 years of age and has been employed by Respondent for the past ten years. He testified that he is a paint supervisor for Respondent, and that his duties include a variety of tasks associated with the maintenance of swimming pools. He testified that on June 28, 2016, he arrived at his place of employment and physically punched a time card. He testified that the time card contained in Respondent's Exhibit 1 indicated that he clocked in to work at 5:45 a.m. and that he clocked out at 8:05 p.m. on June 28, 2016. He testified that the "Paint Proposal" sheets as contained in Respondent's Exhibit 1 were completed by him and described the tasks performed, the date/time of the job and the customer names. He testified that the sheets were then turned in to the office so that the company could charge customers for the work he performed. He testified that it was important that the sheets were correct and turned in so that the company could bill for the work.

Petitioner testified that the final job and time entry on June 28th was the Williamson job, from which he departed at 3:45 p.m. He testified that the Williamson job site was in Staunton, which was approximately a 30-45 minute drive to the office. He testified that he was involved in a motor vehicle accident that occurred at 6:53 p.m., and that the accident took place while he was dropping off a personal water bill at the water company which was located two minutes or less from Respondent's place of business. He testified that he was in the parking lot at the water company about ten feet from the street, when the driver of another vehicle struck the vehicle he was driving. He testified that a fellow employee, Mr. Hamel, stopped at the accident because he saw that his company truck was involved.

At the time of arbitration, Petitioner was unable to explain his specific whereabouts from 3:45 p.m. until the time of the accident at 6:53 p.m. Petitioner testified, however, that he was "almost positive" that he was at a job in Highland, Illinois, after the Williamson job in Staunton but could not recall. Upon further questioning, Petitioner could only testify "I want to say I was at Pabst." (T. 36). He further testified that employees were allowed to go to the bank on Tuesdays to cash their paychecks, but did not testify that he was cashing/depositing a pay check on the day of the accident, but rather was dropping a personal water bill at the water company.

The medical records of Alton Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on June 29, 2016, at which time it was noted that he was status post motor vehicle collision the day prior and was complaining of left shoulder pain and back pain. It was noted that Petitioner was a restrained driver at a stop when another car swerved to miss a vehicle and hit Petitioner on the front driver side, and that there was no

airbag deployment. It was noted that Petitioner had no noticeable pain yesterday, and that he woke up with left shoulder and back pain. The diagnoses were noted to be that of motor vehicle collision, shoulder pain and lumbar strain. (PX1).

The medical records of Saint Anthony's Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on July 1, 2016, at which time he underwent x-rays of the lumbar spine which were interpreted as revealing no definite acute osseous abnormality; diffuse demineralization which makes evaluation for abnormalities difficult; minimal curvature convex to the left; moderate degenerative changes at L5-S1 and mild degenerative changes in the remainder of the lumbar spine. (PX2).

Various radiology reports were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent an MRI of the lumbar spine at MRI Partners of Chesterfield on August 4, 2016, which was interpreted as revealing (1) advanced disc height loss, circumferential disc bulge and superimposed foraminal protrusion at L5-S1, with associated endplate spurring and posterior element hypertrophy; there are severe bilateral foraminal stenoses at this level but no definite central canal stenosis; (2) degenerative Grade 1 anterolisthesis at L4-5 with central broad-based protrusion, erosive facet arthropathy, ligamentum flavum hypertrophy and resulting mild central canal stenosis and bilateral foraminal stenosis; (3) L3-4 annular disc bulge with posterior element hypertrophy resulting in dural displacement and bilateral foraminal stenosis but no central canal stenosis. Petitioner also underwent an MRI of the cervical spine at the same location on the same date, which was interpreted as revealing (1) left foraminal protrusion with endplate spurring at C3-4 resulting in severe left foraminal stenosis; (2) C4-5 bilateral foraminal protrusions, C5-6 lobulated central broad-based protrusion or bilateral foraminal protrusions, and C6-7 right lateral recess epicenter broad-based protrusion resulting in ventral cord flattening and severe foraminal stenoses; there is mild central canal stenosis at the C4-5 and C5-6 levels. (PX3).

The medical records of Multicare Specialists were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on August 1, 2016 for a chief complaint of neck pain, mid back pain, low back pain, elbow pain and wrist pain. It was noted that after work Petitioner drove to his work to pay a bill and was parked in the parking lot in the work truck, and that a woman driving a four-door car ran the stop sign in the parking lot and struck him on the driver's side of the truck he was in. It was noted that Petitioner complained of pain in his cervical spine, thoracic spine, lumbar spine, bilateral elbows and bilateral wrists, that the pain in his wrists radiated upward to his elbows and shoulder, that he had numbness and tingling in the bilateral upper extremities and lower extremities and that he had the numbness and tingling in his elbows and hands before the accident but it had gotten worse. The impression was that of cervical disc protrusion; lumbar disc protrusion; bilateral ulnar nerve neuropathy; bilateral carpal tunnel syndrome; thoracic pain. Petitioner was instructed to begin physical therapy, placed under work restrictions, advised to get carpal tunnel splints, and ordered to undergo an MRI of the cervical and lumbar spine as well as an NCV/EMG of the bilateral upper extremities. (PX4).

The records of Multicare Specialists reflect that Petitioner was seen on August 2, 2016, at which time no significant changes since his first visit were noted. Petitioner was instructed to continue physical therapy, continue restrictions, wear carpal tunnel splints at night and undergo the MRIs. At the time of the August 3, 2016 visit, it was noted that Petitioner continued to feel about the same. At the time of the August 4, 2016 visit, it was noted that Petitioner had a slight increase in soreness because he was in the MRI machine. At the time of the August 8, 2016 visit, it was noted that Petitioner stated over the weekend he remained quite miserable and that he continued to have pain in his neck and low back, as well as his upper extremities. At the time of the August 9, 2016 visit, it was noted that Petitioner tried going in to work and even with his restrictions, the pain increased in both his neck and low back and that even

riding in a car was aggravating all of his pains. Petitioner was taken off work at that time by Dr. Brooks. (PX4).

The records of Multicare Specialists reflect that Petitioner was seen on August 10, 2016, at which time it was noted that he continued to have quite significant pain but it was not as intense since he did not go to work. Petitioner was to remain off work until further notice, and it was noted that they were working on getting him set up to see Dr. Gornet. At the time of the August 11, 2016 visit, it was noted that Petitioner stated that his neck and back were feeling slightly better and that being off work had helped considerably. At the time of the August 15, 2016 visit, it was noted that Petitioner stated he was doing slightly better since he was no longer working but he continued to have quite significant pain throughout his neck and back. It was noted that Petitioner stated that his hands constantly "tingle." It was noted that Dr. Brooks was still working on getting Petitioner in to see Dr. Gornet in regards to his neck and back and that they were also working on getting him to Dr. Paletta for his elbows and wrists as soon as the EMG/NCV was set up. At the time of the August 16, 2016 visit, it was noted that Petitioner continued to have quite significant neck and back pain, and that the pain from his neck radiated down into both hands. (PX4).

The records of Multicare Specialists reflect that Petitioner was seen on August 17, 2016, at which time it was noted that he felt like a "train wreck" and that he had left-sided neck pain, lower back pain and pain in the arms, elbows and wrists. It was noted that Petitioner was scheduled for injections to begin in a few weeks and that he was to continue physical therapy per Dr. Gornet. At the time of the August 18, 2016 visit, it was noted that Petitioner stated that overall he felt about the same, that therapy had helped to give him some relief in regard to his neck and back, that Dr. Gornet wanted him to try six weeks of physical therapy as well as six weeks of spinal manipulation and that he then would be set up with epidural injections. At the time of the August 22, 2016 visit, it was noted that Petitioner stated that his neck and back did not hurt nearly as much and that over the weekend his pain was much more tolerable than it had been. At the time of the August 23, 2016 visit, it was noted that Petitioner stated that he felt overall the same as yesterday and that he felt slightly better than he had in the past week. (PX4).

The records of Multicare Specialists reflect that Petitioner was seen on August 24, 2016, at which time he stated that he continued to improve slightly, that his neck and low back pain was down to a 2/10 and was no longer constant and that he was not noticing as much pain throughout his elbows and wrists. At the time of the August 29, 2016 visit, it was noted that Petitioner had an increase in pain in both his neck and back over the weekend, that he could not get comfortable at night and that he woke up every hour while trying to sleep. It was noted that Petitioner was scheduled for injections to the cervical and lumbar spine. At the time of the August 31, 2016 visit, the exact same description regarding Petitioner's ongoing symptomatology was noted as that contained in the note of August 29th. At the time of the September 1, 2016 visit, it was noted that Petitioner had pain at a 4/10 for his back and a 5/10 for his neck, and that he stated that he continued to have a tingling sensation in both hands. (PX4).

The medical records of Dr. Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner was seen on August 16, 2016 at the referral of Dr. Eavenson. It was noted that Petitioner's main complaint was neck pain and low back pain. It was noted that Petitioner's problems began on or about June 28, 2016, that he was a driver in a work truck and was stationary in a parking lot waiting to cross onto a street, that there was a stop sign and that an oncoming car ran the stop sign, that a car was crossing the intersection, that the offending vehicle swerved to avoid striking the crossing vehicle and swerved again, striking Petitioner's truck. Petitioner was recommended to undergo an "aggressive" treatment program including continued chiropractic care and physical therapy, as well as injections at L5-S1, facet rhizotomies bilaterally at L4-5 and L5-S1 and epidural steroid injections in the cervical spine at C5-6 and C6-7. Petitioner was also placed under work restrictions. (PX5).

The Operative Report pertaining to an injection dated August 30, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report documents that Petitioner underwent L5-S1 ILESI with fluoroscopy by Dr. Helen Blake for a pre- and post-operative diagnosis of bilateral lumbar radiculopathy. (PX6).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Time/Job Sheets were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The time card reflects that Petitioner was an "early start" on June 28, 2016 and clocked in at 5:49 a.m. and clocked out at 8:05 p.m. The time card further reflects that the jobs performed on the date of accident included Greco, Pabst and Williamson. The records reflect that Petitioner arrived at the Greco job site at 6:20 and departed at 8:18; that he arrived back at the Greco job site at 12:00 and departed again at 1:35; that he arrived at the Pabst job site at 8:00 and departed at 10:00; and that he arrived at the Williamson job site at 12:00 and departed at 3:45. (RX1).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has failed to prove that he sustained an accidental injury on June 28, 2016 that arose out of and in the course of his employment with Respondent.

A claimant bears the burden of proof by a preponderance of the evidence that his injury arose out of and during the course of employment. *First Cash Fin. Servs. v. Indus.Comm'n*, 367 Ill.App.3d 102, 105, 853 N.E.2d 799, 803 (1st Dist. 2006). If an employee is injured while he was using employer-provided transportation which expanded his range of employment for the employer's benefit, the injury may be compensable. *Hood v. Indus. Comm'n of Illinois*, 158 Ill.App.3d 81, 84, 510 N.E.2d 908, 910 (5th Dist. 1987). Compensable injuries also include arising out of acts the employer either instructed the employee or incident to his assigned duties reasonably expected him to perform. *Id.*

The Arbitrator finds Petitioner has failed to establish that he was performing tasks for his employer's benefit at the time of the accident at issue. The Arbitrator notes that the evidence reflects that Petitioner was paying his personal water bill when the company vehicle he was driving was struck by another in the parking lot of the water department. The Arbitrator finds that the act of paying his personal water bill was not incidental to Petitioner's assigned duties, nor was it a duty reasonably expected of him. The evidence reflects that Petitioner was not engaged in business travel, but rather was on a personal errand at the time of the motor vehicle accident at issue.

The Arbitrator recognizes that a "traveling employee" is held to be "in the course of his employment" from the time he leaves home until he returns. *Cox v. Illinois Workers' Comp. Comm'n*, 406 Ill.App.3d 541, 545, 941 N.E.2d 961, 965 (1st Dist. 2010). However, a finding that a claimant is a traveling employee does not relieve him from the burden of proving that his injury arose out of and during the course of employment. *Id.* The test for determining whether an injury to a traveling employee arose out of and in the course of his employment is the reasonableness of the conduct in which he was engaged and whether the conduct might normally be anticipated or foreseen by the employer. *Id.*

The Arbitrator finds that the motor vehicle accident did not occur while Petitioner was engaged in an activity which was both reasonable and foreseeable. While the relatively small deviation from the route back to Respondent's facility to pay a personal water bill may be foreseeable, the Arbitrator finds that the unknown whereabouts of Petitioner from 3:45 p.m. until 6:53 p.m. establishes a substantial deviation between Petitioner's last known work activity and his return to Respondent's office. The

Arbitrator notes that while 45 minutes of that time could arguably be explained by the amount of time necessary to travel from the last job site to the office, there still remains more than two hours of time that is unaccounted for until the point at which Petitioner was performing a personal errand. The Arbitrator finds that such an extensive gap is not reasonable, nor is it foreseeable. While the Arbitrator recognizes that Petitioner testified as to activity that the employer acquiesced in, if not approved of (such as going to the bank to deposit paychecks), Petitioner did not testify that he was doing any of those things at the time of the incident at issue. In fact, Petitioner could not explain his whereabouts for the gap of over two hours beyond testifying "I was working. That's all I do is work. I don't do nothing else but work." (T. 16).

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has failed to prove that he sustained an accidental injury on June 28, 2016 that arose out of and in the course of his employment with Respondent.

In light of the Arbitrator's findings with disputed issue (C), the Arbitrator makes no findings with respect to disputed issues (F), (J) and (L), as those issues are rendered moot. The claim is denied.