STATE OF ILLINOIS)
)
COUNTY OF LA SALLE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dan French,
Petitioner,

vs.

No: 02 WC 49642
03 WC 03421

Wal-Mart Stores, Inc. / Sam's Club,
Respondent.

OPINION AND ORDER

Petitioner was found to be permanently and totally disabled by a Commission arbitrator on December 15, 2008. This arbitrator's decision was affirmed and adopted by the Commission on November 8, 2010. In March 2013, the Third District Appellate Court upheld that decision. Now before the Commission for decision are motions filed by both parties. Petitioner's motions are for payment of medical expenses under §8(a) and for penalties and attorney's fees under §19(l), §19(k) and §16 of the Workers' Compensation Act. Respondent's motions are for termination of permanent total disability benefits under §8(f) and for suspension of benefits under §12 of the Act.

These motions were heard over a three-day proceeding before Commissioner Joshua Luskin on February 18, 2016, February 19, 2016, and March 14, 2016. Oral arguments were held on July 13, 2016. So there can be no doubt, the Commission iterates here that it has considered the entirety of the lengthy record and been advised of the facts and law. For the reasons stated in this Opinion and Order, the Commission finds that Petitioner is not permanently and totally disabled. More specifically, the Commission finds that Petitioner's disability ceased to be total no later than February 21, 2014, and thereafter his condition was one of partial disability. In accordance with its finding, the Commission terminates the December 15, 2008 arbitrator's award of permanent total disability and enters an award of permanent partial disability reflecting 20% loss of use of the person as a whole under §8(d)(2). Petitioner's motions are denied in their entirety.

ISSUES

The issues before the Commission are as described below:

(1) Whether Respondent has proven that Petitioner is capable of returning to work and earning as much as before his accident, warranting the termination of the award made under §8(f) and the entering of an award under §8(d);

(2) Whether Respondent has proven that Petitioner unnecessarily obstructed and/or failed to submit to Respondent's March 12, 2015 independent medical examination, justifying suspension of Petitioner's disability benefits payments under §12;

(3) Whether Petitioner has proven need for a motorized scooter, medical cannabis, the services of a personal assistant, and prospective fusion surgery, such as would entitle him to payment of incurred and prospective expenses for the same under §8(a); and

(4) Whether Petitioner has proven that Respondent has engaged in vexatious delay, unreasonable denial of benefits, or otherwise committed bad faith such as would warrant penalties and attorney's fees under §19(l), §19(k) and §16.

BACKGROUND

Petitioner's claims invoke Respondent's alleged longstanding bad faith conduct toward him. Respondent's claims invoke Petitioner's alleged exaggerations and outright misrepresentations regarding his condition. To fully evaluate the parties' motions now before the Commission, it is necessary to go into the history between Petitioner and Respondent.

The following "Background" section is divided into three parts, roughly describing: (i) history of this matter from Petitioner's filing of his first Application for Adjustment of Claim to about a year after the Appellate Court decision, that is, through spring 2014; (ii) events throughout summer 2014, during which time Petitioner represented himself *pro se*; and (iii) events from August 29, 2014 forward, with attention to the March 12, 2015 independent medical evaluation that is the subject of one of Respondent's motions.

Filing of Application up through spring 2014 (including procedural history): Petitioner, Dan French, 28 years old at the time, alleged lower back injury sustained while handling freight for Respondent, Wal-Mart Stores, Inc. a/k/a Sam's Club a/k/a Wal-Mart Associates, Inc. ("Wal-Mart"), on two dates of accident, September 8, 2002 and June 9, 2003. The claims were consolidated and heard at an initial §19(b) proceeding before Arbitrator James Giordano on October 22, 2003. Arbitrator Giordano found that French's lower back injury was work-related (or, in the language of workers' compensation law, "arose out of and in the course of his employment") and awarded temporary total disability benefits from September 9, 2002 through November 10, 2002 and from June 9, 2003 through June 27, 2003. (RX 1:001-006). This arbitrator determined that French's injury was in the nature of sprains or strains and had resolved. Regarding French's claim that he was unable to work following the second accident of June 2003, Arbitrator Giordano specifically found that French was not credible. (RX 1:005). The testimony of one of French's coworkers indicated that, on June 27, 2003, the coworker had observed French operating a jet ski and riding in a recreational boat during the period in which French purportedly was incapacitated[1]. The coworker stated further that French asked him not to tell any of Wal-Mart's managers what the coworker had observed. Arbitrator Giordano found this coworker

[1] Of note, between that time and the present, French was captured on surveillance video driving an SUV that was pulling a trailer upon which were loaded two jet skis. He is recorded backing this SUV and trailer into the driveway and garage of his residence. Then he is recorded performing some type of maintenance work to one of the jet skis, as he lifts the seat off one of the jet skis and carefully sets it down on the lawn. French was also captured on surveillance video on a recreational boating excursion (with Julie Ajster) on September 3, 2015. (See "Respondent's New Evidence" section of this Opinion and Order.)

credible. (RX 1:004). On review, the Commission affirmed Arbitrator Giordano (with the exception that the Commission found that French further failed to prove the necessity of medical treatment rendered after the date of the jet skiing incident). (RX 1:011).

During the prosecution of his workers' compensation claim, in November 2007, French obtained a decision by the Social Security Administration that he was totally permanently disabled, with a date of disability of June 9, 2003. (French has ever since collected Social Security Disability benefits. He is also on Medicare.) (Tr. 3/14/16 p. 56).

A permanency hearing was held before Arbitrator George Andros in May 2008. In a decision of December 15, 2008, Arbitrator Andros deemed French to be totally and permanently disabled. Arbitrator Andros ordered Wal-Mart to pay 149 weeks of temporary total disability benefits (amounting to $44,391.57) and permanent total disability ("PTD") benefits of $376.66 weekly for life. These figures were based on French's earnings of $23,238.00 per year in his employment by Wal-Mart. Arbitrator Andros also ordered Wal-Mart to pay French's medical expenses, including a lumbar fusion at L5-S1 performed by Dr. George DePhillips in January 2004. (RX 1:007-019). This decision was affirmed on review by the Commission.

Regarding his ultimate finding that French was totally incapacitated, Arbitrator Andros wrote that his determination was "not premised centrally on the petitioner's testimony." (RX 1:012). Arbitrator Andros acknowledged several times that his predecessor, Arbitrator Giordano, specifically found Petitioner to be an incredible witness. (RX 1:010, 1:014). Rather, Arbitrator Andros placed reliance on Dr. DePhillips' opinion that French was unemployable and on the corroborative testimony of Julie Ajster and her friend Jennifer Kiesewetter. (RX 1:014, 1:017). Both of these lay witnesses were attorneys employed at the time at the office of Peter F. Feracutti, a claimant-oriented workers' compensation law firm. (RX 1:034 -035).

Ajster was, and remains, French's longtime significant other. She is also French's present legal counsel in the instant matter. (She was not his counsel at the time of the hearing before Arbitrator Andros.) In his decision, Arbitrator Andros noted that Ajster resided with French and had opportunity to observe French's constant pain and extensive limitations as to his activities and functioning. No less than three times, the arbitrator referred to Ajster's status as an "officer of the court" in support of his perception of her as a credible witness.[2] (RX 1:014, 1:016 – 017).

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[2] Arbitrator Andros chose to place less stock in the testimony of other witnesses who testified about their observation of French, including Sheriff's Deputy Dawn Dove. Dove testified that she stopped French and Ajster in the couple's vehicle for traffic violations, whereupon Dove observed that French "tried to get out of the vehicle [and] that he was enraged." Dove further testified that a week later she observed French riding a bike around a park for ten to fifteen minutes. (RX 1:017). Arbitrator Andros referenced Dove's potential bias arising from the fact that she had been "threatened to be sued by Julie Ajster in reference to the traffic stop." The arbitrator also discounted Dove's bike testimony and instead favored the testimony of Ajster, who "indicated that the petitioner did not even own a bike, and she has never seen him on a bike in fifteen years." (RX 1:017).

Of note, between that time and the present, French was captured on surveillance video riding a bike. (See "Respondent's New Evidence" section of this Opinion and Order). Of note also, between that time and the present, Ajster has demonstrated willingness to sue law enforcement officials for the act of arresting and prosecuting French. On April 8, 2015, French, represented by Ajster, filed a federal civil rights lawsuit in the Northern District of Illinois, captioned "DANNY FRENCH vs. BRIAN TOWNE, State's Attorney of LaSalle County; AARON HOLLENBECK, LaSalle Co. Sheriff's Deputy; THOMAS TEMPLETON, LaSalle Co. Sheriff; LASALLE COUNTY, ILLINOIS; SCOTT DEGROOT;

Wal-Mart appealed the matter to the circuit court of LaSalle County. The circuit court, on June 7, 2011, reversed the Commission on the grounds that the Commission violated the "law of the case." French appealed to the Third District Appellate Court. On March 1, 2013, the Appellate Court found that the Commission's decision was not contrary to the manifest weight of the evidence, and the award was thus reinstated. (RX 1: 20-:037).

After this Third District Appellate Court decision, Wal-Mart issued its first payment to French, a check in the amount of $209,788.89, in April 2013. Wal-Mart also began making weekly payments for French's permanent total disability pursuant to the arbitrator's award. (PX 20).

Soon thereafter, French commenced submitting requests to Wal-Mart for reimbursement for a variety of additional medical expenses related to his ongoing needs. As French testified, since the arbitration decision of 2008, his back has gotten "all the times worse." (Tr. 2/18/96 p. 10). To the present date, his additional expenses include those for more than a dozen prescription medications – including 240 tablets of hydrocodone (Norco 10) per month among other medication for pain. (PX 20; RX 25:005). His expenses include mileage in connection with a monthly 200-mile round trip to Dr. Stephen Rittmann, his current primary care physician and the prescriber of his painkillers. Further expenses include those for a Tempur-Pedic orthopedic bed, a motorized scooter, the services of a part-time personal assistant -- his sister, Donna Craig -- and, as of November 2015, medical marijuana. (PX 2; PX 6; PX 7).

The last three aforementioned items – motorized scooter, personal assistant, and medical cannabis – represent incurred expenses for which French expressly seeks reimbursement in his current §8(a) motion. As for future expenses, French requests that Wal-Mart be ordered to pay for prospective fusion surgery, allegedly recommended by orthopedic surgeon Dr. Thomas McNally in July 2014. Not expressly mentioned in his current motion, but referenced in his brief in support of the §8(a) motion, is a more recent prescription for a therapy dog, obtained from psychiatrist Dr. Atul Sheth. (PX 12). It is presumed that French does or would seek §8(a) benefits as well for this therapy dog, notwithstanding that French already is the longtime owner of a beloved dog -- he refers to this pet as his "daughter" -- and presumably has been paying for this companion animal's maintenance for some years. (Tr. 2/18/16 p. 195).

Summer 2014 and Petitioner's *pro se* activity: In any event, on May 9, 2014, French's attorney, James McPhedran, withdrew his representation of Petitioner. From that time through August 29, 2014, French was left to act *pro se* in his dealings with Wal-Mart's then-attorney, Mark Matranga of the law firm Wiedner & McAuliffe. French did not hesitate personally to contact Matranga (and Wal-Mart's claims adjuster in Arkansas) with considerable frequency, by telephone, email and fax. Before long, the relationship between French and Matranga reached a critical point. It is apparent that French felt ignored and disrespected by Wal-Mart and believed that Matranga was not being sufficiently diligent in getting Wal-Mart to approve French's requests promptly.

JOHN ATKINS; and PERU POLICE DEPARTMENT" (case no. 15 cv 03089). (RX 59). The complaint alleges false arrest and malicious prosecution by the defendants in connection with French's 2014 arrest and eventual grand jury indictment for a count of "Felony Harassment by Telephone" (for harassment of attorney Jonathan Brandt) and a count of "Felony Threatening a Public Official" (for threatening Sheriff's Deputy Hollenbeck, one of the named defendants). In retrospect, this Commission can see that Sheriff's Deputy Dove was altogether believable, back in 2008, regarding what she observed and what she was subjected to by French and Ajster.

On June 30, 2014, French, *pro se*, filed his first motion for §8(a) expenses and penalties regarding prescription medications and the aforementioned orthopedic bed. Concurrently, French filed a notice of hearing indicating a hearing date before Commissioner David Gore some two weeks hence. On July 2, 2014, French vented his frustration at Wal-Mart's attorney in a profanity-laden voicemail. This voicemail is the first of at least five abusive voicemails left for Matranga at his office:

> Yeah. This is probably 150 times I called your office, and they say you're there, but when I say who I am they gave – they go right to your answering machine. So I don't know if you're the fucking President of the United fucking States or you're so motherfucking important not to take my fucking calls. But I want to fucking know if something is up because I'm going to the doctor today, and I'm going to be up in your motherfucking area today. I will be up there today in your fucking area, and I want my motherfucking doctor to come over there and knock you the fuck out because you haven't paid him, you cocksucker. You haven't paid him, and you haven't did fucking dog shit.
>
> If I have to come into your office and fucking grab you by the fucking neck and strangle you out of there and then tell your fucking wife what kind of a piece of shit you are, I'll do that. I'll do that, you son of a bitch. I'm telling you. You're making me mad over this. You're making me wait on my back. Well, you're going to be waiting on your back there, sweetheart. You're going to be waiting on your back, you fucking sweetheart. Motherfucker. Wait until the niggers get a hold of your fucking ass, fucking [unintelligible] fuckers. Them niggers. Fuck you. Fucking answer my fucking phone.

(Tr. 2/18/16 p. 175; RX 47).

As mentioned above, French had noticed his §8(a) motion to be heard before Commissioner Gore. The motion was scheduled for hearing July 18, 2014. On July 17, 2014, Matranga contacted Commissioner Gore's office and successfully obtained a continuance of some two months.[3] French was further enraged. On the evening of July 22, 2014, he left two more voicemails. French makes reference to surgery purportedly recommended by Dr. McNally and berates Matranga:

> Yeah. I'm up here with Dr. McNally, and he says I need my surgery right away. So we need to start work on that. Just forget about the God darn case to settle it. Just tell him [Matranga] to get a hold of Wal-Mart, and we need to get – It's about $500,000. I'm going to get every dime I can out of Wal-Mart, every dime, but I need an okay from him, and I need that right away. Tell him he can get his little squeaky ass to his fucking [unintelligible] because I've got pain in my back and that motherfucker knows it. So I'm not going to threaten anybody or anything else, but I need my fucking surgery done right away. We're not waiting months. We're not waiting years. You tell that stupid son of a bitch to call Wal-Mart and get it fucking done. Do you understand me? I want my

[3] This original §8(a) motion was eventually heard before Commissioner Gore on September 19, 2014. Ajster appeared on French's behalf. During that hearing, the parties stipulated that the issues involved at that particular time (regarding prescriptions and orthopedic bed) were resolved, and that motion was withdrawn. A new §8(a) motion, referencing the motorized scooter, personal assistant, medical cannabis, and prospective surgery was filed November 14, 2014. (RX 15).

fucking surgery done and I mean done right away. I'm not wasting – That stupid fucker called the arbitrator at the last moment, that stupid squeaky son of a bitch. He knows he's a squeaky prick.

(Tr. 2/18/16 pp.191-192; RX 47). Minutes later, French called again. He continues his rant, threatens Matranga and his wife with physical violence, and becomes increasingly unhinged:

Yes, I don't understand why you don't answer my phone calls. I don't know if you're the most chicken shit motherfucker I ever met but your wife and you are the most chicken shit motherfuckers. You did a dirty motherfucking thing to me when you fucking did that arbitrator. Me and you are not on the same page, you dirty bastard, you know that. You fucking know that. And I'm up here at Dr. McNally's and he says that I have to have surgery right away. And I'm going to have fucking surgery right away. So you get your fucking ass -- fuck your other cases. Fuck your other cases. I need surgery right away and that means tomorrow. And if you don't contact me back motherfucker, you better. And I tell you what you son of a bitch, you fucking motherfucker, I'll camp out at your house. I know where you live. I'll send every fucking nigger I know up there. Every fucking nigger. You coward. Motherfucker. You're a coward. You know that. You're a fucking coward. You do that to a fucking guy, you stupid son of a bitch. You're a coward. You're a fucking coward.

And your wife? I'm going to tell her you're a fucking pig that you've been out fucking every fucking whore and everything else too, that's why you fucking [unintelligible] won't answer your fucking phone. You're a fucking pig. And I'll call you a pig to your face, you son of a bitch. I'd love to meet you out someplace, you dirty bastard, you dirty son of a bitch. And I'm not [unintelligible] ...

You haven't reached my calls [unintelligible]. You called the arbitrator and you fucking did that [unintelligible]...You knew I wanted to go to that arbitrator and get my penalties. And I'll get my penalties one way or the other -- out of your ass or out of your wife's ass, you son of a bitch. You hear me? I'm not [intelligible]. I'm not waiting no two more months for back surgery, you stupid son of a bitch. I want you to understand this. I am done with you. These niggers are coming to your fucking house from the south side of fucking Chicago. I'll pay them fucking ten thousand dollars. I don't care... I'll send every nigger I know up there... You're a coward. You're a coward.

I got your address and everything else... You're not no warrior. You're a pig. You're a fucking two-faced pig. You're a two-faced pig. Won't fucking face a man. I'd love to see you. I'll catch you, I'll catch you. Ask any motherfucker that knows me. I will find you and I will fucking talk to you, man to man And we'll see if you're a man, 'cause I'm a real man. I've been dealing with this for twelve fucking years, you son of a bitch. And you ain't going to fucking [unintelligible] me, you fucking prick. Somebody's going to fucking pay for this, motherfucker. You're going to postpone this, keep postponing this and postponing this -- We're going to fucking have goddamn problems, you and me, and I'm telling you that right now.

(RX 47). The audio recording of the latter voicemail was not played at hearing but was submitted into evidence, as were other voicemails left on July 23, 2014 and August 3, 2014. (RX 47, RX 53). When questioned about these voicemails, French denied that he ever threatened Matranga, denied that he was the caller who left the voicemails, and also began pleading the Fifth Amendment. (Tr. 2/18/16 pp. 167, 176, 188). French's voice was later identified on these recordings by Brett King (former friend of French) (Tr. 2/19/16 pp. 73-76) and Meghan Ahrens (Matranga's assistant) (Tr. 2/19/16 pp. 309-312). As well, French was heard and observed by Commissioner Luskin on two dates of hearing. To this Commissioner, who has listened to all the recordings, French's voice and the voice on the recordings appear to be one and the same.

On July 29, 2014, Matranga's law firm, Wiedner & McAuliffe, found it necessary to inform French that he could no longer contact anyone at the firm by phone or email, and all communications would henceforth be done by U.S. regular mail. (PX 15). Soon thereafter, French was notified of the postponement and then cancellation of an independent medical evaluation ("IME") that Respondent had arranged for August 4, 2014 with orthopedic surgeon Dr. Kern Singh. A letter from Wiedner & McAuliffe to French explained: "The reason for this [cancellation] is that Dr. Singh has declined to examine you. His reasons for doing so are the same reasons as those which caused Mr. Matranga to seek an Order of Protection in this case." (RX 8). In short, Dr. Singh refused to see French after being apprised of French's behavior, including the voicemails.[4]

On August 29, 2014, Ajster formally entered her attorney appearance in this matter.

August 2014 through present, including aborted IME of March 2015: After entering her appearance, Ajster and Matthew Rokusek, the new Wiedner & McAuliffe attorney handling this matter for Wal-Mart, reached an agreement for another IME. This time, French was to be evaluated by orthopedic surgeon Dr. Steven Mather on March 12, 2015. French and Ajster arrived at Dr. Mather's office that day. However, this IME ended up being called off as well -- again due to French's behavior. French got into an argument with Dr. Mather's assistant, used profanity, challenged another patient in the waiting room to a fight, and was asked to leave by Dr. Mather's staff. As Dr. Mathers' report of this aborted IME related:

> Mr. French came into the exam room for some initial pre-history questions by my assistant. He indicated to my assistant that the work injury as that he was twisting and lifting a lot of freight. He was working alone with no help and felt severe pain. His co-worker took him the emergency room.
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> Immediately after that question by my assistant Kristi, he stopped answering questions. The patient said he had to get up and immediately get some water. He then walked out to the waiting room where his girlfriend/friend [Ajster] was accompanying him (this is the

[4] Ajster objected to the voicemails on the grounds of relevance at hearing. However, these voicemails are relevant to evaluating French's motion for penalties and fees. That is, as part of Petitioner's claim of an over-arching pattern of bad faith on the part of Wal-Mart, Petitioner cites this cancellation of the IME with Dr. Singh. But according to Wal-Mart, Dr. Singh was unwilling to see French upon learning of French's threats against Wal-Mart's attorney. The Commission finds that French did leave these voicemails, that Dr. Singh was reasonable in his refusal to see French, and that the cancellation of this initial IME was not an instance of bad faith on Wal-Mart's part. Relatedly, the voicemails also are relevant to evaluating Wal-Mart's motion to suspend benefits under §12 as it pertains to the believability of the account provided by Dr. Mather regarding what transpired on March 12, 2015. (See "Discussion" section.)

same person who indicated to my assistant Kristi that she was acting as his lawyer and wanted to be present for the IME but was told that was not our policy). In any event, Mr. French did not get any water, but sat down next to her and they had words with each other, and Mr. French told her that she needed to call the lawyer.

While she was calling the lawyer, Mr. French used inappropriate, highly offensive language in the waiting room. After a couple of "F-bombs," our receptionist indicated that he should refrain from using such language as there are ladies and children in the area. Mr. French then indicated to her "well, then tell that lady to come scratch my F—ing balls." One of my other patients who had his 5-year-old child with him said, "hey, stop using that language." Mr. French then challenged him to a fight outside. He did not use any spinal protective stance, maneuvers, or seem to be in any pain. He told the other patient, "Dude, you picked the wrong guy to fight with." After several minutes of F-bombs and abusive language, Mr. French was instructed to leave. He walked without any difficulty, carrying his cane with him, out to the parking lot. He indicated to the other patient that he would be "waiting for him" when he left our office. Mr. French walked with a normal heel-toe gait, no limp.

(RX 17). At hearing, French denied that he used abusive language or challenged anyone at Dr. Mather's office to a fight. (Tr. 2/18/16 pp. 253-257). The doctor's assistant, Kristi Chirumbolo, provided a witness statement, which was admitted as RX 18 for impeachment purposes. The account contained therein is wholly consistent with Dr. Mather's report of March 12, 2015 and, along with Dr. Mather's rendition of events, serves to severely undercut the believability of French's denial. (Tr. 2/19/16 pp. 398-402; RX 17; RX 18).

On March 19, 2015, Wal-Mart filed its motion to suspend benefits for French's refusal to submit to, or his unnecessary obstruction of, the §12 evaluation with Dr. Mather. (RX 4). Eventually, an IME with Dr. Mather did go forward without incident on July 31, 2015. This IME was conducted in a hearing room at the Commission in Chicago, Illinois. The results of this IME will be discussed in the "Respondent's New Evidence" section below.

At some point before the summer of 2015, Wal-Mart hired Delta Associated Investigations to conduct video surveillance on French. Stationary video surveillance was done in front of French's residence in June 2015, and an investigator followed French for active surveillance in early September 2015. On October 19, 2015, based on the surveillance video, Dr. Mather's IME report, and other newly acquired evidence, Respondent filed its motion to terminate French's PTD benefits.

PETITIONER'S CLAIMED DISABILITY

In support of the motion for termination of PTD benefits, Respondent presented newly acquired evidence of Petitioner's condition. Before this new evidence is addressed, the Commission turns to the history and nature of Petitioner' disability, and past and present treatment, as evidenced in medical records and other evidence presented by Petitioner.

As already noted, French was found by Arbitrator Andros to have sustained low back injury on September 8, 2002 and again on June 9, 2003. Notwithstanding that Arbitrator Andros' predecessor found that French suffered strains that resolved by June 27, 2003 (date of the jet ski incident), French

subsequently underwent lumbar fusion surgery at the L5-S1 level. This operation was performed by orthopedic surgeon Dr. George DePhillips in January 2004. (PX 19 pp-13-14). Dr. DePhillips testified in an evidence deposition on June 6, 2007 that the fusion created additional stress on the adjacent disc of L4-L5, and that therefore French might need an additional surgery at L4-L5 in the future. Dr. DePhillips also testified that French would require pain management and, although not a vocational expert, the doctor ultimately stated, "Mr. French was in my opinion unemployable and therefore totally disabled." (PX 19). French has not returned to Dr. DePhillips since 2008. (Tr. 2/18/16 p. 139).

Hearing testimony of Petitioner and his relatives: The hearing testimony of French – elicited largely through leading questions posed by Ajster – especially in conjunction with the testimony of his sister and personal assistant, Donna Craig, is remarkable for the picture painted of seemingly all-encompassing helplessness of French. French claims that he spends much of the day inactive and in bed. There is allegedly a permanent dent in his mattress due to his bedridden state. (Tr. 2/18/16 pp. 149-150). He claims he cannot walk farther than half a block and/or 100 feet without an assistive device. (Tr. 2/18/16 pp. 243-244). He alleges frequent falling due to his right leg giving out underneath him. (Tr. 2/18/16 pp. 15-16). He asserts difficulty with bending at the waist and picking things up from the ground. (Tr. 2/18/16 pp. 243-244). He is under the influence of his prescription pain medications and cannabis at virtually all times, and his low back pain is constant. (Tr. 2/18/16 p. 124-125).

It is claimed that French is so physically limited he is unable to do anything without assistance except for getting up in the morning. (Tr. 2/18/16 p. 126). It is claimed that Craig's assistance is required to feed him, dress him, turn on the shower for him, and hand him his towel after he is done showering. (Tr. 2/18/16 pp. 328-329). And it is claimed that French, who has a ninth grade education, is so intellectually limited that, as well as being illiterate, he "doesn't know numbers," and therefore Craig's assistance is required to dial numbers into his iPhone, at least when he seeks to call someone who is not in his iPhone's preset contacts list and/or whose number cannot be pulled up through voice activation. (Tr. 2/18/16 p. 373). Craig also has to help him enter internet searches on his iPad and help him "look up something on eBay." (Tr. 2/18/16 p. 374).

Craig attested that she is "very close" to her brother. (Tr. 2/19/16 p. 355). The only other witness testifying for French was Devin Borostowski, fifteen years old. Borostowski is Craig's son and French's nephew. Borostowski resides four days per week at the home of French and Ajster. (Tr. 3/14/16 p. 287). French gives Borostowski cash for items such as school supplies, lunch, YMCA membership, and his "high priced" clothes. (Tr. 3/14/16 pp. 288, 363, 380). Borostowski "considers [French] as a dad pretty much." (Tr. 3/14/16 p. 329). Similar to his mother, Borostowski provided testimony corroborative of French's alleged extensive physical and mental limitations. According to Borostowski, his uncle spends two days out of every weekend lying in bed. (Tr. 3/14/16 p. 300). Borostowski has "never" seen his uncle pick up a heavy object. He has "never" known his uncle to leave the house unaccompanied. (Tr. 3/14/16 p. 303). He has "never" witnessed his uncle read anything -- Borostowski added: "Like, he don't even – like he doesn't know how to, like, text either. Like he'll talk to the voice thing, you know." (Tr. 3/14/16 p. 305). To Borostowski's knowledge, French has never driven any of the multiple automobiles known to have been in French's possession. (Tr. 3/14/16 pp.307, 365).

Regarding those automobiles: French testified that he does own a number of automobiles, but he does not drive them. (Tr. 2/18/16 p. 318). These automobiles have included three Porsches and a Ferrari. Borostowski verified that a photograph submitted as RX 55 is from his Facebook page, and this photograph depicts him posing among his uncle's three silver Porsches in front of the Ajster/French

residence. (Tr. 3/14/16 pp. 352). As well, Borostowski testified regarding a red Ferrari bearing the vanity license plate "Dan 1," housed at the Ajster/French residence.[5] (Tr. 3/14/16 pp. 354, 361; RX 61).

Regarding cognitive abilities, it is claimed that French can barely read or write. (Tr. 2/18/16 pp. 339-340). French asserted that all written forms and applications submitted to physicians, social services agencies, and the like were read and filled out on his behalf by Ajster or his sister. (Tr. 2/18/16 pp. 260, 297). He asserted unfamiliarity with correspondence that bore his signature or otherwise indicated his authorship on its face, including emails sent from the address "danfrench1210@live.com." (Tr. 2/18/16 pp. 300-301). He asserted he does not know, or otherwise is unable to learn, how to make meaningful use of a computer or the internet, and therefore it is suggested that he has never written a single email in his entire life. (Tr. 2/18/16 pp. 298-299). French suggested that when he does operate by himself electronic devices owned by him (including an iPhone, iPad, and a Smart TV) -- for example, as when he did internet "research, research, research" into medical marijuana and a spinal cord stimulator -- most or all of that operation was done through voice activation only. His research also included watching a TV program titled "Weed." (Tr. 2/18/16 pp. 145, 157, 284, 341).

French averred that he is mentally compromised at virtually all times by prescription medications and/or pain. (Tr. 2/18/16 p. 124-125). At the start of his second day of testimony, March 14, 2016, he informed the Commissioner that his testimony of February 18, 2016 was done while he was mentally impaired. ("I was on Oxycontin and Norcos and everything when I came up ...And that's the reason why the first time I got up here I didn't even know where I was[.]") (Tr. 3/14/16 pp. 33-34).

Prescriptions from Dr. Stephen Rittmann: Since the surgery of 2004, French has taken prescription pain medication on a consistent basis for chronic and debilitating low back pain. He testified that he believed he is chemically dependent on pain medication. (Tr. 2/18/16 pp. 261-263). Prior to September 2013, he had been obtaining prescriptions for narcotics from Peru, Illinois physician Dr. Constantino Perales. In August 2013, Dr. Perales was arrested by the Drug Enforcement Agency for illegal drug sales. French then prevailed upon Dr. Stephen Rittmann of Schaumburg, Illinois. On French's first visit, on September 6, 2013, Dr. Rittmann -- a primary care physician -- explained that he was not a pain specialist, but would be willing to fill French's prescriptions for the short term until such time that French could see a provider with expertise.[6] (RX 25:072). As it happened, French did have

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[5] It is remarkable that an individual who has been unemployed since mid-2003 can come into ownership of such vehicles. Of note, not only does French claim limited physical and mental resources, he has claimed a paucity of monetary resources. Regarding his relationship with Ajster, French attested that the two have been a couple for "20-something years" but are unmarried, and he asserted that his finances are separate from hers. In his words, "She pays her bills. I pay mine." (Tr. 2/18/16 p. 147). On October 27, 2014, in support of his application for a State-sponsored personal assistant, French signed a "Home Services Program Financial Data Sheet," wherein he certified that his "Total Family Unit Income" consisted solely of $717.00 of SSDI (Social Security Disability Income) received per month. The space for Workers Compensation Income was left blank. (RX 49). (Tr. 2/18/16 pp. 241-242).

[6] Dr. Rittmann's note of the first encounter with French, who was accompanied by his "attorney wife," reads:

> Strangest thing I have seen lately ...This 38 year old disabled male comes with his attorney wife from near Peru, Illinois as was told by a friend that I was the best doctor. They both do a lot of talking and sometimes over-talk each other, making understanding everything a little difficult. They state that their old family MD who has been giving him narcotics was busted by the DEA and is no longer in practice and they are desperate to get hooked up with another doctor who will take over narcotics; states they don't mind driving up here and also go to U. of C for recurrent skin lesions. Have explained to them I am not a pain specialist

familiarity with and prior treatment from a pain specialist, Dr. Deofil Orteza of Bureau Valley Pain Management. French had seen Dr. Orteza for treatment of "failed back syndrome" back in 2011, and he later received epidural injections from Dr. Orteza in September 2014 and April 2015. (PX 10; Tr. 3/14/16 p. 86). It is not explained why French chose not to return to Dr. Orteza to fill his narcotics prescriptions. At present, Dr. Rittmann remains the source of most of French's prescription medications, including hydrocodone (Norco), Xanax, Valium, Cymbalta and Cialis.

Dr. Rittmann's records indicate that French consistently complained of low back pain. (PX 11; RX 25). French also reported occasional pain traveling down his right leg and his right leg giving out, causing him to fall. (RX 25:033). Due to these reports of pain and falling, Dr. Rittmann prescribed a cane, a walker, and eventually a motorized scooter. (PX 7; RX 25:041). These complaints did not keep French from physical activity. On February 18, 2014, Dr. Rittmann indicated that French had exerted himself with "work he is doing to help wife get her office ready." (RX 25:058) Notably, French also consistently reported to Dr. Rittmann that his exercise level was "Occasional." (PX 11; RX 25).

On September 16, 2014, Dr. Rittmann wrote, "[French] wondered if he is a candidate for medical marijuana and I stated this might be possible but I really was not educated enough especially with his dependence on meds to tell him one way or the other." (RX 25:038). October 14, 2014, the doctor indicated that French again was "interested in trying medical marijuana." (RX 25:035). Subsequently, Dr. Rittmann accommodated French's interest by signing a physician's certification form in connection with French's application to be a patient in the Illinois Medical Cannabis Pilot Program. Since November 9, 2015, French has been using medical cannabis (three ounces every two weeks), as well as prescription medications for pain. (PX 6).

Finally, Dr. Rittmann also provided a prescription for a personal assistant. (PX 2). This was done at the prompting of Ajster (on July 24, 2014, Dr. Rittmann wrote that "[French's] wife wonders about a personal aide as she has to work"). (RX 25:044). French then applied to the State of Illinois Department of Human Services' Home Services Program for this assistant. Upon obtaining approval of his application, French hired his sister, Donna Craig. (PX 4). Craig is not a licensed nurse or rehabilitation specialist, but attests that she has "life coach" experience. (Tr. 2/18/16 pp. 359). Craig began working in January 2015 for French. She testified that she performs two to three hours of assistance for him every weekday. (Tr. 2/18/16 pp. 356-357). She is paid $13 per hour by the State of Illinois for her services. (PX 5). She received more than $11,000 in the course of a year and attested that this job had been her primary source of income for some time.[7] According to Craig, in addition to tasks such as feeding and dressing French, she does housework such as washing dishes, cleaning and mopping. As to this housework performed at the residence shared by French and Ajster, Craig claimed that she did work that inured to the benefit of French only. (Tr. 2/18/16 p. 332, 371).

French, in addition to taking the antidepressant Cymbalta, takes Seroquel for anxiety as prescribed by psychiatrist Dr. Atul Sheth. French began seeing this doctor in May 2015. (PX 23).

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but can fill meds short term until we can direct them to someone else. Will have to get pain med contract. Discussed how when the DEA shuts down a doctor what happens to the patients????

(RX 25:072).

[7] Craig is also paid by the same State of Illinois services program to be a personal assistant for her and French's elderly parents three hours per weekday as well. (Tr. 2/18/16 p. 356).

(French also claims to suffer from anxiety and depression since becoming disabled.) Dr. Sheth also provided French a prescription for a therapy dog. Regarding his observations of French's cognitive function, Dr. Sheth wrote:

> "Cognitive function and fund of knowledge are intact and age appropriate. Short and long term memory are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Vocabulary and fund of knowledge indicate cognitive function in the normal range. Insight into problems appears fair."

These findings are noted in every record following the June 3, 2015 office visit, including French's most recent visit in advance of the hearing of January 19, 2016. (PX 23).

As noted already, Dr. Rittmann is a primary care physician and informed French at the first visit that he did not have the expertise of a pain management specialist. Regarding French's persistent back issues and possible surgical intervention therefor, Dr. Rittmann again felt compelled to inform French of his lack of qualifications. On October 31, 2013, Dr. Rittmann wrote, "I cannot continue to provide care as this is outside the scope of my expertise" and thus referred French to Dr. Thomas McNally for evaluation of his back. (PX 11; RX 25:068).

Dr. Thomas McNally consultation: On July 22, 2014, French was seen by Dr. McNally. Contrary to French's claim, Dr. McNally did not conclude that French could benefit from an additional fusion surgery, much less did the doctor recommend one. Dr. McNally saw French on just one occasion. As his report indicated, the doctor first wished to review copies of French's prior EMG/NCS studies and obtain new ones, and he also discussed other options including a spine stimulator with French. All indications are that Dr. McNally was at a preliminary stage in his evaluation of French, and the doctor wished to obtain more information before reaching any firm conclusions about what, if any, additional treatment should be rendered. (RX 25). The discussions with French regarding fusion and other treatment options were for informational purposes. It is apparent that French came away from that visit with the impression that Dr. McNally was urging immediate emergency back surgery and was ready to render it once Wal-Mart gave approval – judging from the extremely agitated voicemails French left for Matranga on the evening of July 22, 2014. However, French's impression was unfounded. At any rate, there is no evidence that old or new EMG/NCS studies were provided to Dr. McNally or that French did any follow-up whatsoever with the doctor. The fact is that no surgical recommendation, current or otherwise, exists from Dr. McNally.

RESPONDENT'S NEW EVIDENCE

The Commission now turns to Respondent's newly acquired evidence. Respondent contends that this evidence shows that French is not nearly as incapacitated as he claims to be, and concomitantly, that he is capable of returning to work and earning at least as much as before his work-related injury. Accordingly, Respondent requested that French's permanent total disability benefits be terminated in favor of an award of permanent partial disability under §8(d)(2) of the Act. Respondent's evidence includes stationary and active video surveillance, security video footage from a casino, a YouTube video, the medical opinions of Dr. Singh and Dr. Mather, and hearing testimony of Brett King. Respondent also submitted a vocational assessment report.

Video evidence: Respondent conducted stationary video surveillance through Delta Associated Investigations at the Ajster/French residence on June 9 and June 11, 2015. The videos were submitted into evidence as RX 29 and RX 31. Notwithstanding Ajster's testimony before Arbitrator Andros that French had not ridden a bicycle in years, one video clip shows French atop some kind of bicycle or moped as he rides away from the residence. (RX 29; RX 30:002). Another clip shows French bending effortlessly from the waist as he wipes something off the bumper of a Porsche in his garage. (RX 29; RX 30:001). A clip from the afternoon of June 11, 2015 shows French behind the wheel of an SUV that is hitched to a trailer with two jet skis loaded on the trailer. French is shown backing this SUV and trailer into the driveway and garage. Later that afternoon French is shown detaching the seat from one of the jet skis by lifting it off the jet ski; he then bends at the waist while gently placing the seat down on the lawn. (RX 31).

Active surveillance was done from August 31, 2015 through September 7, 2015. This active surveillance video was submitted into evidence as RX 33. On September 3, 2015, the investigator captured video of French and Ajster on a recreational boating excursion. The video shows an SUV pulling a "Sea-Doo" recreational boat away from the couple's residence. The investigator follows the SUV to the Illinois River. There, French is shown behind the wheel of the SUV as he attempts to back the SUV, with the boat on its trailer, into position by the landing at the water's edge. Meanwhile, Ajster stands outside the vehicle and gives directions to him. Finally, the couple is able to get the boat into the water and themselves into the boat. The video shows French hoisting himself up from the ground and getting his body over the edge of the boat and into the boat. After the couple spends some time in the boat, its motor appears to fail. The video shows French bending at the waist as he checks the boat's engine. Finally, both French and Ajster take out oars and paddle the boat back to shore.

Respondent also obtained video footage captured by security cameras at Jumer's Casino of Rock Island, Illinois. This footage is of French, accompanied by Ajster, on May 15, 16 and 24, 2015. (RX 26; RX 27). This video shows French walking, standing and moving about through various areas of the resort, including the lobby, casino area, dining room, and hallway to their hotel room. He is shown ambulating for stretches clearly in excess of 100 feet, moving without any apparent difficulty and without an assistive device. He is shown as being alert and engaged while sitting at blackjack table with Ajster by his side.[8] As Petitioner does point out, a clip from May 24, 2015 shows French being pushed in a wheelchair from his hotel room out to the parking lot. However, this clip also shows that French, while seated, is swinging his lower legs back and forth and making contact with the ground, in a manner of walking and propelling the chair forward, while the chair is being pushed from behind. (PX 13; RX 27).

Finally, Respondent submitted a YouTube video that depicts French in a loud arm-wrestling match on February 21, 2014. (RX 43). This incident was witnessed by Brett King and was uploaded to the internet. (Tr. 2/19/16 p. 59). King testified that he (King) was among a group of people, including French and a very well-muscled man named Corey Andreoni, playing poker that night. According to King, at some point, French declared that he could "take on" Andreoni in an arm-wrestling match, and the two agreed to square off. (Tr. 2/19/16 p. 57). The video of the match shows French laughing and

[8] During cross-examination, French was asked whether Ajster accompanied him on casino trips. He answered, "Absolutely not. Absolutely not." (Tr. 2/18/26 pp. 319-320). Ajster did not correct her client during this instance of blatant falsehood from French. When Respondent submitted the Jumer's security video into evidence, Ajster acknowledged that she was in those videos.

energetically engaging with his brawny opponent, throwing his full weight with enthusiasm into the contest, before ultimately being defeated. (*See* RX 42; RX 43; RX 44).

King, a former friend of French and Ajster, also testified that he played basketball with French at the YMCA and that they went on a day-long recreational "four-wheeling" excursion. King testified that he, French, and Borostowski went to a multi-acre off-road park called "The Cliffs of the Insane Terrain" in Marseilles, Illinois in October 2014. There, they spent hours driving ATVs (all-terrain vehicles) over rugged trails, mud pits, hills and the like. He testified that French even crashed through a barbed wire fence and into a tree. (Tr. 2/19/16 pp. 22, 31-32; 38-39). King's impartiality as a witness could reasonably be questioned, given his personal history with French and Ajster.[9] However, King's testimony is not inconsistent with the videos and other evidence of French's physical capability.

Independent medical evaluation and records review: As mentioned above, an IME was initially scheduled with Dr. Singh for August 2014, but this IME was cancelled after the doctor indicated unwillingness to see French upon being apprised of French's threats against Matranga. However, Dr. Singh did perform a medical records review and submitted a written report of the review. (RX 10). He opined that while French was status post L5-S1 fusion and had degenerative disc disease at L4-5, he had "no instability at L4-5" and his pain complaints "are not anatomic in nature and do not correlate to the L4-5 level." (RX 10:002). It was the doctor's opinion that French was not a candidate for a spinal cord stimulator and was capable of returning to work without restrictions. (RX 10:002).

Respondent also submitted two reports from Dr. Mather: (1) a report of March 12, 2015, written after the aborted evaluation of that day, containing records review (RX 17); and (2) the IME report, dated August 31, 2015 (RX 19). Dr. Mather examined French without incident on July 31, 2015. In the IME report, Dr. Mather opined that French was status post L5-S1 fusion and that the fusion was solid. He reported that French had adjacent segment disc degeneration at the L4-L5 level; however, x-rays and MRIs of June 26, 2014 show that the disc was stable. There was no nerve root compression and no clear radiculopathy. Dr. Mather opined that French was not a candidate for surgery or a spinal cord stimulator.

Regarding medications, Dr. Mather felt that French's narcotics use was excessive and that the Norco should be limited to 60 tablets per month. Dr. Mather felt that Cymbalta was unnecessary and also unrelated to his spinal condition. As to another medication, the doctor wrote that French's use of Cialis "is clearly not related" to his work injury or his low back.

Dr. Mather opined that French could return to work at the Medium physical demand level with occasional bending:

> "Mr. French does appear to have some capability for employability. He has computer skills, and his upper extremities are very strong, impressively strong. I believe that a 25

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[9] King currently is being sued for defamation by French for statements made in connection with a pending criminal proceeding against French for felony phone harassment of another attorney. King has also been contacted by the Attorney Registration and Disciplinary Commission regarding charges of perjury against Ajster . (In the matter of: Julie Lynn Ajster, Attorney-Respondent, No. 6277029, 2016 Ill. Atty. Reg. Disc. LEXIS 3).

to 50 pound lifting restriction given how impressively strong he is, is reasonable. I would limit his bending to no more than 8 times per hour."

(RX 19:006).

Vocational assessment report: Respondent presented the testimony and vocational assessment report, dated October 2015, of Certified Rehabilitation Counselor Daniel Minnich. (RX 23). Minnich performed his assessment based on Dr. Mather's IME report, the description of French's job at Wal-Mart, and previous jobs held by French as reported by French in his job application to Wal-Mart. (Tr. 2/19/16 pp. 338-339). Minnich noted, among other reported work experience, French's experience as a supervisor for a lawn maintenance business. (Tr.2/19/16 p. 348).

Minnich also wrote, "In addition it was also noted that Mr. French has been supplementing his income by performing internet car sales," and that this activity indicated an excellent skill that would provide for many work opportunities. (RX 23:005). Significantly, during cross-examination, Ajster did not challenge this reference to French's internet car sales activity, and instead chose to question Minnich about what jobs in Minnich's report would be available to French if French, hypothetically, were illiterate. (Tr. 2/19/16 pp. 360-362). In the end, Minnich's assessment was that French could pursue occupations at the Medium Level and earn wages commensurate with his previous wage. (RX 22).

DISCUSSION

In seeking the termination or reduction of permanent total disability benefits, an employer has the burden of proving a change in the claimant's employability such that the claimant is able to return to work and earn at least as much as before the accident. *See* King v. Industrial Commission, 189 Ill.2d 167, 724 N.E.2d 896, 244 Ill.Dec.8 (2000).

Regarding its ultimate determination that French is not, or is no longer, entitled to permanent total disability benefits, the Commission underscores the finding that French is not a credible witness. As for Ajster, the lack of candor and intellectual dishonesty she displayed at hearing served only to undermine her client's case.[10]

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[10] In particular, Ajster sought to testify as a witness for French after witness testimony had commenced on February 18, 2016. She had not made this intention known to either Wal-Mart's attorneys or the Commissioner before that moment, even though she had opportunity – and indeed, she had calling – to disclose such intention at the start of the hearing, when a motion to exclude witnesses from the hearing room was made by Wal-Mart's counsel. The Commissioner inquired, "The only witness we've got right now is [Petitioner's] assistant, yes?" Ajster stated, "Yes." Wal-Mart's motion was then granted. (Tr. 2/18/16 p. 7).

Ajster claimed that she "just assumed" that opposing counsel knew she wanted to testify as a witness, and she "never thought it would be an issue" as it regarded her failure to advise the Commissioner of her intention when he first inquired about witnesses. (Tr. 2/18/16 pp. 58, 63). After apologizing to the Commissioner, she argued that there was no conflict of interest presented by her acting as both attorney and witness for her client. (Tr. 2/18/16 pp. 58-66). Her argument was unavailing, and she was not permitted to testify. French was given the option of having the hearing reconvened at a later date so that he could retain new counsel and have Ajster act as witness at that time. This option was declined. (Tr. 2/18/16 pp. 65-66).

A. Petitioner Is Not Permanently Totally Disabled.

Taking the evidence as a whole, the Commission concludes that French's disability is far from total. It certainly is not as extensive as French claims. Not only are his claims of extensive physical limitations well refuted by the evidence -- especially the video evidence -- he contradicts himself multiple times during his testimony.

As it has in past cases, the Commission places great weight on the video evidence as a true measure of the claimant's real condition of ill-being. (*See* Snyder v. Select Beverages Inc., 2000 Ill.Wrk. Comp. LEXIS 600, 00IIC 0654 and the cases collected therein.) In French's case, the video clearly shows an individual who is far from incapacitated, and definitely not the limited person French professes to be. This evidence dramatically impeaches his testimony regarding his physical limitations and concomitant ability to return to work. Certainly, the February 21, 2014 arm wrestling video demonstrates that by then French was not, or was no longer, at a state of total disability. This video shows him vigorously exerting himself with no apparent ill effects, at an activity requiring physical effort significantly in excess of his claimed abilities.

As for his testimony at hearing, French himself (at apparently less guarded moments) offered testimony that is at odds with the narrative of a bedridden, physical and mental invalid crippled by constant pain and drugs. For example, during questioning from Ajster about Dr. McNally's recommendation, French made reference to the doctor's advice that French engage in physical activity such as swimming while awaiting his sought-after surgery. (Tr. 2/18/16 p. 105). French then elaborated:

> "He [Dr. McNally] wanted me to at least try to get up and get at it because laying in bed all the time, you're just no good. It's no good. So I took his advice and started swimming. It's been helping my back, but it gets sore at night real bad, but after that the swimming does help."

(Tr. 2/18/16 p.107). On another occasion, when questioned by Ajster about how often and how far he can drive, French stated that he last drove "probably about six months ago," that he drove "not that far," and that he has never driven on his own from his residence in Dalzell, Illinois to Chicago, a distance of approximately 100 miles. (Tr. 2/18/16 pp. 117-118). However, this is at odds with earlier testimony about his medical cannabis expenses, where he stated that he drove to Canton, Illinois – about 100 miles away from his residence, and in November 2015 – to make his purchase from a medical marijuana dispensary. As French stated to his attorney:"Yeah. I had to drive to Canton. Yep." (Tr. 2/18/16 pp. 94).

On March 14, 2016, Ajster moved to disqualify Respondent's attorneys on the grounds that French *pro se* had just filed a lawsuit against them. (Danny French vs. Mark Matranga *et al.*, case no. 16 L10, Circuit Court of Bureau County, Illinois, filed March 9, 2016.) (PX 18; RX 57). This lawsuit named Matranga, Wal-Mart, and the law firm of Wiedner & McAuliffe as defendants, and alleged intentional infliction of emotional distress in connection with their handling of French's workers' compensation claim. Notwithstanding her earlier assertion that her acting as a witness for her client would have presented no conflict of interest, Ajster now contended that Respondent's attorneys' ability to represent Wal-Mart was now compromised by this lawsuit. Her motion was denied. (Tr. 3/14/16 pp. 13-19).

Regarding his claims of illiteracy and lack of computer skills, French testified that he did internet research on his medical conditions and possible treatment options. He spoke of the "research, research, research" that he did regarding medical marijuana and a spinal stimulator. (Tr. 2/18/16 p. 145, 154). He stated, "I read everything." (Tr. 2/18/16 p. 155). Respondent's attorney asked, "Mr. French, can you read or not? You can, right? You're reading articles?" To this direct question, he replied, "Yes, I can read... But I cannot read, like, big words." (Tr. 2/18/16 p. 252).

The evidence of Petitioner's reading and writing ability is plentiful. Scores of emails and other documents purporting on their face to be authored by French have been submitted into evidence. In particular, Petitioner himself submitted, as PX 20, a voluminous collection of emails exchanged between him and Matranga over the course of summer 2014 regarding French's efforts to obtain expenses reimbursement. During hearing, Ajster offered to "stipulate" that all of these emails, letters, faxes and other written communications were composed and transmitted entirely by her, at the purported direction of French. (Tr. 2/18/16 pp. 309, 314). Ajster offered this so-called "stipulation" during cross-examination of French regarding a letter from French that was faxed to Wal-Mart's claims adjuster, Marcy Dyer, in late March 2014. (RX 50). This fax communication appeared to be transmitted to Dyer following a contentious phone call placed by French.. The letter read:

> "Ms. Dyer, I believe there was a misunderstanding yesterday. I called to speak with you and the receptionist or whoever refused to let me talk to you stating that I had an attorney and you could not speak with me. My prior attorney Jim McPhedran sent you a letter stating he was withdrawing from my case, so you should have been able to speak with me. When you refused to speak with me is when I became upset....Yesterday was the first time I ever lost my temper..."

The letter ended with, "If email works better for you, then please let me know. My email is danfrench1210@live.com." (Tr. 2/18/16 p. 307).

At hearing, French claimed he was wholly unfamiliar with this letter, did not write it (as he is illiterate) does not have an email address (as he does not know how to use a computer), and suggested that Dyer sent the letter to herself. Finally, Ajster interjected, "I'll stipulate that I wrote it, and the danfrench1210 is an email account controlled by me." When asked whether she would also stipulate that French lost his temper, Ajster hedged, stating, "I don't think it was with Ms. Dyer" and then, "I mean, he probably yelled at her. He said, 'Answer the phone when I call.'" (Tr. 2/18/16 pp 309-311).

At one point during the hearing, Ajster even purported to conduct a test of French's reading ability (or lack thereof). She held the first page of one of Petitioner's exhibits before French, whereupon French attested that he could not recognize any of the words at the top of the page. The words were "Personal Assistant State of Illinois Evaluation Recommendation." (Tr. 2/18/16 pp. 288-289). The Commission finds this demonstration of French's illiteracy to be not compelling.

B. Petitioner Has Not Proven Need for a Motorized Scooter, Personal Assistant, Medical Marijuana, or Prospective Surgery

The Commission finds that French has not proven a need for the motorized scooter, personal assistant, medical marijuana, or prospective fusion surgery, and therefore denies his §8(a) motion in its entirety. The Commission finds that orthopedic surgeons Dr. Mather and Dr. Singh provided medical opinions that are far more authoritative and credible regarding French's condition and reasonable

ongoing needs than any witness presented by Petitioner. Petitioner's lay witnesses, Craig and Borostowski, are not trustworthy witnesses insofar as they have not just blood ties but financial ties to him. With regard to Dr. Rittmann, it bears repeating that this primary care physician -- the prescriber of the motorized scooter, personal assistant and medical marijuana -- had himself expressly noted in his records that he was "not a pain specialist" and that he was "not educated enough" to advise French about medical marijuana. On October 31, 2013, the doctor wrote, "I cannot continue to provide care [to French] as this is outside the scope of my expertise." That Dr. Rittmann continued to see French is not sufficient proof that French's motorized scooter, personal assistant, and medical cannabis are reasonable or medically necessary. The Act does not require an employer to provide every modality that possibly could relieve the effects of a claimant's work injury.

As well, Petitioner's claims of need for the past and future medical services referenced in his motion are severely undercut by his mendacity. Where a witness willfully and deliberate misstates the facts on material points, the trier-of-fact may disregard the uncorroborated testimony of such witness. MacDonald v. Industrial Commission, 39 Ill.2d 386, 235 N.E.2d 824 (1968). French has deliberately misrepresented his condition to the Commission and to his medical services providers, including Dr. McNally. In Dr. McNally's July 22, 2014 report, it is indicated that French told the doctor that he is "very inactive and lies in bed most of the day." (PX 9). This is inaccurate, as the video evidence demonstrates. The Commission is not obligated to accept a medical opinion when there is evidence to support the Commission's determination that the factual basis for the opinion is faulty and contradicted by other evidence. Sorenson v. Industrial Commission, 281 Ill.App. 3d 373, 666 N.E.2d 713 (1996). Even as Dr. McNally's July 22, 2014 report indicates nothing more than a tentative suggestion of fusion surgery among other treatment options, this suggestion is based on false information.

C. Petitioner Unnecessarily Obstructed the March 2015 IME

Regarding Respondent's motion to suspend benefits under §12, the Commission finds that Respondent has proven that French unnecessarily obstructed or otherwise refused to submit to the IME scheduled for March 12, 2015 before Dr. Mather. Thus, suspension of benefits from March 12, 2015 to July 31, 2015 -- when the IME was done at a hearing room in the Commission -- would be justified. See, e.g., R.D. Masonry v. Industrial Commission, 215 Ill.2d 397, 830 N.E.2d 584 (2005).

Respondent has proven that this IME failed to go forward due to Petitioner's misconduct. That is, the Commission finds that Petitioner used abusive language towards the doctor's staff and a patient in the waiting room and threatened the patient with physical violence. Dr. Mather acted reasonably in refusing to go through with the IME that day. When questioned at hearing, French denied the specific account of his behavior as documented by Dr. Mather. The Commission notes that the behavior recounted by the doctor (and by his assistant) is wholly consistent with the abusiveness and combativeness displayed in the voicemails left for Matranga, and finds that French's denials of this abhorrent behavior as to both Matranga and Dr. Mather's staff and patients to be not credible.

Lastly, Petitioner's motion for penalties and attorney's fees is denied in its entirety, for reasons that should be readily apparent by now.

CONCLUSION

For the reasons stated, Respondent's motion for termination of permanent total disability benefits under §8(f) in favor of an entry of an award of permanent partial disability under §8(d)(2) is granted. Relative to the extent of the permanent partial disability, the Commission awards permanent partial disability benefits representing 20% loss of use of the man as a whole. Respondent's motion for suspension of benefits under §12 is granted. Petitioner's motions are denied in their entirety.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §8(f) permanent total disability award is terminated as of February 21, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay permanent partial disability benefits to Petitioner the sum of $268.14 for 100 weeks, representing 20% loss of the person as a whole under §8(d)(2), commencing February 21, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's disability benefits be suspended from March 12, 2015 to July 31, 2015 under §12.

IT IS FURTHER ORDERED that Respondent shall have credit for all amounts paid 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), if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's motions under §8(a) and for penalties and attorney's fees under §19(l), §19(k) and §16 are 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 the Circuit Court.

DATED: SEP 12 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-07/13/16
jdl/ac
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STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

☒ 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

Marilyn Guymon,
Petitioner,
vs.

16IWCC0612
NO: 06 WC 6568

Pinnacle Foods Corp,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability, 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.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 23 2016
KWL/vf
O-9/19/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0612

GUYMON, MARILYN
Employee/Petitioner

Case# 06WC006568

PINNACLE FOODS CORP
Employer/Respondent

On 1/5/2015, 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 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3263 DODDS LAW OFFICE
TERRY W DODDS
624 N MAIN ST
BLOOMINGTON, IL 61701

0358 QUINN JOHNSTON HENDERSON ETAL
CHRIS CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

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

16IWCC0612

MARILYN GUYMON,
Employee/Petitioner

v.

PINNACLE FOODS CORP.,
Employer/Respondent

Case # **06** WC **6568**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Champaign**, on **11/26/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0612

FINDINGS

On **1/14/06**, 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 ***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 **$15,237.56**; the average weekly wage was **$293.03**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$22,190.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$22,190.00**.

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

ORDER

Petitioner's claim for maintenance benefits pursuant to Sectio 8(a) of the Act is denied.

Respondent shall pay Petitioner permanent partial disability benefits of $175.82/week for 50 weeks, because the injuries sustained caused the 10% loss of her person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

12/17/14
Date

ICArbDec p. 2

JAN 5 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 60 year old hand packager for respondent (Lenders Bagel), sustained an accidental injury that arose out of and in the course of her employment by respondent on 1/14/06, when she slipped and fell while taking out trash with another employee. Petitioner began working for respondent in 2005. Petitioner hit her head and was taken to the emergency room at Carle Clinic in Champaign, IL. Petitioner's Application for Adjustment of Claim filed 2/21/06 alleges an injury to the back of her head, neck, and bulging disc.

This matter was heard pursuant to Section 19(b) of the Act on 8/27/08. This issues in dispute at that time were causal connection, temporary total disability, and prospective medical in the form of a cervical surgery to be performed by Dr. Wright. On 12/29/08 Arbitrator Mathis issued his Arbitration Decision. During that hearing petitioner claimed that she fell back and hit her head. She claimed she lost consciousness and could not remember anything that happened after that. She described a burning and pain to her bilateral forearms and hands. She also described a bit of tingling in her toes. Petitioner was diagnosed with Grade II subluxation of C7 on T1at Sarah Bush Lincoln Health Center by Derek Stout. She underwent a CT of the brain. The impression was no evidence of acute areas of hemorrhage, infaction, or masses within the brain. Petitioner next treated at Carle Clinic and was diagnosed with a mild cord contusion. Dr. Jimenez reviewed the MRI and assessed 1) prominent prevertebral soft tissue abnormality consistent with edema and/or fluid along with posterior paraspinal soft tissue edema within the upper neck; 2) multilevel degenerative disease with disc osteophyte complex with bone marrow signal changes within the C5 and C6 vertebral bodies which likely represent bone marrow edema; and 3) subtle spinal cord T2 hyperintensities at C4-C5 levels possibly reperesenting edema associated with mild cord contusion. Dr. Wright diagnosed petitioner with a central cord syndrome and significant cervical stenosis and recommended petitioner have a spinal decompression surgery and removal of the discs at both C4-C5 and C5-C6. Dr. Wright opined that the fall on 1/14/06 contributed to her condition at that time, and accelerated the need for the surgery he was recommending. He was of the opinion that "the main value of doing the surgery was to provide greater volume around the spinal cord and prevent the likelihood of her suffering further cord injury should she fall or otherwise injure herself again". At trial petitioner testified that she had serious limitations with walking, standing and sitting. She testified that she could only walk approximately 50 feet before beginning to have pain or discomfort. She testified at the trial in August of 2008 that she could only sit or stand for 10-15 minutes before she began beginning to experience pain or discomfort. She denied any problem with this before the injury. She also complained of diffuse paresthesias in the arms and legs and intermittent cramping. At the time of the trial on 8/27/08 petitioner was authorized off work by Dr. Wright.

Following the hearing, Arbitrator Mathis issued his decision on 12/29/08 and found that petitioner's accident arose out of and in the course of her employment by respondent on 1/14/06 and her present condition of ill-being is causally related to the injury she sustained on 1/14/06; that petitioner is entitled to payment for temporary total disability benefits from 5/3/08-8/27/08, for a period of 16 weeks or $4,688.48; respondent was to authorize the surgical procedure recommended by Dr. Wright and the other doctors at Carle Spinal Institute, as well as, any and all other reasonably related medical; and that respondent's denial of medical benefits and authorization for the proposed surgery was not vexatious and penalties were denied.

Respondent timely filed a Petition for Review under Section 19(b) of Arbitrator Mathis' 19(b) Arbitration Decision filed 12/29/08. The Commission, after considering the issues of prospective medical care, as well as the causal connection of petitioner's employment and her temporary total disability, and being advised of the facts and law, modified the Decision of the Arbitrator in part, and affirmed and adopted the remainder of the Arbitrator's Decision on 4/15/10.

The Commission noted that the Arbitrator found petitioner suffered a spinal cord injury as well as soft tissue injuries in her left lower neck. Other findings pertaining to her neck were found by the Arbitrator and included multilevel degenerative disease of the cervical spine, scoliosis and the narrowing of the discs at C4-C5, C5-C6, and C6-C7, while petitioner was hospitalized. The Commission noted that petitioner underwent a dozen physical therapy sessions and made progress toward her goals but still complained of discomfort in her neck and arms that consisted of pain in her neck and numbness and tingling in both arms. It was also noted that petitioner had complaints of difficulty walking, including a lack of strength in her legs.

The Commission affirmed the Arbitrator's award of temporary total disability and found the medical expenses incurred in treating petitioner were both causally related to her injury on 1/14/06 and reasonable. The Commission disagreed with respondent that petitioner had reached maximum medical improvement on 5/17/06 and found that respondent should be credited for temporary total disability benefits made after 5/17/06. The Commission based this finding on petitioner's continuing complaints of ill-being and the fact that petitioner had not yet been released to return to work by the doctors at Carle Clinic. The Commission found that petitioner's symptoms commenced contemporaneously with the accident and have persisted ever since. The Commission found that even if petitioner had reached maximum medical improvement, there was no evidence that petitioner was offered a sedentary position or a vocational assessment as required and, as a result of respondent's failure to offer either, the petitioner would still be entitled to maintenance in the amount of temporary total disability.

The Commission then went on to reverse the Arbitrator's ruling that required respondent to authorize the recommended surgical procedure finding it was not causally related to petitioner's 1/14/06 injury based on Dr.

Wright's and Dr. VanFleet's opinion that the surgery would stabilize her spinal cord and that would reduce the risk of petitioner suffering paralysis should she fall, but such surgery would not change her symptoms. The Commission found that the both Dr. Wright and Dr. Fleet testified that the injury brought to light petitioner's need for the surgery, but neither testified that the injury itself caused the need for the surgery. The Commission affirmed the Arbitrator's finding as to penalties and fees.

The Commission ordered the respondent to pay petitioner temporary total disability benefits in the amount of $219.35 per week from 3/3/08 through 8/27/08 because the injuries sustained caused the disabling condition of the petitioner, and the disabling condition is temporary and not yet reached a permanent condition pursuant to Section 19(b) of the Act. The Commission further ordered that respondent shall not be required to authorize or pay the expense of petitioner's prospective surgery, and that petitioner's petition for penalties and fees was denied.

On 5/3/10 petitioner presented to Dr. Harm for a surgical evaluation. She complained of neck pain for 4 1/2 years. He noted that Dr. Wright thought surgery at C4-C5 and C5-C6 could help minimize the chance of future damage, but not help her current symptoms. She stated that her arms bother her including the forearm and the hand. She also complained of numbness in her legs and symptoms that go to the head. She complained of numbness in her hands and three small fingers bilaterally. She reported that if she walks too much she gets numbness in her legs. She also reported difficulty with balance. Dr. Harm reviewed an MRI taken 3/31/10 that showed narrowing at C4-C5 and C5-C6, with no extra room in the spinal cord at these spots. He also noted a disk bulge at C7-T1 on the right that might be causing her symptoms. He was of the opinion that it also showed foraminal stenosis that might be causing some of her arm symptoms. He believed her major symptoms were coming from a contusion to the spinal cord which had not been able to heal completely or her brain injury. He stated that surgery would not help these problems. His impression was that her spinal cord contusion was better on the MRI, but based on the continued symptoms, must be permanent. He also opined that some of the symptoms could be coming from her brain injury.

Petitioner underwent an anterior discectomy and fusion at C5-C6 and C6-C7 performed by Dr. Harm. Petitioner followed up post-operatively with Dr. Harm. On 9/15/10 she stated that she was not a whole lot better than she was before surgery. She stated that she was not having a lot of pain before surgery, but her spinal cord was not working right. He thought she had a myelopathy. He noted that the cervical fusion was performed to make room for her spinal cord. He told her before surgery that the surgery was good with helping with the pain and keeping her from getting worse, but does not always make patients better. She stated that her numbness was not better and her legs still did not work right. Petitioner's son told Dr. Harm that his mom was

walking better than she used to, but was not as good as she would like to be. Dr. Harm was of the opinion that petitioner did not get the results she expected from the surgery, but did get the expected results from his point of view. He recommended a repeat MRI to make sure there was no longer any pressure on her spinal cord. If none was seen, he recommended that she see a neurologist. If additional pressure was seen on her spinal cord, then additional surgery may benefit her. Dr. Harm's impression was status post anterior cervical disc fusion for myelopathy in a patient who quit progressing and is a little better, but not as good as she wants to be.

An MRI performed 10/7/10 showed she was well decompressed with post operative changes at C4, C5, and C6. Also noted was degenerative disc disease at C3-C4, C6-C7 and C7-T1. He referred petitioner to a neurologist.

On 1/21/11 petitioner's attorney sent a letter to respondent's attorney requesting vocational rehabilitation. On 1/26/11 respondent's attorney sent a response to petitioner's attorney denying his request for vocational rehabilitation stating that respondent was going to appeal the Commission's Decision on TTD, and he had never received any job search information from petitioner. He stated that he did not think the case as it stood at that time warranted any vocational rehabilitation. On 2/16/11 petitioner reported that she was not having any pain following her surgery.

Petitioner appealed the Commission's Decision and Opinion on Review to the Circuit Court. The Circuit Court affirmed the Commission's Decision and Opinion on review. Petitioner then appealed the Circuit Court's Order and on 4/17/12 the Appellate Court, Fourth Judicial District affirmed the Order of the Circuit Court.

On 5/1/12 respondent's attorney drafted a letter to petitioner's attorney informing him that respondent was not going to appeal the Decision of the Appellate Court, and instructed the respondent to issue petitioner a draft in the amount of $3,547.09, which was for the temporary total disability award plus interest due. He further requested that if he believed petitioner was entitled to ongoing maintenance and temporary total disability benefits that he should forward information that supports his claim. None was forthcoming until trial on 11/26/14.

On 7/9/12 respondent's attorney drafted another letter to petitioner's attorney requesting medical records to evaluate any ongoing temporary total disability exposure. He noted that petitioner's attorney had not made any demand for these benefits. He also requested petitioner's job search logs. Respondent's attorney offered $5,000 to resolve petitioner's claim. No job search logs were offered until 11/26/14.

On 7/16/12 Dennis Gustafson, a vocational rehabilitation consultant, drafted a vocational assessment report following a vocational assessment of petitioner at the request of the petitioner's attorney. Gustafson

reviewed information relative to a cervical spine injury on 1/14/06, and a face to face interview with the petitioner on 5/25/12. Petitioner reported that she had not worked since 1/14/06. Petitioner gave a history of a 10th grade education and a GED in 1985. She reported that the majority of her work had been in manufacturing related work. She also worked as a waitress, cook helper, and kitchen helper after high school and between factory jobs. She also worked for 2 years as a nurse assistant. Petitioner worked for 15 years for Brown Shoe Company where she performed a variety of tacking, gluing and other jobs related to the manufacture of women's shoes. She also worked 8 years in bindery work for RR Donnelley, and was a temporary employee at AMPAD. Petitioner reported that her symptoms had improved somewhat since her injury, but she continued to experience some residual nervous system effects. She complained of numbness in her hands and fingertips. She stated that she also had numbness in her feet that comes and goes. Petitioner stated that when she stands she experiences a tightening pain and when she sits for too long, her legs go to sleep making it difficult for her to get up. She stated that when bending over she gets light-headed and has to move slowly when changing positions. She stated that she was instructed not to drive for 4 years and when she resumed, did so on a limited basis and only short distances around town. She reported problems when turning her head while driving. Petitioner reported some difficulty with her hearing and has entirely lost her sense of smell. She stated that when walking, she looks down at her feet due to often time experiencing a tendency to trip. Gustafson relied on a physical therapy evaluation at Carle Therapy Service on 12/6/11. That assessment concluded a sedentary to light physical demand level, with sitting, standing, and walking tolerances each at 15 minutes, allowing the ability to alternate among all positions. Gustafson felt that these restrictions would normally be found only within office work activity and petitioner had no such work background, and no manufacturing or service jobs related to her work background could be productively performed given such a work requirement. He concluded that no jobs for which she might be considered based upon work history are capable of being productively performed by her given the assessed work restriction requirements.

Gustafson administered the Perdue pegboard due to reports of finger numbness. The scores suggested the likely inability to meet productivity standards for jobs emphasizing manual work activity of any kind. Gustafson opined that petitioner would be unable to productively perform any manual occupations at an adequate level of productivity sufficient to successfully maintain employment. He also opined that no manual jobs exist that would allow for equal opportunity to sit, stand, and walk during the work period and still meet productivity requirements. Given the nature of her work background, education, lack of personal computer knowledge, assessed physical limitations, age of 65, etc., he opined that no jobs, as normally performed, exist for which petitioner would be hired and within which she would be able to sustain the requisite productivity to maintain employment. He opined that petitioner is not competitively employable at this time.

On 10/18/12 the evidence deposition of Gustafson, vocational rehabilitation consultant, was taken on behalf of the petitioner. Gustafson opined that his decision was based on his examination of her and the restrictions in the physical therapy evaluation dated 12/6/11. Gustafson admitted that he did not speak to anyone at respondent about their productivity requirements. He did not know if vocational rehabilitation would benefit petitioner. He testified that petitioner gave him no indication that she looked for any work since the date of accident.

On 10/25/12 respondent subpoenaed petitioner's medical records and bills from Carle Hospital from 8/28/08 to present. Records were sent for the period 9/24/08 through 2/22/13. On 9/24/08, 10/8/08, 3/3/09, 4/29/09, 6/23/09, 8/6/09, 10/16/09, 6/4/10, 9/13/10, 10/18/10, 2/10/11, 2/17/11, 3/1/11, 3/31/11, and 1/17/13. petitioner presented to Dr. Vassay for conditions unrelated to her head or neck. She was treated for COPD, allergies, skin lesion, skin irritation by mouth, chest pain, shortness of breath, bronchitis, obesity, hyperlipidemia, hypothyroidism, colon polyps, diverticulosis coli, history of smoking, gastritis, chronic constipation, numbness in fingers and toes, infected right index finger, B12 deficiency, elevated cholesterol, sleeping problems, restless leg syndrome, and GI problems. On 11/16/09 Dr. Vassay ordered an MRI of brain due to recent numbness complaints in her right hand. It was not authorized by her insurance. An EMG of the right upper extremity was normal. There were no further references to the brain in any other of Dr. Vassay's records. Petitioner did finally undergo the MRI of the brain on 3/31/10. The impression was bifrontal traumatic encephalomalacia involving the left olfactory cortex, likely accounting for petitioner's anosmia. No acute intracranial abnormality was noted. Mild cerebellar atrophy was noted, as well right superior ophthalmic vein varix. These findings were unchanged from the MRI of the brain performed in 2000. On 3/3/10 petitioner also underwent an MRI of the cervical spine. The impression was increased size in C7-T1 right foraminal disc protrusion resulting in moderate foraminal stenosis; stable moderate C5-C6 and mild-moderate C4-C5 central spinal canal stenosis; stable severe left C5, severe bilateral C6, and moderate to severe bilateral C7 foraminal stenoses; and stable myelomalacia at the C5 level. On 10/7/10 petitioner underwent an MRI of the cervical spine. The impression was intercal C4-C6 anterior fusion; stable subtle cord signal abnormality, probably gliosis; improved thecal sac narrowing at C4-C5; moderate thecal sac narrowing at C5-C6 similar to the previous study; and mild progression of the thecal sac narrowing at C6-C7.

On 2/1/13 the petitioner underwent a Section 12 examination performed by Dr. Van Fleet, at the request of the respondent. In a letter dated 1/17/13 respondent's attorney noted that prior to her cervical spine surgery petitioner had stopped seeing Dr. Wright as of 5/24/07, and did not resume treatment at Sarah Bush Lincoln Health Center until 4/23/09 when she complained of unrelated problems, and then did not seek any treatment

until she complained of numbness in her right upper extremity on 10/28/09 and had a nerve conduction study that was normal. Dr. Van Fleet took a history from petitioner and performed a physical examination. Dr. Van Fleet also performed a record review that included MRIs and x-rays of petitioner's cervical spine. Dr. Van Fleet noted that he had previously examined petitioner in 2006 and recommended at that time that petitioner undergo a C4-C5 and C5-C6 anterior cervical discectomy and fusion with anterior cervical plating for her cervical spinal stenosis. He opined at that time that petitioner had sustained a central cord type syndrome following the fall, but had in fact stabilized at the time of his examination in 2006. He opined that the surgery would be necessary to prevent her from deteriorating as far as her neurologic status better, but would not necessarily be inclined to make her neurologic status better, hence the rationale for labeling her at maximum medical improvement.

Petitioner told Dr. Van Fleet that she underwent surgery by Dr. Harm on 6/10/10 and it seemed to help with some of her upper extremity symptoms. She stated that she had no problems following the operation. Petitioner told Dr. Van Fleet that she was not working and had retired when she turned 66 years old. She told him she had no intention of returning to work. She stated there was a delay in obtaining the surgery due to the appeals following the Arbitrator's Decision on 12/29/08. Petitioner reported that she was not having any level of pain and did not require any kind of pain medication. Her physical examination revealed rotation of the neck 70 degrees bilaterally, flexion to her chin and chest, extension of her neck to 30 degrees, symmetric range of shoulders, symmetric reflexes at the biceps, brachioradialis and triceps, negative Hoffman's sign bilaterally, and no difficulty with rapid alternating movements in the upper extremities.

Dr. Van Fleet's diagnosis was post cervical spinal fusion secondary to cervical spondylotic myelopathy and central cord syndrome. He opined that petitioner has a stable prognosis. He did not believe petitioner was restricted in terms of returning to full duty work. He noted that she would generally be restricted based on her age and a normal geriatric work-related program, and could work light duty. He opined that her current condition of ill-being is not causally related to her employment. He further opined that petitioner did not have any permanent impairment as a result of the injury at work and she did not demonstrate any significant abnormalities on her physical examination. He opined that petitioner reached maximum medical improvement from the fall on 7/14/07.

On 1/7/13 the evidence deposition of Dr. Harm, an orthopedic spine surgeon, was taken on behalf of petitioner. He testified that it was hard to tell how much of petitioner's problems were coming from the brain, the contusion to the cervical spinal cord that surgery could not help, and how much might be coming from the pressure on her nerves or cervical spine. Dr. Harm testified that a cord signal change can get better, stay the same or get worse after an accident. With respect to petitioner he testified that it had not gotten worse after the

injury. He opined that the stenosis in her cervical spine was not made worse by the injury. Dr. Harm testified that before the injury petitioner had disc bulging with spurs at the disc margin from the front of the spine narrowing the spinal cord, and had arthritic spurs from the back of the spinal cord growing forward narrowing the space available for the spinal cord before the injury on 1/14/06. Dr. Harm could not opine when petitioner reached maximum medical improvement would it have been from the accident and the underlying condition. Dr. Harm could not opine if petitioner's symptoms after the surgery were related to the fall or other causes in the neck or elsewhere that could be causing the symptoms. Dr. Harm testified that he could not relate the claimed brain injury to the fall on 1/14/06. Dr. Harm testified that he treated petitioner in 2003 for degenerative changes in her lumbar spine. He believed she had degenerative disc disease, arthritis, and probably neuritis or something going on with the nerves themselves. He testified that he suspected that the symptoms she was having in 2003 with respect to her legs could have been coming from the irritation of the spinal cord in the neck. At that time, he thought there might be something going on systemically and she should see a neurologist. Dr. Harm placed no restrictions on petitioner when he was last examined her on 9/15/10. He stated that from the time of surgery to the time of healing he restricted her to lifting no more than 10-15 pounds. Dr. Harm could not opine whether or not petitioner's symptoms post surgery were coming from her spine or her abnormal brain.

On 1/18/13 the deposition of Mark Masse, PT, DPT, was taken on behalf of respondent. Masse has a doctorate in Physical Therapy. Masse performed a functional abilities assessment of petitioner on 12/6/11. Following his physical assessment he opined that petitioner could sit, stand and walk for 15 minutes at a time, with the ability to alternate from sit, stand and walk within these limits. He placed petitioner in the sedentary to light physical demand level with these noted restrictions. Masse testified that missing 4 of 12 physical therapy sessions post surgery would indicate that the petitioner was not compliant. He also testified that a FCE is more comprehensive than the exam he performed. Masse noted a slight inconsistency in her testing.

On 2/13/13 the evidence deposition of Dr. Harry Bremer, a physician whose practice is limited to adult neurology, was taken on behalf of the petitioner. On 2/3/10 Dr. Bremer examined petitioner. He noted that it was somewhat difficult to obtain a straightforward history, but he believed everything dated back to the fall on 1/14/06. He reviewed none of petitioner's medical records. Petitioner stated that she could not smell since the accident and has had fairly persistent numbness in her hands and ulnar side of her forearms, right worse than left. She also complained of numbness in her legs and difficulty walking, and restless sleep. Post examination, his impression was bilateral hand paresthesias that might be secondary to the spinal cord trauma/contusion from the fall; inability to smell (anosmia) from closed head injury in January of 2006; concerns for gait abnormality. On 4/12/10 petitioner returned to Dr. Bremer. He reviewed the MRI of the brain and cervical spine from

3/31/10. His impression was status post fall with bifrontal encephalomalacia; and cervical spine cord myelomalacia (shrinkage of the spinal cord) at C5 level. He believed these findings were permanent and related to her fall. He believed the anosmia was most likely due to a shearing of nerve fibers at the cribiform plate.

Dr. Bremer believed that the MRI of the brain from 3/31/10 did not show any findings to account for her gait or walking difficulties, but were consistent with her inability to smell. He believed head trauma is a known cause for loss of smell. He testified that hitting the back of the head can cause brain trauma to the front portion of the brain. Dr. Bremer testified that when he saw petitioner subsequent to the surgery on 6/10/10 petitioner told him that she felt that her walking was improving, and he noted that she had a normal gait and her walking was grossly normal. Dr. Bremer testified that if petitioner fell in 2007 and had a head trauma that could possibly contribute to her walking or balance issues if it was severe enough. Dr. Bremer agreed that the MRI of the cervical spine on 5/22/07 showed the cord contusion was much improved and less prominent than the exam on 2/21/06. He also agreed that the MRI of the cervical spine on 3/31/10 noted "previously noted intramedullary T2 signal abnormality at the C5 level is considerably less conspicuous compared to studies dating back to February of 2006". Dr. Bremer opined that in the records presented to him there was no diagnosis of a brain injury immediately following the accident, and he was the first to diagnosis her with a brain injury 4 years after the accident. He testified that cerebellar atrophy means it was of an indeterminant age and of uncertain significance clinically. Dr. Bremer opined that chronic sinusitis and smoking can affect a person's perception of their ability to smell and petitioner had prior reports of chronic sinusitis and is a smoker. Dr. Bremer then reviewed an MRI of the brain taken in March of 2000 and noted that the findings were similar to those on the MRI of the brain after the fall. Dr. Bremer opined that petitioner's cord contusion is due to her fall and the cervical spine stenosis can be a contributing factor to have worsened her cord contusion. Dr. Bremer opined that numbness in the hands and forearms would be related to a cord compression at C4-C5. He could not opine that her other difficulties with numbness in her legs, walking troubles, and bladder symptoms were related to the cord compression at that level or to other unrelated factors. He testified that bowel and bladder function, and walking issues can be related to lumbar spine findings, and her lumbar spine condition is not related to the injury on 1/14/06. Dr. Bremer offered no opinion on petitioner's ability to work.

On 7/3/13 the evidence deposition of Dr. Van Fleet, an orthopedic surgeon, was taken on behalf of respondent. Dr. Van Fleet opined that petitioner sustained a spinal cord contusion as a result of accident on 1/14/06, but when he examined petitioner on 2/1/13 she was essentially symptom free and not restricted in terms of returning to work based upon his examination, other than her age and her federal government benefit status.

On cross examination Dr. Van Fleet opined that petitioner had degenerative changes in her back prior to her injury. He opined that central cord syndrome typically will affect the upper extremities more than the lower extremities. Dr. Van Fleet opined that when petitioner fell her preexisting myelopathy became clinically apparent. Dr. Van Fleet reviewed Dr. Masse's tests and did not agree with them. He stated that anyone categorized with a motor strength of 2 over 3 out of 5 could not possibly walk through the door, and petitioner clearly could. Dr. Van Fleet testified that petitioner had a normal gait in the office and the hallway when he examined her. Dr. Van Fleet testified that motor strength testing has a subjective component to it. Dr. Van Fleet was of the opinion that clinical myelopathy is something that people are very functional with, and he has seen people do a lot heavier activities than petitioner did for respondent with a fairly significant spinal cord compression.

On 7/29/13 Bob Hammond, a Vocational Consultant with Hammond Vocational Consultants drafted a Vocational Report with respect to petitioner at the request of respondent. Hammond performed a labor market research. He looked for positions in the light and sedentary categories. He had information that petitioner had a 10th grade education with a GED completed in 1985. He also took into account that petitioner had performed manufacturing related work, food service as a waitress and cook's helper, and 2 years as a nurse's assistant. Hammond developed a list of 15 employment opportunities based on this information. The positions paid from $8.35 to $10.50 an hour.

On 8/6/13 respondent's attorney drafted a letter to petitioner's attorney. Attached was the Vocational Report of Bob Hammond. He requested that petitioner apply for the jobs listed therein. He also requested that petitioner's attorney forward evidence of the petitioner's job searches, including the name of the people she spoke with.

On 10/11/13 the evidence deposition of Bob Hammond, was taken on behalf of respondent. Hammond testified that at the time he performed the research into the labor market, there were a number of positions that were available within the parameters respondent provided, in the Charleston/Mattoon labor market area. He testified that some of the 15 positions he identified were entry level positions and required no high school education of experience. Based on the wages he identified for the 15 jobs he found he opined that petitioner had not suffered any wage loss on account of her prior job versus the jobs she could now obtain since she was making approximately minimum wage at the time of the injury and she could make minimum wage today. He further opined that some of the 15 jobs offered wages above minimum wage. Hammond testified that Purdue Pegboard Test was not relevant to the jobs he identified or her job for respondent. He further opined that if

petitioner is retired, on Medicare and has no intention of returning to work, then that motivation interferes with her ability to get out there and look for work on a regular basis.

On cross-examination Hammond testified that he did not specifically take Dr. Masse's restrictions and opinions into consideration when performing his labor market survey, but did assume petitioner could work at the light and sedentary categories. Hammond testified that if petitioner scored below the 1 percentile ranking for fine finger dexterity, the she could do absolutely no fine finger dexterity activities, including buttoning a shirt or pants, tying shoes, starting a car, or operating a key, etc., and would not have been able to finish the test, which she did, and it would have been invalid.

On 3/28/14 respondent's attorney drafted another letter to petitioner's attorney. He noted that they had spoken and petitioner's attorney noted that petitioner was recently seen by Dr. Skaletsky. He requested the report. He also noted that petitioner's attorney had stated that petitioner was in the process of completing job searches. He requested that petitioner's attorney forward him the job searches. Petitioner did not offer an job search records until the trial on 11/26/14 .

On 4/15/14 petitioner presented to Dr. Chen. She reported that after her surgery she slowly recovered and believed she was doing better with walking pretty independently, although with complaints of memory issues and loss of smell sensation. She reported that over the last few months she has had more difficulty walking, and was more wobbly. She reported that the weakness was more generalized including arms and legs. She stated that her memory was about the same as before. Dr. Chen ordered an MRI.

On 5/8/14 the evidence deposition of Dr. Skaletsky was taken on behalf of the petitioner. Dr. Skaletsky performed a Section 12 examination of petitioner on 4/1/14. Following an examination and record review Dr. Skaletsky's impression was that petitioner sustained a brain injury with resultant post-concussive syndrome and cervical spine cord contusion with resultant cervical myelopathy as a result of the fall on 1/14/06. He recommended outpatient head injury rehabilitation and programs, adaptive devices and assistance with activities of daily living for the brain injury. He agreed that the purpose of the spinal surgery was to prevent further spinal cord injury. Dr. Skaletsky believed no further treatment was necessary. He opined that petitioner's preexisting degenerative disc and joint disease of the cervical spine were asymptomatic prior to the injury on 1/14/06. He admitted that he reviewed no medical records before the accident. He opined that the fall caused a cord contusion with edema and subsequent spinal cord signal change. He opined that petitioner was not a candidate for competitive employment at any work level based on the opinions of Masse and Gustafson, and his examination, and this opinion is related to the fall. Dr. Skaletsky opined that petitioner did not sustain an injury to her lumbar spine as a result of the injury on 1/14/06, but her difficulty with walking is not related to the

lumbar spine. He also opined that her current neurologic state of dysfunction as it relates to the brain and spinal cord is related to the fall on 1/14/06. He based this on her post accident symptoms. He opined that petitioner reached MMI in the middle of 2007.

Dr. Skaletsky, a neurosurgeon, testified that in no other records before his does petitioner complain of memory deficits. He stated that he was the first one to take that history 8 years after the injury. He based his causal connection totally on petitioner's history that her problems started after the accident. Dr. Skaletsky admitted that the objective evidence of the MRI of the brain before the injury and after the injury were the same and explains her loss of smell. He opined that loss of taste and smell are closely related and she was probably experiencing loss of smell in 2000. Dr. Skaletsky admitted that he had no objective evidence by way of testing to confirm her claim of memory loss. He opined that there were no acute findings of any acute injury of the brain on any of the brain imaging studies, and based his finding on petitioner's history. Dr. Skaletsky opined that memory loss can be associated with growing older. He admitted that petitioner, during her first arbitration, was able to testify as to her symptoms and the doctors she had seen post accident. Dr. Skaletsky opined that petitioner's symptoms were consistent with cord dysfunction below the level of C4-C5, and admitted that petitioner's cord contusion was at C5. Dr. Skaletsky admitted after seeing diagnostic tests for petitioner's cervical spine prior to the injury that petitioner had cervical complaints including cervical radiculopathy that date back to at least the 1990's, and that she sustained some prior neck trauma or cervical sprain. He also admitted, after reviewing petitioner's medical records before the injury, that petitioner had other conditions before the injury not related to the injury, such as heart problems, smoking and lumbar spine problems. Dr. Skaletsky testified that chronic smoking can hasten the degenerative process in both the lumbar and cervical spine. Dr. Skaletsky agreed that following the emergency room visit after the injury and the IME by Dr. Van Fleet in March of 2006, petitioner did not seek any further medical treatment until she presented to Dr. Harm a year later and gave a history of taking a spill. He admitted that during the period between the accident and when she saw Dr. Harm due an unrelated fall, that she had improved, and then deteriorated after the unrelated fall. Dr. Skaletsky agreed that petitioner may have had some kind of trauma to her head that required the MRI of the brain in 2000.

On 5/9/14 petitioner underwent an MRI of the cervical spine. The results showed a new grade I anterolisthesis at C2-C3, a new moderate left foraminal marrowing, and new severe left C2-C3 facet arthrosis. The finding of no abnormal bright STIR signal within the left pedicle and pars of C2 was identified as nonspecific, and could potentially reflect a stress reaction or marrow edema related to progressive arhtrosis of the left C2-C3 facet.

On 5/12/14 petitioner also underwent an MRI of the thoracic spine. The impression was degenerative disc disease with Schmorl's nodes at T10-T11 and T11-T12 levels with a small T11-T12 central disc protrusion. An MRI of the lumbar spine taken the same day revealed moderate to severe thecal sac narrowing at L4-L5, moderate bilateral foraminal narrowing at L5-S1; left paracentral and foraminal disc protrusion at L3-L4 narrowing the left subarticular recess and left neural foramen; and grade I retrolisthesis at L2-L3 and L5-S1.

On 5/20/14 petitioner complained to Dr. Chen of a lot of low back pain and some intermittent neck pain.

On 6/16/14 petitioner underwent a Section 12 examination performed by Dr. Michael Oliveri, Ph.D., a psychologist with a specialty in clinical neuropsychology, at the request of the respondent. The evaluation consisted of a clinical interview, formal neuropsychological testing, review of available medical records, and collateral interview with petitioner's daughter. Dr. Oliveri noted in the EMS record dated 1/14/06 that there was a history of a fall one year ago with "with loss of loc". Petitioner reported that she was diagnosed with AFib two weeks ago. Her current complaints were ongoing struggle with low back pain in the lumbar region. She perceived short-term memory problems, and diminished handwriting quality. Her mood was stable. She stated that at times she feels mildly dysphoric. Petitioner's daughter indicated that petitioner has good and bad days as it relates to memory. She stated that since 2006 her cognitive problems seemed to be getting worse. She stated that petitioner struggles with persisting pain and had been diagnosed with COPD. She also reported fitful sleep and nightmares. Petitioner described a history of heavy drinking and characterized herself as a "weekend drinker". She stated that she elected to discontinue on her own 10-15 years ago.

Following a neuropsychological examination and testing Dr. Oliveri assessed nearly normal neurocognitive profile. He was of the opinion that petitioner's neuropsychological assessment results included some features of problematic validity. His impression was that her objective test performance reflected a general preservation of new learning, memory, information processing, perceptual-spatial, and executive functions. Her verbal linguistic skills were within normal range capacity. Overall, Dr. Oliveri was of the opinion that petitioner's profile was not diagnostic of residual acquired brain-behavior dysfunction referable to the 1/14/06 injury. He was further of the opinion that her variable performance on verbal fluency measures could well be a late-effect of remote inferior/mesiofrontal injury as documented per serial imaging in 2000 and 2010. As it relates to her subjective memory complaints, Dr. Oliveri was of the opinion that the results do not provide an objective foundation for residual compromise. Overall, he was of the opinion that she was doing relatively well from a brain-behavior prospective despite cerebrovascular risk factors.

Dr. Oliveri also assessed Somatoform Disorder NOS, wherein psychological/stress factors are contributing to the development, maintenance, and/or exacerbation of somatic/cognitive symptoms. He opined that this coping style is not referable to a known illness or injury such as the 1/14/06 injury.

Dr. Oliveri found it significant that the 2000 brain imaging was positive for ventral/mesial frontal lobe injury. He noted that chronic anosmia is a common correlate of such neuropathology. He was further of the opinion that such bifrontal encephalomalcic change is correlated with pre-existing traumatically induced moderate-severe acquired brain injury that predated the 2000 brain MRI. Dr. Oliveri opined that as a result of the 1/14/06 injury petitioner sustained a mild concussion and she did not require any management for cerebral concussion during the initial post injury epoch. He opined that in light of the severity, a good outcome would be anticipated with a return to baseline within a matter of weeks to months. Dr. Oliveri opined that with respect to the 2006 injury, residual acquired brain-behavior dysfunction was not confirmed, and he had no recommendations for any sort of neuropsychological intervention or neuro-rehabilitation. He opined that the personality and cognitive changes being referenced in 2014 are not specific to the injury in 2006 or its severity, nor do the medical records support them. Dr. Oliveri opined that concussive symptoms are maximal in the immediate post trauma period, followed by a progressive improvement and then a plateau. He noted that this is not consistent with petitioner's daughter's history that petitioner's cognitive symptoms were worsening over time. Dr Oliveri opined that from a neuropsychological perspective there are (a) no indications of a residual condition, (b) no restrictions, and (c) no indications that petitioner suffered neuropsychological impairment related to the injury on 1/14/06.

On 7/1/14 petitioner presented to Dr. Johnson. She complained of back pain radiating down her legs bilaterally to her knees. She rated her back pain as a 5/10. Dr. Johnson reviewed an MRI of the lumbar spine performed 4/5/14 that showed multilevel degenerative disc disease, minimal at L2-L3; loss of disc height and signal at L3-L4; left paracentral foraminal protrusion at L3-L4; L4-L5 loss of disc signal and height, moderate to severe spinal stenosis; and grade I retrolisthesis, small annular tear and left paracentral disc protrusion at L5-S1. A complete review of her systems was performed by Dr. Johnson and was normal. No atrophy of the lower extremities was noted and her sensation was intact to light touch bilaterally. Petitioner was also able to come to toe tip position. Her impression was lumbar spondylosis with spinal stenosis and radicular symptoms. Dr. Johnson recommended physical therapy, chiropractic care, and L4-L5 injections.

On 10/1/14 the evidence deposition of Dr. Oliveri was taken on behalf of respondent. Dr. Oliveri opined that it was significant that petitioner had neurologic symptoms in June of 2000 including a change in her taste that resulted in a brain scan being performed that was significantly abnormal, and showed tissue that was soft

and degraded in quality, involving the undersurface of the frontal lobes, greater on the left side but also involving the right. He opined that such a finding is often correlated with head trauma, and Dr. Monippallil in May of 2013 made reference to a history of a skull fracture. Dr. Oliveri opined that it was significant that the brain scan performed right after the injury on 1/14/06 was negative for any abnormality, and that petitioner gave a history of falling a year prior. He opined that her Glasgow coma score of 13 to 15 and her negative head CT were indicative of a mild concussion on the date of injury. Dr. Oliveri found it significant that the findings on the brain MRI in 2010 were similar to those on the brain scan performed in 2000. Dr. Oliveri opined that loss of taste can exist following a traumatic brain injury and petitioner had these complaints following her brain MRI in 2000.

Dr. Oliveri opined that the mini mental status examination Dr. Skaletsky performed on petitioner in April of 2014 is simply a screening of basic cognition, and not used for diagnostic purposes 8 years post-trauma to diagnose residual acquired neurocognitive dysfunction. He was of the opinion that this brief screening lacks sensitivity and specificity in coming to a conclusion that there was a relationship between petitioner's change in personality and that the irritability in 2014 were referable to her injury on 1/14/06. Dr. Oliveri opined that atrial fibrillation reflects a cardiovascular and cerebrovascular risk factor for cognitive dysfunction. He also opined that the medications she takes for her blood pressure and cholesterol are also cerebrovascular risk factors. He stated that these conditions put a person at a higher risk for cognitive change that exceeds normal aging. He also noted that petitioner was taking an anti-depressant. Dr. Oliveri was of the opinion that people with chronic back pain can have cognitive complaints, absent a head trauma. Dr. Oliveri opined that varying memory loss is also associated with aging, and as one moves from the 40's to the 50's and to the 60's, there is measurable change that can be detected in the testing. He also opined that alcohol can prematurely age the brain and lead to cognitive problems, especially if it's a dependent alcohol pattern over the course of decades.

Dr. Oliveri noted that petitioner was generally alert and attentive and exhibited normal orientation during her testing. He noted that she was not grossly confused and tolerated the tests quite well. He did note that petitioner was fairly self critical throughout the tests, often commenting she did not feel she was doing well, when in fact that may not have been the case. Dr. Oliveri noted an inconsistent level of performance during the testing of the verbal fluency which was consistent with the areas where she had an abnormality on the brain scan in 2000. All other areas tested were within the formal parameters. Dr. Oliveri noted that petitioner reported remote memory problems that are not typical acquired memory problems after a mild concussion. He opined that if she suffered a concussion after the accident on 1/14/06, the symptoms had resolved. Dr. Oliveri opined that petitioner's current symptoms as they relate to petitioner's personality and cognitive change, are not specific

to the 2006 injury, but are the kind of changes most likely due to the kind of abnormality that was demonstrated on the 2000 scan of her brain. Dr. Oliveri opined that the normal CT scan following the injury showed no indication of brain swelling, or bleeding. Dr. Oliveri was of the opinion that petitioner did not provide full effort during the testing which reflects poorly on her credibility.

On cross examination Dr. Oliveri agreed that there was a laceration on the back of her head after the fall in 2006, and a normal CT, and that is why he assessed a mild concussion at that time. Dr. Oliveri noted that Dr. Harm did not assess a brain injury, but thought that some of her symptoms could come from a brain injury. He also noted that Dr. Skaletsky concluded that some of petitioner's symptoms could have come from a brain injury. However, he denied her symptoms could have come from a brain injury related to the injury on 1/14/06. Dr. Oliveri testified neuropsychology focuses on the brain function, and the rehabilitation of the brain dysfunction. Dr. Oliveri opined that petitioner's post-injury cognitive disturbances, memory defects, and personality changes are not a result of a brain injury petitioner may have sustained on 1/14/06. Dr. Oliveri opined that petitioner does not have cognitive disturbances. He opined that any personality changes petitioner has are not related to the accident on 1/14/06, but could be related to an injury suggested by the 2000 brain scan.

Respondent offered into evidence the report of an MRI of the brain performed on 6/20/00 that was performed because petitioner reported a change in taste and sensation under the chin. The impression was focal encephalomalacia of the inferior frontal cortex bilaterally, greater on the left. Also noted was an area of cortical loss involving the right frontal lobe adjacent to the falx of the upper convexity. The findings suggested the possibility of a previous head trauma. Respondent also offered into evidence a Department of Orthopedics report for petitioner from 5/5/03. Petitioner's major complaint at that time was right leg symptoms, mostly numbness for 3-4 weeks. She stated that it felt like bugs crawling across her leg when she reclines. She also reported some back pain. She reported that she had a history of a skull fracture. An MRI reviewed at that time showed degenerative disk disease and a bit of facet arthritis and a bulge at L3 or L4 which would not explain her symptoms. Petitioner was assessed with a neuropathy or neuritis and referred to a neurologist. Petitioner was also diagnosed with a back that was aging before its time. Petitioner was instructed to stop smoking and exercise. Petitioner also reported muscle spasms throughout her body and Dr. Harm was of the opinion that there could be something going on systemically. In August of 2003 Dr. Harm was of the opinion that petitioner's EMG studies suggested a possible early peripheral neuropathy. On 5/22/07 petitioner underwent an MRI of the lumbar spine that was compared to an earlier exam dated 4/28/03. It revealed that the generalized disc bulging at L4-L5 was much more prominent with the interval appearance of at least mild spinal stenosis at this level. On 5/22/07 petitioner also underwent an MRI of the cervical spine. The impression was disc disease

in the cervical spine most prominent at C5-C6; broad based disc bulging at C4-C5 resulting in neural foraminal narrowing greater on the left with at least mild spinal stenosis; moderate spinal stenosis with bilateral neural foraminal narrowing at C5-C6; right neural foraminal narrowing at C7-T1, slightly greater; mild edema and/or myelomalacia of the spinal cord at C4 and C5, slightly compared to the MRI on 2/21/06.

Prior to working for respondent petitioner worked in various production and manufacturing positions over the years. She also worked at Brown Shoe in a shoe manufacturing position and did bindery work at RR Donnelley.

Petitioner offered into evidence a list of 67 positions she applied for from 10/15/13 through 11/24/14. She listed the location of the company and position she applied for. She did not identify who she directed the application to, did not include any of her applications, or responses she received from any of these potential employers. She also never presented this list to respondent before trial on 1/26/14, despite multiple requests for the same from respondent in years past.

Petitioner also entered into evidence a video of herself walking on 8/14/14. The video is approximately 3 minutes long and shows the petitioner taking her dog for a walk on uneven terrain. Petitioner is seen walking with a normal gait, albeit slower on the uneven terrain. The petitioner did not appear to be in any distress.

Petitioner testified that she has 85% numbness all over her body, with most of the numbness in her legs, feet and hands. She stated that she cannot raise her little finger on the right hand when extended. Petitioner, who was diagnosed with neuropathy prior to the accident, testified that she cannot feel the floor when she walks. Petitioner testified that she does not walk straight, and wobbles. She testified that her knees, lower back and hips hurt when she walks. Petitioner is still smoking. She reported pain in her neck, knees and low back. She stated that when she walked to her sister's house 6 blocks away she stopped twice along the way due to breathing problems. Petitioner has COPD, obesity, hypothyroidism, low B12, urinary incontinence, high cholesterol, and anemia. Petitioner reported difficulty hooking her bra in the back due to the numbness in her hands. Petitioner does not feel she can return to any work. Petitioner has a valid driver's license without any restrictions. Petitioner testified that she has self imposed restrictions.

Petitioner's sister Virginia Leonard testified on behalf of petitioner. She testified that petitioner moved in with her after her husband died 2008 so she would not be alone. She stated that she does most of the work around the house. She testified that petitioner does not sweep, do dishes, mop floors, or do laundry. She testified that petitioner gets unsteady and her walk has changed since 2006. She claims she noted memory problems in petitioner a year after the accident, in 2007.

Petitioner's daughter, Terra Sanders, testified on behalf of the respondent. She stated that petitioner's physical being deteriorated extremely after the accident. She reported that she noticed problems with standing, walking, topical numbness, and doing activities of daily living She also noted that she observed petitioner's mental capacity diminishing since the accident. She noted that petitioner must stop regularly when walking due to breathing difficulties. Sanders testified that petitioner had no problems before the injury on 1/14/06. She stated that she helped her mother complete online applications for jobs, which did not begin until 10/15/13. She admitted petitioner had low back problems before the accident.

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

Brain Injury

The issues of causal connection, temporary total disability and prospective medical expenses were raised at the 19(b) hearing on 8/27/08. Petitioner had alleged an injury to the back of her head, neck and bulging disc on her Application for Adjustment of Claim filed 2/21/06, and made no amendments to that prior to the trial on 8/27/08.

Arbitrator Mathis found that petitioner sustained an accidental injury on 1/14/06, and that her current condition of ill-being is causally related to the injury on 1/14/06. The arbitrator also awarded petitioner temporary total disability benefits from 5/3/08-8/27/08, and directed respondent to pay for the surgical procedure recommended by Dr. Wright. On 4/5/10 the Commission modified the Decision of the Arbitrator in part, and affirmed and adopted the remainder. The Commission noted that the Arbitrator found the petitioner suffered a spinal cord injury as well as soft tissue injuries in her left lower neck as a result of the injury. The Commission noted petitioner had complaints of discomfort in the neck and arms that consisted of pain in her neck and numbness and tingling in both arms, as well as complaints of difficulty walking, including a lack of strength in her legs. The Commission affirmed the Arbitrator's award of temporary total disability and found medical expenses incurred treating petitioner were reasonable and causally related to the accident. The Commission also found petitioner had not yet reached maximum medical improvement based on petitioner's ongoing complaints that had commenced contemporaneously with the accident and had persisted since. The Commission also reversed the Arbitrator's ruling with respect to the surgery recommended by Dr. Wright. The Commission held that the surgery was not causally related to the petitioner's accident on 1/14/06. The Circuit Court affirmed the Commission and on 4/17/12 the Appellate Court affirmed the Commission's Decision.

Petitioner is now alleging a brain injury as a result of the accident on 1/14/06. Petitioner did not claim this injury on her Application of Adjustment of Claim filed 2/21/06, did not amend her Application for Adjustment of Claim at trial, and did not present any evidence of a brain injury during the trial on 8/27/08. In support of this

claim petitioner offered into evidence the report of Dr. Harm who examined her on 5/3/10. Dr. Harm could not opine if petitioner's symptoms were coming from her spinal cord contusion, which had not completely healed, or her brain injury. This is the first reference in any of the medical records to a brain injury following the injury on 1/14/06. Dr. Harm referred petitioner to a neurologist. Dr. Harm testified that it was hard to tell which symptoms were coming from the brain, the spinal cord contusion, or the compression on the nerves of the cervical spine. He opined that he could not relate the claimed brain injury to the fall on 1/14/06.

On 11/16/09 Dr. Vassay ordered an MRI of the brain due to "recent" numbness complaints in her right hand. However, there was no reference to any brain injury. The MRI of the brain was performed on 3/31/10 and showed bifrontal traumatic encephalomalacia involving the left olfactory cortex, likely accounting for petitioner's anosmia. Also noted was mild cerebellar atrophy and right superior ophtalmic vein varix. The arbitrator notes that these findings were the same as those on the RI of the brain performed in 2000.

Petitioner was examined by Dr. Bremer, a neurologist. Based only petitioner's history, and no review of any of petitioner's medical records, he believed all petitioner's symptoms dated back to the injury on 1/14/06. He admitted that he did not review any of petitioner's treatment records. However, when crossed examined during his deposition Dr. Bermer opined that if petitioner had a fall in 2007 and had a head trauma, that could possibly contribute to her walking or balance issues, if it was severe enough. The arbitrator finds there is credible medical evidence to support a finding that petitioner did fall in 2007, and landed on her face. After reviewing petitioner's records, Dr. Bremer opined that the records showed no diagnosis of a brain injury immediately following the accident on 1/14/06, based on the fact that a CT scan of the brain taken after the injury was normal. He testified that he was the first person to diagnosis a brain injury 4 years after the injury. During his deposition Dr. Bremer had the opportunity to review an MRI of the brain petitioner underwent in 2000. He noted that the findings on that MRI were similar to those shown on the MRI taken 3/31/10.

Petitioner also had Dr. Skaletsky examine petitioner on 4/1/14. Prior to his examination of petitioner he also admitted that he did not review any of her treating records and admitted that all his findings were based on the history petitioner provided him. However, after Dr. Skaletsky had the opportunity to review petitioner's treating records, both before and after the injury on 1/14/06, he opined that petitioner never complained of any memory problems before presenting to him 8 years after the injury. After reviewing the MRIs of the brain in 2000 and 2010 Dr. Skaletsky was of the opinion that the findings on both were the same and explained her loss of smell. He opined that loss of taste and smell are closely related and she was probably experiencing loss of smell in 2000. He opined that there is no objective evidence by way of testing to confirm petitioner's claimed memory loss. He was also of the opinion that memory loss can be associated with growing older and that

petitioner was about 68 when he examined her. Dr. Skaletsky opined that petitioner may have had some kind of trauma to her head that required the MRI of the brain in 2000. The arbitrator notes that petitioner had provided a history of a skull fracture before the accident on 1/14/06.

On 6/16/14 petitioner was examined by Dr. Oliveri. While performing a record review he noted that in the EMS record dated 1/14/06 there was a history of a fall with loss of consciousness a year prior. Petitioner's daughter stated that her mom had good and bad days as they relate to her memory. She stated that her cognitive problems seemed to be getting worse since 2006. However, the arbitrator finds there is no evidence to support this claim in the medical records until she presented to Dr. Skaletsky in 2014. He opined that petitioner's profile was not diagnostic of residual acquired brain-behavior dysfunction referable to the 1/14/06 injury. He further opined that her variable performance on verbal fluency measures could well be a late effect of remote inferior/mesiofrontal injury as documented on the 2000 MRI of the brain, which was unchanged on the 2010 MRI of the brain. Dr. Oliveri opined that it is significant that the 2000 MRI of the brain was positive for ventral/mesial frontal injury, and chronic anosmia is a common correlate of such neuropathology. He further opined that such bifrontal encephalomalcic change is correlated with pre-existing traumatically induced moderate-severe acquired brain injury that pre-dated the 2000 brain MRI. Dr. Oliveri also found it significant that the brain scan performed right after the injury was negative for any abnormality, and that the petitioner had given a history of falling a year prior. He opined that all diagnostic tests confirm that all petitioner sustained with respect to her head following the injury on 1/14/06 was a mild concussion. Given that petitioner had given a history of heavy drinking before discontinuing alcohol 10-15 years ago, and was 68 year old at the time of the injury, Dr. Oliveri opined that varying memory loss is also associated with aging and alcohol use can prematurely age the brain and lead to cognitive problems, especially if it is a dependent alcohol pattern over the course of decades.

The arbitrator finds it significant that Dr. Oliveri noted an inconsistent level of performance during the testing of the verbal fluency that was consistent with the area where petitioner had an abnormality of the brain scan in 2000. All other areas tested were within formal parameters. He noted that the remote memory problems petitioner reported were not typical acquired memory problems following a mild concussion, which is all he opined petitioner sustained on 1/14/06. He opined that petitioner's current symptoms as they relate to her personality and cognitive change, are not specific to the 2006 injury, but are the kinds of changes most likely due to the kind of abnormality that was demonstrated on the 2000 scan of her brain.

The MRI of the brain performed in 2000 was performed because petitioner reported a change in her taste and sensation under the chin. Since the findings on the 2000 MRI of the brain were the same as those on the

3/31/10 MRI of the brain, Dr. Oliveri suggested the possibility of a head trauma prior to the 2000 MRI of the brain. Additional evidence that may support this is a history petitioner gave on 5/5/03 that she had a prior skull fracture.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained a brain injury as a result of the injury on 1/14/06. The arbitrator bases this finding on the fact that the results of the MRI of the brain in 2010 was unchanged from those initially identified on the MRI of the brain performed in 2000; that petitioner had a prior head trauma and loss of taste prior to the MRI of the brain performed in 2000; that petitioner had a normal CT of the brain performed after the injury on 1/14/06; that there is no mention of any brain injury in any medical records after the injury on 1/14/06 until petitioner presented to Dr. Harm in 2010; that there is no mention of any memory loss in any medical records until 2014, 8 years after the accident; that petitioner reported a history of a skull fracture prior to 5/5/03; that petitioner had unrelated falls both in the year prior to the injury on 1/14/06, and in 2007 where she landed on her face; and, the fact that there is no causal connection between petitioner's current brain condition and the injury on 1/14/06 by any treating or examining doctor after reviewing petitioner's medical records prior to, and after the injury on 1/14/06.

Spinal Cord Contusion

As a result of the injury on 1/14/06 petitioner was diagnosed with a mild cord contusion. An MRI of the cervical spine taken after the injury was reviewed by Dr. Jimenez and revealed 1) prominent prevertebral soft tissue abnormality consistent with edema and/or fluid along with posterior paraspinal soft tissue edema within the upper neck; 2) multilevel degenerative disease with disc osteophyte complex with bone marrow signal changes within the C5 and C6 vertebral bodies which likely represented bone marrow edema; and 3) subtle spinal cord T2 hyperintensities at C4-C5 levels possibly representing edema associated with mild cord contusion. Petitioner complained of burning and pain to her bilateral forearms and hands. She also described a bit of tingling in her toes. It was found that the fall aggravated petitioner's preexisting spinal cord condition. Petitioner testified that she had serious limitations with walking, standing and sitting. She stated that should could only sit or stand for 10-15 minutes before she began to experience discomfort.

The Commission held that petitioner sustained a spinal cord injury as well as soft tissue injuries in her low neck that was causally related to her injury on 1/14/06 and she had not reached maximum medical improvement. They based this holding on a finding that petitioner's symptoms commenced contemporaneously with the accident on 1/14/06 and had persisted ever since. The Commission further held that the surgery recommended by Dr. Wright to stabilize petitioner's spinal cord and reduce the risk of her suffering paralysis should she fall,

but such surgery would not change her symptoms, was not causally related to the injury petitioner sustained on 1/14/06. This finding was affirmed up to the Appellate Court

Having reviewed the credible medical evidence after 8/27/08, the arbitrator finds there exists credible medical evidence, that the examining and treating doctors after 8/27/08 reviewed, to support a finding that petitioner's symptoms did not commence contemporaneously with the accident on 1/14/06, but existed before that date. In 2000 petitioner underwent an MRI of the brain because petitioner had complaints of change in her taste and a sensation under her chin. The arbitrator finds it significant that the findings on the brain MRI performed in 2000 were the same as those on the MRI of the brain taken in 2010. Also reviewed after the hearing on 8/27/08 by the treating and examining doctors was a report dated 5/5/03 wherein petitioner had complaints of right leg numbness and other symptoms that felt like bugs were crawling across her leg. She also reported back pain and a history of a skull fracture. An MRI of the back taken at that point revealed degenerative disk disease, a bit of facet arthritis, and a bulge at L3-L4. Petitioner was assessed with neuropathy or neuritis and referred to a neurologist. An EMG performed in August of 2003 demonstrated findings suggestive of a possible neuropathy. She was also diagnosed with a back that was aging before its time. Petitioner reported muscle spasms throughout her body that Dr. Harm believed was due to something going on systemically in her body. Additionally, the EMS report on the date of the injury includes a history of another fall in the year prior to the injury on 1/14/06.

Despite petitioner's claim that her symptoms following the accident persisted, after reviewing the treating records from Carle Hospital from 8/27/08 through 2/22/13, as well as the examining physicans' records the arbitrator finds that petitioner's symptoms did not persist continually since 1/14/06. The records reviewed show that petitioner presented 15 times to Dr. Vassay for COPD, allergies, skin lesion, skin irritation by mouth, chest pain, shortness of breath, bronchitis, obesity, hyperlipidemia, hypothyroidism, colon polyps, diverticulosis coli, history of smoking, gastritis, chronic constipation, once for numbness in her fingers and toes, infected right index finger, B12 deficiency, elevated cholesterol, sleeping problems, restless leg syndrome, and GI problems. None of these records seem to support a finding that petitioner treated for her cervical spine or any other conditions related to the injury on 1/14/06 at Carle Hospital during this period.

When Dr. Bremer, petitioner's examining physician, examined her on 2/3/10 she had a normal gait and her walking was grossly normal. He further opined that if petitioner fell in 2007 and had a head trauma that could possibly contribute to her walking or balance issues if it was severe enough. He also opined that at this point that petitioner's spinal cord contusion, which she sustained as a result of the injury on 1/14/06 was much improved and less prominent. He also noted that a cervical spine MRI performed on 3/31/10 showed a

previously noted intramedullary T2 signal abnormality at C5 was considerably less conspicuous that compared to what it was on 2/21/06. Dr. Bremer opined that petitioner's cervical spine stenosis could be a contributing factor to the worsening of her cord compression. He related the numbness in her hands and forearms to a cord compression at C4-C5, that she sustained as a result of the accident on 1/14/06, but could not relate petitioner's other difficulties: numbness in her legs, walking troubles, and bladder symptoms to the cord contusion she sustained at C4-C5 as a result of the accident on 1/14/06. He opined that these symptoms could be related to her lumbar spine, and her lumbar spine is not related to the accident.

When petitioner presented to Dr. Harm on 5/3/10, after the unrelated fall on 5/18/07, she reported that her arms bothered her, including her forearm and hand. She also complained of numbness in her legs with symptoms to her head, and numbness in her hand and three small fingers bilaterally. Despite the fact that petitioner's mild cord contusion was at C4-C5, Dr. Harm was of the opinion that the disc bulge at C7-T1 on the right might be causing some of her symptoms, and the foraminal stenosis, which is not related to her the injury she sustained on 1/14/06, might be causing some of her arm symptoms. Dr. Harm could not opine if petitioner's symptoms were coming from the C4-C5 spinal cord contusion, her unrelated pressure on the nerves of her cervical spine, or her unrelated brain injury.

Dr. Van Fleet also opined that central cord system will typically affect the upper extremities more than the lower extremities. Despite petitioner's complaints that she could not walk straight and wobbled, the arbitrator finds Dr. Van Fleet on 2/1/13 noted that petitioner was essentially symptom free, and told Dr. Chen that she was walking pretty independently until only a few months prior when she started to experience more difficulty walking, and was more wobbly. She also reported that her weakness was now more generalized including her arms and legs.

The arbitrator finds it significant that when Dr. Skaletsky, petitioner's examining physician, reviewed petitioner's treating records and examined her on 4/1/14, he opined that following her initial treatment after the accident, and respondent's IME by Dr. Fleet in March of 2006, petitioner's condition improved and she did not seek any further medical treatment until she saw Dr. Harm following an unrelated fall on 5/18/07 where she landed on her face. An MRI of the cervical spine performed after that injury showed petitioner's cervical spine condition was worse as compared to the one that was taken after the injury on 1/14/06. Dr. Skaletsky also opined that petitioner's current symptoms were consistent with a cord dysfunction below the level of C4-C5, and petitioner's cord contusion was at C5. He also opined, after performing a medical review, that petitioner's cervical complaints, including her cervical radiculopathy date back to at least the 1990's, and that she had sustained some prior neck trauma or cervical strain before the injury on 1/14/06.

On 4/5/14 petitioner reported to Dr. Chen that after her surgery she slowly recovered and was walking pretty independently. She then went on to give a history of more difficulty walking, and being more wobbly, over the past two months. She also reported more generalized weakness, including her arms and legs.

An MRI performed 5/9/14 showed a new grade I anterolisthesis at C2-C3, a new moderate left foraminal narrowing; and a new severe left C2-C3 facet arthrosis. Also noted were findings that could potentially reflect a stress reaction or marrow edema related to a progressive arthrosis of the left C2-C3 facet. No findings of a cord contusion were noted at C5. MRIs of the thoracic spine and lumbar spine taken on 5/12/14 revealed degenerative disc disease with Schmorl's nodes at T10-T1 and T11-T12 levels with small T11-T12 central disc protrusion; moderate to severe thecal sac narrowing at L4-L5; moderate bilateral foraminal narrowing at L5-S1; left paracentral and foraminal disc protrusion at L3-L4 narrowing the left subarticular recess and left neural foramen; and Grade I retrolisthesis at L2-L3 and L5-S1. Following these diagnostic tests petitioner reported a lot of low back pain and intermittent neck pain to Dr. Chen. At that time petitioner complained of back pain radiating down her legs bilaterally to her knees. Petitioner was diagnosed with lumbar spondylosis, spinal stenosis, and radicular symptoms.

Although the arbitrator does not have the ability to change the findings of the 19(b) decision that is now final, the arbitrator finds, based on the credible medical evidence that was admitted at the hearing on 11/26/14, that petitioner was not asymptomatic prior to the accident on 1/14/06, and in fact had symptoms related her cervical and lumbar spine, as well as her brain, and had sustained a skull fracture and at least one other fall prior to the accident on 1/14/06. Based on the credible medical evidence, the arbitrator agrees that the petitioner sustained a spinal cord contusion at C4-C5 and other soft tissue injuries as a result of the injury on 1/14/06, but that the symptoms related to this injury were improving until she sustained another unrelated injury on 5/18/07 where she fell on her face and subsequently underwent another cervical spine MRI that shows her unrelated underlying spinal condition was worse than it was following the accident on 1/14/06. The arbitrator finds it significant that Dr. Skaletsky opined that after this unrelated fall petitioner's condition degenerated significantly. The arbitrator further finds it significant that no doctor, examining or treating, could opine that petitioner's current condition of ill-being was is causally related to the cord contusion, her unrelated brain injury, or preexisting cervical condition. Even Dr. Skaletsky opined that petitioner's current symptoms were consistent with a cord dysfunction below C4-C5 (where petitioner's cord contusion was noted), and there were no findings of a cord contusion noted at C5 on the MRI of the cervical spine dated 5/9/14. Additionally, the arbitrator finds petitioner's testimony that she has had the same complaints inconsistent with the credible records. The arbitrator bases this opinion on the fact that from 8/27/08 through 2/22/13 petitioner did not report any complaints to Dr.

Vassay regarding her imbalance and inability to walk, and only mentioned numbness in her fingers and toes once; that when Dr. Bremer examined petitioner on 2/3/10 she had a normal gait and her walking was grossly normal; that when Dr. Van Fleet examined petitioner on 2/1/13 petitioner was essentially symptom free; and that when Dr. Chen examined petitioner on 4/5/14 she stated that she slowly recovered after the surgery and was walking pretty independently until a two months prior.

Based on the above as well as the credible evidence, the arbitrator finds the petitioner's current condition of ill-being is not causally related to the injury she sustained on 1/14/06, after 8/27/08. The arbitrator bases this finding on the fact that petitioner was symptomatic prior to the injury on 1/14/06; that petitioner sustained a cord contusion at C4-C5, and an aggravation of her preexisting and symptomatic cervical spine condition as a result of the injury on 1/14/06; and that after her Section 12 examination in March 2006, her condition was improving and she did not seek any further treatment until after she sustained another unrelated fall on 5/18/07, after which her improving condition deteriorated significantly, as did her cervical MRI findings. Since no doctor opined that the fall on 5/18/07 was causally related to the fall on 1/16/04, that petitioner had already sustained an unrelated fall a year prior to the accident on 1/14/06, and the cervical MRI of 5/9/14 showed no cord contusion at C5, the arbitrator finds the petitioner's current condition of ill-being as it relates to her cervical spine is not causally related to the injury she sustained on 1/14/06.

K. WHAT MAINTENANCE BENEFITS ARE IN DISPUTE?

Petitioner claims she entitled to maintenance benefits from 8/28/08 through 11/26/14. Petitioner is not claiming any additional temporary total disability benefits. Having found the petitioner's current condition of ill-being is not causally related to the injury she sustained on 1/14/06 after 8/27/08, the arbitrator denies petitioner's claim for maintenance benefits for period 8/28/08 through 11/26/14. Based on the additional credible medical evidence the treating and examining doctors reviewed after 8/27/08 the arbitrator finds the petitioner's current condition of ill-being as it relates to her brain is not related to the injury on 1/14/06, and her current condition of ill-being as it relates to her cervical spine is not causally related to the accident after the date of the Arbitrator's decision on 8/27/08.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner's claim for maintenance benefits pursuant to Section 8(a) of the Act from 8/28/08 through 11/26/14 is denied.

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

As a result of the injury on 1/14/06 the arbitrator finds the petitioner sustained an aggravation of her preexisting cervical spine condition, a mild concussion, and a mild cord contusion at 4-C5, that was improving

until she sustained an unrelated fall in 2007 wherein she fell on her face, and her condition deteriorated significantly thereafter. At the time of unrelated fall on 5/18/07 petitioner still had some complaints of discomfort in her neck and arms that consisted of pain in her neck and numbness and tingling in both arms. The arbitrator finds petitioner had some of these preexisting conditions prior to the injury on 1/14/06 that were made worse by the fall on 1/14/06. The arbitrator further finds that these symptoms were improving until she sustained another unrelated fall (she had one a year prior to the accident on 1/14/06) on 5/18/07 and her condition deteriorated significantly after that. The arbitrator also finds that none of petitioner's treating physicians, Dr. Bremer, Dr. Harm or Dr. Skaletsky could opine that petitioner's current symptoms are related to the mild cord contusion she sustained on 1/14/06. They also opined that her preexisting cervical spine condition was improving until she sustained that unrelated fall on her face in May of 2007.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner sustained a 10% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act as a result of the injuries she sustained on 1/14/06.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Noe Araujo,

Petitioner,

vs.

NO: 07 WC 5358

16IWCC0599

Clear Staffing Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 10, 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.

16IWCC0599

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $43,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 16 2016
TJT:yl
o 9/12/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARAUJO, NOE
Employee/Petitioner

Case# **07WC005358**

CLEAR STAFFING INC
Employer/Respondent

16IWCC0599

On 2/10/2015, 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:

1072 THE EPSTEIN LAW FIRM
JACK R EPSTEIN
4346 W 26TH ST SUITE 2000
CHICAGO, IL 60623

0075 POWER & CRONIN LTD
JOHN FASSOLA
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

16IWCC0599

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

Noe Araujo
Employee/Petitioner

v.

Clear Staff, Inc.
Employer/Respondent

Case # 07 WC 05358

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **December 1, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

☐ TPD ☒ Maintenance ☐ TTD

16IWCC0599

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 **Vocational Rehabilitation**

FINDINGS

On 01/30/2007, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, the 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 Petitioner earned $13,520.00; the average weekly wage was $260.00.

On the date of accident, Petitioner was 21 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 $3,342.88 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,342.88.

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

ORDER

Respondent shall pay the Petitioner the amount of $173.32/week from January 31, 2007 to March 20, 2007, May 1, 2007 to May 14, 2007, July 24, 2007 to September 3, 2007, January 23, 2008 to February 7, 2008 and September 2, 2008 to September 16, 2008, representing 19 2/7 weeks, pursuant to Section 8(a) of the Act, as stipulated by the parties.

Respondent shall pay the Petitioner the sum of $173.32/week for a further period of 250 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused permanent partial disability of 50% loss of person as a whole. See Addendum.

The Arbitrator finds the Petitioner failed to prove entitlement to maintenance benefits under Section 8(a) of the Act. See Addendum.

The Arbitrator finds the Petitioner failed to prove entitlement to Vocational Rehabilitation pursuant to Section 8(a) of the Act. See Addendum.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the

date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Kethi Steffen — Signature of Arbitrator

2-9-15 — Date

ICArbDec p. 2

FEB 10 2015

ILLINOIS WORKER'S COMPENSATION COMMISSION

NOE ARAUJO	)	
Petitioner,	)	
Vs.	)	No. 07 WC 005358
	)	
CLEAR STAFFING, INC.	)	
Respondent.	)	

FACTUAL HISTORY

Stipulations:

The parties agree that on January 30, 2007 the Petitioner and the Respondent were operating under the Illinois Workers' Compensation Act and that their relationship was one of employee and employer. On the above date the Petitioner sustained accidental injuries that arose out of and in the course of employment. The Respondent was given notice of the accident within the time limits stated in the Act.

Issues:

At issue in the hearing is as follows: 1) is the Petitioner's current condition of ill-being causally related to his work for the Respondent; 2) nature and extent of the injury; 3) request for maintenance; 4) request for vocational rehabilitation.

Evidence Presented

The Petitioner, Noé Araujo ("Petitioner") testified that he was employed by Clear Staffing, Inc.,("Respondent"), a temporary labor agency, and was working as an assistant to a machine operator at a metal factory known as Mecalux for one year before January 30, 2007. (Tx. 31-33) The Petitioner also testified that for the duration of his employment, he essentially performed the same job duties and that only on occasion was asked to perform different duties. (Tx. 33) The Petitioner testified that he worked with a large machine that provided the metal that was used by the other machines in the factory. (Tx.33-34) The Petitioner also testified that this

machine ran very quickly. (Tx. 34) The Petitioner testified that his job duties included cutting metal material in particular measurements and disposing of excess material from the machine that was not to be used anymore. (Tx. 33) Excess material would exit the machine through its sides. The Petitioner also testified that in order to dispose of the excess material from the sides of the machine, he had to switch over from one side of the machine to the other. (Tx. 34)

The Petitioner testified that on January 30, 2007 he went to work as usual, and began warming up the machine by inserting the first roll of metal for the day, which weighed 25 tons. (Tx. 34) The Petitioner testified that he was observing the machine to make sure it was running properly while at the same time cutting off the debris that exited the machine through its sides and feeding the debris to small machines on the side of this machine. (Tx. 35) The Petitioner testified that the machine was running smoothly when he noticed that on the opposite side of the machine, some of the material got stuck. (Tx. 35) The Petitioner testified that in order to get to the other side of the machine, he would either go around the machine or, to save time, he would simply go across the machine. (Tx. 35) The Petitioner testified that immediately before the accident, he went across the machine and felt himself falling. He attempted to brace his fall by using his left arm as a support. His left arm entered the machine and the blades that cut the material inside the machine seized his arm. (Tx. 36) The Petitioner also testified that his arm was inside of the machine only for a few seconds before he pulled it out. (Tx. 43) The Petitioner testified that as soon as the machine operator, who is also the Petitioner's brother, saw that the Petitioner fell, he immediately stopped the machine. (Tx. 36) The Petitioner testified that by the time the machine was stopped, he had already sustained severe lacerations to his left arm from the base of his left thumb to an area at least three or four inches above the elbow joint. (Tx. 37-38) The Petitioner testified that his arm was destroyed and described his injuries as one "could

even see my bone, I had no skin. I had no muscles, no tendons, no nerves." (Tx. 44) Petitioner testified that he was taken to Loyola Hospital via ambulance. (Tx. 38)

At the hearing the Arbitrator observed the Petitioner's injured left arm. (Tx. 66) The Arbitrator notes that "the area past the wrist for about four inches seems to be much narrower and smaller in terms of muscle. Also the are closest to the elbow extending towards the hand about five to six inches from the elbow also seems to be a lot smaller in terms of muscle mass in that area." (Tx. 67) He also had a slight tremor in his hand/arm. The petitioner was able to move his arm and able to gesture during his testimony.

The Petitioner also testified that as part of the procedures performed at Loyola, skin was taken from his left leg, and a tendon was taken from his left ankle in order to place these onto his left arm. (Tx. 70-71)

The Petitioner testified that due to the accident, he was in the hospital for several weeks. (Tx. 39) Moreover, the medical records indicate that the Petitioner suffered a long course of treatment that lasted approximately four years, from January 30, 2007 through July 8, 2010. (Px. 1) During the aforementioned course of treatment, the Petitioner endured surgeries including, but not limited to:

1. January 30, 2007: "left forearm, microvascular vein graft repair radial and ulnar artery, microscopic repair ulnar and median nerve, repair FCU, FDP, FDSX4, FPL, PL, long arm splint." (Px. 1)
2. February 2, 2007: "Irrigation and debridement left arm, split thickness skin graft to the left arm, 200 square centimeters." (Px. 1)
3. February 15, 2007: "Irrigation and debridement left forearm wound." (Px. 1)

The Petitioner testified that he was released from the hospital with light duty restrictions on March 20, 2007. (Tx. 39) The Petitioners restrictions were no use his left arm and no work in an environment that consisted of extremely hot or extremely cold temperatures. (Tx. 45) The Petitioner testified that he returned to work for the Respondent on March 21, 2007. (Tx. 50) Additionally, the Petitioner testified that when he returned to work, the Respondent gave him work that only consisted of sitting on a chair for eight hours a day, 40 hours a week. (Tx. 46) The Petitioner testified that he was not permitted to speak to other co-workers, listen to music, read the newspaper, a book, or magazine, use the telephone, nor was he allowed to watch television, much less get up and walk around. (Tx. 46) Additionally, the Petitioner testified that even though he did not directly ask his supervisor Byron Figueroa if he could use any of the previously mentioned materials, however, when the Petitioner reached for a newspaper, book, or magazine, he was told that he could not do that. (Tx. 48) Furthermore, the Petitioner testified that he was specifically told by Mr. Figueroa that he was not allowed to speak to other people, use headphones, or use his telephone. (Tx. 49) The Petitioner testified that on March 21, 2007, when he returned to work, he asked Mr. Figueroa if he could have work, to which Mr. Figueroa replied that there was no other work available and that the Petitioner must remain seated. (Tx. 50-51) The Petitioner testified that he was on light duty from March 21, 2007 through May 1, 2007, and that during that time he was not given any other work besides remaining seated in a chair. (Tx. 51-52) The Petitioner testified that on May 1, 2007 he returned to the hospital for another procedure relating to the skin on his left arm. (Tx. 53 and Px. 1) Furthermore, the Petitioner testified that he returned to work for the Respondent on May 15, 2014 with another light duty slip. (Tx. 53) The Petitioner testified that Mr. Figueroa provided him with the same type of work he was given pursuant to his previous light duty slip. (Tx. 53-54)

The Petitioner testified that he returned to the hospital for further procedures on his left arm on July 24, 2007. (Tx. 54) The Medical records show that on July 24, 2007, the Petitioner presented to Loyola Hospital for surgery performed by Dr. Vandevender. (Px. 1) The Procedures performed by Dr. Vandevender on the date mentioned supra were "EIP tendon transfer opensplasty, scar revision" (Px. 1) The Petitioner testified that after the July 24, 2007 procedure, he was released from the hospital on September 3, 2007. (Tx. 54 and Px. 1) The Petitioner also testified that he returned to work on September 4, 2007 with another light duty slip. (Tx. 54) When the Petitioner returned to work, Mr. Figueroa, once again, proceeded to provide the Petitioner with the same type of work that he was given pursuant to his two previous light duty slips. (Tx. 55) The Petitioner also testified that he returned to the hospital for additional procedures on his left arm on January 23, 2008 and was off work until February 7, 2008 and after this date he returned to work with a light duty slip. (Tx. 56 and Px. 1) The Petitioner testified that he was given the same type of light duty work that he was previously employed by employer. (Tx. 56)

On [illegible] Petitioner presented to Loyola Hospital for a Functional Capacity Examination (hereinafter "FCE"), performed by physical therapist, Christopher Cook. (Px. 1) The physical therapist noted that, at the examination, the Petitioner put forth genuine effort, and he also found that the Petitioner was performing at the sedentary demand levels for work. (Px. 1) Additionally, the Petitioner was assigned the following work restrictions per the FCE of "no activities requiring repetitive lifting with the left hand. No sustained overhead activities. No activities that require crawling." (Px. 1) On June 9, 2008 the Petitioner was examined by Dr. Darl Vandevender, and Dr. Vandevender found that the Petitioner is at functional maximum medical improvement with regards to the left upper extremity and assigned permanent work

restrictions based on the FCE: as follows: "[Petitioner] will be limited to use of left hand as per FCE. Sedentary level of work with left hand-use as assist hand. Sensation in left hand is limited and [Petitioner] should avoid exposure to heat/cold. [Petitioner] is at MMI with regards to functional use of left upper extremity. (Px. 1)

The Petitioner testified that on September 2, 2008 he returned to the hospital for additional procedures on his left arm and was off work until September 16, 2008. (Tx. 56) The Petitioner also testified that on September 17, 2008 he returned to work pursuant to another light duty slip and was once again given the same type of work that he was customarily given due to his work restrictions. (Tx. 56-57) Additionally, the Petitioner testified that he worked light duty from September 17, 2008 until January 11, 2011 performing the same duties that were mentioned supra. (Tx. 57) The Petitioner testified that he performed his duty of remaining seated eight hours a day, five times a week for a grand total of forty hours. (Tx. 58) In addition, the Petitioner testified that remaining seated for forty hours a week made him feel impotent, anxious, and desperate. (Tx. 60). The Petitioner testified that on January 11, 2011 he asked his supervisor Byron Figueroa (hereinafter "Figueroa") if he could have three days off because he did not feel well. The Petitioner testified that Figueroa consented to this request. (Tx. 60-61)

At the hearing for this matter, Byron Figueroa testified on behalf of the Respondent. Figueroa testified that he is the branch manager for the Respondent, and that he has worked there for thirteen years. (Tx. 124) Figueroa testified that between January 6, 2011 and January 11, 2011, the Petitioner did not call, or present to work. Figueroa testified that the Petitioner did not request time off and if an employee does not report to work during three consecutive days it is considered a voluntary resignation. (Tx. 133) On Monday January 17, 2011 the Petitioner returned to work for the Respondent, at this time Mr. Figueroa asked the Petitioner to see him in

his office, at which time only Figueroa and the Petitioner were present, and informed the Petitioner that he no longer had a job because he missed three days of work. (Tx. 63-64) The Petitioner testified that he considered himself to be terminated from employment. (Tx. 65)

After being dismissed from Clear Staffing, Inc., the Petitioner attempted to find other employment, however he was unable to do so due to his work restrictions, inability to speak English, his limited skills, and permanent restrictions due to his condition after the work-related accident. (Tx. 74-76) The Petitioner testified that he applied for at least a hundred jobs. (Tx. 73-74) However, he did not produce any written record, documentation or details of the same. In addition, the Petitioner testified that he also tried to obtain employment in his native country of Mexico by calling his friends and family that live there and asking them if there are any job opportunities for him there that will accommodate his work restrictions, however, he was told that there were no such jobs available. (Tx. 84-87) Moreover, the Petitioner testified that when he lived in his native town of Tilzapotla, Morelos, Mexico, he worked as a rancher with his father at their family's ranch. (Tx. 20-23) When the Petitioner worked as a rancher, he worked with animals such as cows, horses, and goats, and he planted corn. (Tx. 23) The Petitioner testified that working at the ranch requires activities such as using both arms, working outside, and grasping object with his left hand, which he can no longer do due to his permanent work restrictions. (Tx. 77) Moreover, the Petitioner testified that other than working as a ranch hand, he has no other specialized skills or training. (Tx. 25-26)

On Cross-examination, Petitioner was questioned regarding his testimony that the Respondent just made him sit at the work while he was on a restricted work duty and reporting daily to the staffing services office. Petitioner admitted that during the time he was on restricted duty, he continued to be seen by his treating physician, Dr. Vandevender. (T.93) He admitted,

on cross-examination, that when he would see Dr. Vandevender, the doctor would ask him how he was doing at his light duty work. (T.93) Nonetheless, Petitioner testified that he never told Dr. Vandevender, at any office visit, that he was being asked to sit in a chair eight hours a day and do nothing whatsoever. (T.93) The medical records from Dr. Vandevender (PX1), likewise, do not indicate that Petitioner was not performing any work activities, but rather indicate that he was performing light duty work.

In addition, Petitioner admitted into evidence, as Petitioner's Exhibit 2, the evidence deposition of Kari Stafseth, a vocational counselor at Vocamotive. The deposition transcript includes a number of exhibits, including an initial evaluation report dated May 30, 2012. The Arbitrator notes that the initial evaluation report contains a history from Petitioner, and specifically indicates that the services of a translator were utilized in obtaining the history. The history includes an indication that Petitioner reported light duty work at Clear Staff, including shredding paper and making copies.

Petitioner was additionally cross-examined regarding his testimony that following his separation from Clear Staff, he looked for work. (T.65) He testified that he looked for over 100 jobs, but was advised either that English was required or that the physical requirements exceeded his capabilities. (T.74-76) However, the Petitioner was unable to identify any potential employer to whom he submitted applications. He also failed to provide any documentation in support of his job search. (T.115)

Petitioner's credibility on the issue of his job search was also questioned by statements he made to the vocational counselor, Kari Statseth. Petitioner admitted that he had a vocational meeting, at the request of his attorney, with Kari Stafseth of Vocamotive. (T.95) Mr. Stafseth specifically testified that when she met with Petitioner in May 2012, she asked him whether he

had been looking for work. (PX2, p.46) She further testified that Petitioner told her that he had not looked for work. (PX2, p.46) The vocational report, which is attached to Ms. Stafseth's deposition, indicates that Petitioner reported not having looked for work, and feeling as though he was not capable of working. (PX2)

Petitioner was also asked questions, on direct examination, about potential employment opportunities in Mexico. He testified that his background in Mexico was limited to working on his family's ranch. (T.23) He contended that the job requirements as a rancher exceeded his physical limitations. (T.77) However, the Arbitrator notes that Petitioner admitted, on cross-examination, that he does not have a present intention of returning to Mexico for work. (T.114)

Kari Stafseth- Petitioner's Vocational Rehabilitation Witness

On November 19, 2013, Kari Stafseth (hereinafter "Stafseth) testified on behalf of the Petitioner via evidence deposition. (Px. 2) Stafseth testified that she is a vocational rehabilitation counselor and assesses injured workers' ability to return to employment by completing an in-depth personal interview as well as reviewing medical records, completing labor market surveys to determine the availability of work within a particular labor market. She also assists workers in finding employment by performing retraining and placement services. (Px. 2, P. 5)

Stafseth testified that she met with the Petitioner on May 11, 2012. (Ex. A) Stafseth noted that that the Petitioner completed only six years of primary school education and three years of secondary school education in his native Mexico. The Petitioner does not have a high school diploma and has no additional education or training. (Px. A) Furthermore, Stafseth notes that Petitioner is unable to read a job application or newspaper in English, he is not able to write any amount of English, nor would he be able to complete an interview in English.

After a thorough evaluation, Stafseth opined as follows:

1. "[Petitioner] has lost access to his usual and customary job and line of occupation and those jobs and lines of occupation he has historically performed."
2. "[Petitioner] has significant exposure for total disability."
3. "[Petitioner] is significantly limited with regard to labor markets access in the United States, as well as in Mexico, given the restrictions regarding use of the left upper extremity."
4. "Secondary to the nature of [the Petitioner's] physical disability condition, he will require accommodation in any occupational area which may be considered for him. This factor coupled with his less than limited education, limited work experience and lack of transferrable skills; clearly indicate significant exposure for total disability in this matter."
5. "There is significant probability that [the Petitioner] will independently be able to access only work which is sufficiently limited in quantity, dependability or quality, that there will be no reasonable stable labor market for him and he will be subject to earning only occasional wages."
6. "With regard to the issue of return to work and vocational rehabilitation, it is the opinion of this consultant that due to his less than transferrable skills, [the Petitioner] is not prepared to effectively manage independent job search, and this is the reason recommendation was previously made for rehabilitation services." (Px. 2)

Stafseth also testified that she completed a labor market survey of job in Mexico. She acknowledged that she was unable to and did not directly communicate with any employers but rather based her opinion on website job postings. (Px. 2, P. 28) Stafseth opined that if the Petitioner is not able to receive assistance with returning to employment, his prospect of returning to any type of work is poor, and she does not believe that he will find gainful employment. (Px. 2, P. 29) She concluded after the Assessment that Petitioner was capable of return to employment in specific job areas such as cahier or fast food worker if he received some help in how to interview and present himself. (PX2, p.19-21)

She recommended vocational services but admitted that Petitioner, as an undocumented worker, could not be legally presented by a vocational counselor as a candidate for employment. (PX2, p.37-40). She testified that his potential labor market would be "very limited". (PX2, p.27) but that she was able to determine potential job fields for Petitioner. (PX2, p.41) Ms.

Stafseth did not provide an opinion that no stable labor market existed for Petitioner given his qualifications and physical restrictions.

Sharon Babat – Respondent's Vocational Rehabilitation Witness

Sharon Babat (hereinafter "Babat") testified on behalf of the Respondent via deposition on December 3, 2013. (Rx. 1) She testified that, she performed a Labor Market Analysis in an effort to determine potential job prospects for the Petitioner. (RX1, p.13). She identified potential jobs that did not require English-language skills, did not require a high school diploma, and were within Petitioner's level of physical restrictions. (RX1, p.18-21). In fact, she identified machine operator jobs within the Petitioner's physical restrictions. (RX2, p.93-95) She specifically testified that a stable labor market existed for Petitioner, and that he is not totally disabled from employment. (RX1, p.23-24)

On cross-examination, she reiterated the contacts she made with employers in the Labor Market Survey, indicating that the contacted employers reported available work within Petitioner's physical restrictions and background qualifications. (RX1, p.50-56) She also opined that the available job market did not require vocational rehabilitation and retraining. (RX2, p.68) She noted that a vocational counselor could not legally present Petitioner as a candidate for work in the United States. (RX2, p.84) She testified that it was his lack of legal documentation, rather than his physical restrictions or qualifications that precluded his ability to return to work. (RX2, p.85-86)

Babat was cross-examined during her testimony and remained firm that Petitioner is able to obtain competitive employment within the current labor market in the United States. (Rx. 1) She acknowledged that she did not know the particulars regarding Petitioner's education, special

training, or military history during her first two reports but that she knew of Petitioner's limited education by the date of the third report. Regardless, she testified that the potential jobs that she had identified for the petitioner did not require English-language skills, did not require a high school diploma, and were within Petitioner's level of physical restrictions. (RX1, p.18-21 In addition, Babat testified that at the time she prepared the initial vocamotive report she did not know if the Petitioner could read or write English. (Rx. 1, P. 35)

Babat was vigorously cross-examined regarding whether she had opined that the Petitioner has lost his usual and customary occupation. (Rx. 1, P. 76-77, 91) She denied the same and testified that although Petitioner cannot do heavy duty job due as the one he was doing with clear staffing, he is able to work as a machine operator. (Rx 91-93. She explained that although he cannot go back to the exact same position, there are machine operator DOT codes for which he could work within. (Rx. 92) She explained that these positions are unskilled requiring and requiring repetitive work and that Petitioner could learn the same on the job. She explained that this was similar to learning to move a different type of handle or putting on a label. On redirect by Respondent's counsel, Babat specifically identified the physical and skill requirements of several jobs that fit into Petitioner's medical restrictions. All jobs had a 10 lbs. maximum lifting requirement and sitting or standing while monitoring a running machine. (RX93-95)

Petitioner's Signature

Finally, at the hearing for this matter the Respondent introduced a job application that was allegedly filled out and signed by the Petitioner. (Rx. 4) The Petitioner testified that the signature on the application is not his signature. (Tx. 103)

ANALYSIS/FINDINGS

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

It is undisputed that Petitioner injured his left arm and hand in a workplace accident on January 30, 2007. Petitioner received a crushing injury to this left hand and arm and the Arbitrator heard detailed and compelling testimony regarding the nature of the work accident. Additionally, the Arbitrator had the opportunity to view the Petitioner's left hand and arm in court. The Arbitrator finds that the Petitioner suffered a severe laceration and de-gloving injury to his left arm during the course of his employment. The Arbitrator finds that Petitioner proved that the condition of ill-being to his left hand and arm is causally related to the workplace accident. The same is also supported by the medical documentation and opinions.

Petitioner also contended ongoing conditions to his left ankle and left leg in association with the accident. The medical records reflect that Petitioner had a tendon transfer from his left ankle, and a skin graft from his left leg. This evidence is uncontested. However, there is no indication in the medical records of any ongoing difficulties to Petitioner's left leg or ankle. The medical records are devoid of any active subjective complaints to his treating physician regarding his leg or ankle. Medical records, in fact, show that Petitioner has not been back to his treating physician for over four years. There are no restrictions relating to the Petitioner's left foot or ankle. The Arbitrator finds that the left arm injury required a tendon transfer and a graft from his left leg and that currently, Petitioner, testified that he has a burning sensation and dryness due to this condition and the Arbitrator finds that they are causally connected to the work accident.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) IS PETITIONER ENTITLED TO MAINTENANCE BENEFITS AND IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING:

Maintenance

On the issue of Maintenance, Petitioner has not argued for any specific period of maintenance but rather, has proposed that the Petitioner is permanently and totally disabled. Based on the testimony of the Petitioner and the stipulations between the parties ("AX1") it would appear that Petitioner is seeking maintenance from the dates of January 11, 2011 when he is alleged to have quit work or was fired for non-appearance.

Petitioner testified that he was terminated from employment at Clear Staff while under light duty restrictions. The Respondent disputed this claim and argues that Petitioner voluntarily resigned his employment when he failed to appear and failed to call in for four consecutive work shifts. Respondent witness testified that when he finally came in to pick up a pay check, the Petitioner was advised that he was deemed to have voluntarily quit.

Based on a review of the testimony and supporting documentary evidence, the Arbitrator finds that the Petitioner voluntarily quit his employment and that he failed his burden of proving that he engaged in a meaningful job search within his restrictions. Petitioner testified that during his light duty work release the Respondent forced him to simply sit in one spot and would not let him do anything for the entire 44 months of light duty employment. However, the treating records from Petitioner's physicians indicate that he failed to report the same to his physician. Additionally, the vocational evaluation report prepared by Kari Stafseth on May 30, 2012 (PX2) indicated that Petitioner

reported working for clear Staff for two years after his injury, and stated that he sat at a desk and "would shred paper and make copies. ("PX2")

The Arbitrator finds this documentation to impeach Petitioner's in-court testimony denying that he shredded any paper or made any copies while on his light duty assignment with Clear Staff. It appears that the testimony that he did not sign the Application at Clear Staffing to be improbable.

Lastly, as to the issue of maintenance, the Petitioner has shown lack-luster efforts in attempting to find any employment. Petitioner presented at trial and testified that he applied for over 100 jobs. He failed to give a single specific name, employer or detail of the same. Petitioner has produced no record or a job search and cannot provide even minor details of the same. The documentary evidence that Petitioner told vocational counselor, Ms. Stafseth that he had not looked for work is at odds with his court testimony. (PX2, p. 46) The vocational report, which is attached to Ms. Stafseth's deposition, indicates that Petitioner reported not having looked for work, and feeling as though he was not capable of working. (PX2)

Based on a totality of the evidence, the Arbitrator finds that the Petitioner voluntarily withdrew from his employment and no maintenance are owed.

Nature and Extent

Petitioner has urged for a finding that he is permanently and totally disabled based on the fact that there is no stable job market for him based on his skill and medical restrictions. Respondent acknowledges the serious nature of the injuries and argues that based on the job market analysis and Petitioner's medical limitations, the case is appropriate for a man as a whole award. The Arbitrator finds that the

nature and extent of Petitioner's injuries have resulted in a loss of 50 % of man as a whole. The Arbitrator declines to find that the Petitioner has proven that there is no stable job market for him within his skill sets and subject to his medical limitations.

Initially, the Arbitrator finds little to doubt the extent and severity of Petitioner's injuries as well his resulting limitations. Petitioner suffered serious and permanent injuries to his left arm when his hand/arm was crushed inside a machine and de-gloved. Additionally, Petitioner underwent several procedures/surgeries to repair his hand/arm but is left with a severely diminished left hand member. Petitioner has lost muscle mass, strength and his left hand is narrower than his right. He suffers from discoloration and a slight tremor. The resulting skin grant from leg/ankle causes minor burning and dry sensation to those body parts. The Petitioner's condition has reached MMI but he has significant permanent restrictions consisting of no lifting over 15 lbs., no repetitive activities with his left hand and no tight grasping, crawling or exposure to heat and light with his left hand. The Petitioner is right hand dominant and fortunately, Petitioner did not suffer any harm to his right hand.

The issue of nature and extent of the injury in this case is neither simple nor uncomplicated. Petitioner was and is of a very young age (21years at the time of the injury and 28 years of age currently). Petitioner's work experience prior to arrival in the United States from Mexico was limited to work on his family ranch. His education was limited to elementary and some middle school and his English skills are very poor. Petitioner's work experience in the United States was short and brief and consisted of being a machine operator. To truly, complicate matters, Petitioner is undocumented and has questionable skills and ability in applying for and obtaining work within his limitations.

In balance, Petitioner is otherwise healthy and right hand dominant. His was a minimum

wage worker and per her current restrictions, he can do light duty work. Although his left hand/arm is injured and has lesser strength, it is functional and has a good range of motion with no loss of fingers. There is no medical finding that Petitioner is permanently and totally disabled. The Petitioner's vocational expert Kari Stafesh does not find that there is no stable job market; rather she has opined that he would need help accessing the market and will have difficulty managing his job search due to language barriers. The Respondent's vocational rehabilitation witness, Sharon Babat, completed a labor market analysis and determined that in spite of Petitioner's limited language skills and education there is a stable job market for him. She specifically outlined employers and job openings that fit within Petitioner's physical restrictions and educational qualifications. Essentially, she opined that although Petitioner could not specifically return to his old machine operator job (due to lifting limitations) that there are other machine operator jobs which require less than 15 lbs. of lifting. She explained that such job are repetitive, require minimal on the job training and can be had without vocational rehabilitation or training. Lastly, she concluded that it is Petitioner's lack of legal documentation, rather than his physical restrictions, that preclude him from returning to work.

Therefore, the Arbitrator finds that the Petitioner is not permanently and totally disabled. In support of the Arbitrator's finding that Petitioner is not permanently and totally disabled the Arbitrator is mindful of the following facts and finds them relevant:

1. The Petitioner's lack of legal status is not a factor in this assessment. An undocumented worker can establish entitlement to permanent and total disability if he/she proves that regular employment in the labor market does not exist without regard to the undocumented status. *Economy Packing Company v. Illinois Workers' Compensation Commission*, 387 Ill.App.3d 283 (1st Dist., 2008),

2. Petitioner had found employment with Clear Staff shortly after arriving in the United States, in-spite of his language and educational limitations and his skill set.

3. Sharon Babat, identified jobs in light assembly, machine operator, factory positions and a variety of service positions.

4. Kari Stafseth, Petitioner's expert, indicated a labor market existed for Petitioner in service occupations (cashier, fast food service worker). Her opinion is guarded in that she opined that these prospects are poor but conceded that a job market exists for Petitioner which would pay a minimum wage for $ 8.25 per hour.

5. Petitioner is young and has light duty restrictions only. His dominant hand was not injured and he is in otherwise good health and capable of working full time. Jobs within his restrictions, requiring no training are clearly identified and available.

Petitioner asserts that his is permanently and totally disabled under the 'odd-lot' theory of recovery. Respondent asserts that Petitioner is able to work light-duty and that job are available . In record in Petitioner's case, is devoid of any medical evidence to support a total disability claim. In the absence of such medical evidence where a claimant's "disability is limited in nature so that he is not obviously unemployable... he may qualify for 'odd-lot' status." *City of Chicago v. Illinois Workers' Compensation Commission*, 373 Ill. App. 3d 1080, 1089, 871 N.E.2d 765 (Ill. App. Ct. 1st Dist. 2007). It is the claimant's burden to establish that he is not altogether incapacitated from work, but nonetheless not regularly employable in any well-known branch of the labor market. *Ceco Corp. v. Industrial Commission*, 95 Ill. 2d 278, 286, 447 N.E.2d 842 (1983); *City of Chicago*, 373 Ill. App. 3d at 1089-90. A claimant can establish that he falls in the odd-lot category by showing either of the following: (1) that he engaged in a diligent, but,

unsuccessful job search; or (2) that his age, training, education, experience, and physical condition prevent him from engaging in stable and continuous employment. *Westin Hotel v. Industrial Commission*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342 (Ill. App. Ct. 1st Dist. 2007). If the claimant meets his burden by a preponderance of the evidence, the burden then shifts to the employer to show that work is actually available for the claimant. *City of Chicago*, 373 Ill. App. 3d at 1091. The ability to perform sedentary work and a claimant's failure to search for work within his restrictions are both factors militating against a finding that the claimant is permanently and totally disabled. *Hallenbeck v. Industrial Commission*, 232 Ill. App. 3d 562, 569 (Ill. App. Ct. 1st Dist. 1992) (citations omitted).

The Petitioner does not qualify for 'odd-lot' permanent total disability. He has failed to meet his burden of proof that there is no stable market based on a diligent, thorough but unsuccessful job search. Petitioner identified no specific employers to whom he had applied for work; he provided no documentation of a job search. Additionally, Petitioner's assertion that he has looked for jobs with over 100 different employers was impeached by his statements to Kari Stafseth that he had not looked for work in any capacity. Neither vocational expert states that there is no stable job market. Therefore, the Arbitrator finds the Petitioner has failed to prove entitlement to benefits under Section 8(f) of the Act. The Arbitrator believes Petitioner is appropriately compensated in this matter pursuant to Section 8(d)(2) of the Act. The Arbitrator finds Petitioner has proved disability to the extent of 50 % loss of person as a whole, for a total of 250 weeks of permanent partial disability compensation.

In consideration of this award the Arbitrator restates her consideration of the serious nature of Petitioner's injuries, that he worked as a machine operator, was of young age and will suffer a loss of income as his ability to succeed and get promoted in his work will most likely be

hampered by his physical limitations. Although he has not lost his profession, the scope and nature of the jobs he can perform has been limited. The Arbitrator is mindful of the fact that the Petitioner is not eligible for vocational rehabilitation but is of the opinion that the injuries, although serious, have not totally and permanently disabled the Petitioner.

Lastly, a wage differential award under Section 8(d)(1) was contemplated but not awarded in this case as the potential job positions identified by both vocational experts appear to suggest that employment is available for Petitioner without a loss of income. At the time of the injury, Petitioner was earning $260.00, which is equivalent to an hourly rate of $6.50 an hour. The potential job positions identified by the vocational counselors all paid in excess of that amount. Additionally, under established case law, the Arbitrator does not believe a wage differential award under Section 8(d)(1) of the Act is appropriate. The Arbitrator is not persuaded by the findings of Ms. Stafseth regarding a differential based on the job market in Mexico as the Petitioner is adamant in his desire to not return to Mexico.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (O) IS PETITIONER ENTITLED TO VOCATIONAL REHABILITATION BENEFITS, THE ARBITRATOR FINDS THE FOLLOWING:

The Petitioner is not eligible for vocational rehabilitation benefits under the Act due to his legal documentation status. .

Ketki Steffen
Arbitrator Ketki Steffen

2/9/15
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Karen Trzos,
Petitioner,

vs. NO: 07 WC 31407

Harlem Furniture,
Respondent.

ORDER

Petition for Penalties under §19(k) of the Illinois Workers' Compensation Act and for Attorneys' Fees under §16 of the Act having been filed by Petitioner herein and due notice given, this matter came on for hearing before the Illinois Workers' Compensation Commission on May 26, 2016 in Chicago, Illinois.

Upon the consideration of said Petition and the Commission's independent review of the record and file, the Commission is of the belief that Petitioner's Petition for Penalties and Attorneys' Fees should be denied.

The above stated claim has a long and drawn out history before the Commission. In order to understand the present situation the Commission believes a presentation of the pertinent background must be given.

On July 13, 2007, Petitioner filed an Application for Adjustment of Claim alleging injuries to her whole body as a result of a May 25, 2007 work accident. The claim was initially heard by Arbitrator Erbacci under §19(b) of the Illinois Workers' Compensation Act. On July 14, 2009, Arbitrator Erbacci issued a decision in which he found Petitioner had sustained a work accident on May 25, 2007 and he found Petitioner's claim was compensable. He further found along with temporary total disability that Petitioner was entitled to medical expenses. More specifically, Petitioner submitted evidence of $270,817.92 in medical bills. The Arbitrator noted in his findings that $174,859.99 had been paid by the Respondent for medical expenses through

its group medical plan for which it is entitled to a credit under §8(j) of the Act.[1] The Arbitrator awarded the remaining medical bills pursuant to §§8(a) and 8.2 of the Act. After a Petition for Review was filed and then withdrawn, the July 14, 2009 Arbitration decision became final.

Subsequently, a dispute arose between the parties as to whether Respondent properly paid the remaining medical bills and whether Respondent reimbursed the group medical plan for the medical benefits provided to Petitioner in connection with the work injuries. The Commission held hearings in the matter and issued an order on January 6, 2011 finding that §8(j) credit had been properly awarded to the Respondent and the Respondent was due a credit for payments under the same so long as it held Petitioner harmless and indemnified her against any claims filed by Blue Cross/Blue Shield, Respondent's group carrier. The Commission further found that Respondent had paid the outstanding medical bills on or before November 6, 2009.

On May 24, 2011, Petitioner fell when her hip gave out, and broke her left arm. She had two surgeries on the left arm. Respondent disputed that the fall was causally connected to the May 25, 2007 work accident.

On November 15, 2013, this matter proceeded to arbitration before Arbitrator O'Malley. On the Request for Hearing form, Petitioner claimed Respondent was liable for an additional $156,888.87 in unpaid medical expenses primarily for the left arm. Respondent disputed the same. Additionally, the parties stipulated that Respondent was due a credit of $2,500.00 under §8(j) of the Act. As was further clarified during the proceedings the $2,500.00 was for an advance on the permanency award as was not a true §8(j) credit. On page 102 of the Arbitration transcript Respondent's attorney stated as follows:

> "Can I just have an understanding or stipulation that if the insurance company did pay any of these bills in the Group Exhibit 1 and they can show that they have been paid that they will get credit for that so there is not a duplicate payment."

Petitioner's attorney stated "agreed".

Petitioner's Exhibit No. 1 contained a three page summary sheet of the alleged outstanding medical bills. A review of the itemized bills and/or statements showed that in some but not in all instances adjustments were applied and payments were made through UHCSECHO, AARP/Medicare HMO, United Heathcare Ins. Co./UHC and Secure Horizons Group #18000.

On March 18, 2014, Arbitrator O'Malley issued his decision. In his decision he indicated that Respondent shall be given a credit of $2,500.00 for other benefits. Respondent is entitled to a credit of 0.00 under §8(j) of the Act. Respondent shall pay reasonable and necessary medical expenses of $156,888.87, as provided in §§8(a) and 8.2 of the Act. Respondent shall be given a

[1] The parties stipulated that Respondent was entitled to a $174,859.99 §8(j) credit.

credit for medical benefits that have been paid by the group carrier, and Respondent shall hold Petitioner harmless from any claims by any provider of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

On Review, Petitioner requested special findings that Respondent must pay the entire $156,888.87 in medical expenses according to the fee schedule because it is not entitled to §8(j) credit as it did not pay any part of the premium for the group insurance which Petitioner purchased under AARP. Given the limited information the Commission was provided as to what medical was truly outstanding and who had paid portions of the bills and premiums, the Commission denied the request. Therefore, the Commission's January 14, 2015 Decision and Opinion on Review contained generic order language that stated that Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.[2]

Petitioner appealed the Commission's January 14, 2015 Decision and Opinion on Review to the Circuit Court, but subsequently dismissed the appeal on March 31, 2015. On May 11, 2015, Petitioner filed the current Petition for Penalties under §19(k) of the Illinois Workers' Compensation Act and for Attorneys' Fees under §16 of the Act. Petitioner's current Petition is solely limited to the alleged nonpayment of the medical award. More specifically, Petitioner claimed that Respondent had not paid the $156,888.87 medical award. Petitioner claims that Respondent should pay to Petitioner a total of $282,399.96 in medical expenses, §19(k) Penalties, §16 attorneys' fees and interest. Petitioner breaks down the medical expenses, §19(k) Penalties, §16 attorneys' fees as follows:

"1. The $156,888.87 unpaid medical expenses award of $156,888,87.
2. $78,444.44, for 50% 19-K Penalties for failure to pay the medical expense award of $156,888.87.
3. Section 16 Attorneys Fees for 20% of the medical expenses award which equals $31,377.77.
4. $15,688.88, for a second §16 Fees Attorney Award equal to 20% of §19-K Penalties Award of $78,444.44;
5. $252.39 in accrued interest from March 21, 2014 through March 24, 2016."

On February 16, 2016, Petitioner's attorney sent Respondent a "final demand" letter in which he demanded payment of the entire $156,888.87 in medical expenses. Presently, Petitioner maintains she is entitled to the entire sum of $156,888.87 to be paid directly to her, irrespective of any payments made by the various insurance entities toward the medical bills. Respondent concedes it is not entitled to a §8(j) credit for the medical bills. Rather, Respondent appears to claim a credit pursuant to Tower Automotive v. Illinois Workers' Compensation Commission, 407 Ill. App. 3d 427 (2011) in which the Court held:

[2] The Commission affirmed and adopted the Arbitrator's decision, clarifying some points which are not at issue in the current proceedings.

> "As it relates to the obligation of an employer to provide or pay for the reasonable and necessary medical care for an injured employee, the purpose of the Act is to relieve the employee and his family of the costs and burdens of such care. Colclasure v. Industrial Comm's 14, Ill. 2d 455, 458, 153 N.E.2d 33 (1958). By limiting an employer's obligation under §8(a) of the Act to the amount actually paid [by a collateral source] to the providers of the first aid, medical surgical and hospital services necessary to cure or relieve an injured employee from the effects of an accidental injury, the purpose of the Act has been satisfied; that is to say both he and his family have been relieved of the cost and burdens of that care. It is for this reason that we now hold that the collateral source rule is not applicable to the right to recover under the Act." Tower Automotive v. Illinois Workers' Compensation Commission, 407 Ill. App. 3d at 438 (2011).

The Court noted that in 2005 the legislature saw it fit to amend §8(a) of the Act to provide that employers are obligated to provide and pay "the negotiated rate, if applicable, or the lesser of the health care provider's actual charges or according to a fee schedule subject to §8.2, in effect at the time of 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 necessary to cure or relieve from the effects of the accidental injury. 820 ILCS 305/8(a) (West 2006). The amendatory change to §8(a) of the Act is applicable to claims for accidental injuries that occur on or after February 1, 2006. Tower Automotive v. Illinois Workers' Compensation Commission, 407 Ill. App. 3d at 438-439 (2011).The remaining issue Respondent contends is how much in medical bills, if any, remains to be paid by Respondent and to whom.

Respondent submitted a May 12, 2014 letter addressed to Petitioner's attorney from a subrogation company called Optum, which is apparently an agent of United Healthcare in this matter. The letter indicates that United Healthcare paid the bulk of medical expenses for the left arm injury. United Healthcare retained Optum to pursue a recovery of the medical expenses that were paid. Optum asked to be reimbursed $30,453.00 for medical payments applied to the May 25, 2007 injury. Petitioner's attorney forwarded the letter to Respondent's attorney. Respondent's attorney stated he discussed the matter with Chad Gabert, the Optum attorney. As a result of the discussions, Respondent and Optum reached a tentative reimbursement agreement. Respondent further contends that UnitedHealthcare paid the bills under Medicaid at a medical rate. Furthermore, Medicaid has a lien against Petitioner. Respondent's attorney has been attempting to determine what medical bills were paid and whether the $30,453.00 payment satisfied all of the medical bills. [3]

Petitioner's attorney stated that he spoke with Mr. Gabert and told him that if he negotiated anything with Respondent's attorney it would constitute "a fraudulent scheme to keep

[3] Although Petitioner claims she purchased the United Healthcare policy, this would not affect the reimbursement.

his client from collecting her award for medical expenses and he would be part of this." Petitioner's attorney vehemently asserts that Respondent's negotiations with Optum are a "fraudulent scheme" and "if they pull this off, I go to the FBI and I make a complaint and that's how this is going to end." He also stated that he had "called the ARDC, but they told me not to complain until this case is over, but I have had enough." Further Petitioner's attorney said, "There has been criminal activity I could have complained about and I haven't, but what he just came up here and described to you is a fraudulent scheme to cheat my client out of her award." Petitioner's attorney lastly stated that the Optum attorney indicated he would get his own attorney and from that point forward all communications ceased.

With no further communication from Optum this matter came to a standstill. Respondent still attempted to subpoena payment records. Specifically, Respondent appeared before Commissioner Tyrrell in January of 2016 to request that a subpoena be issued to Optum requiring it to produce any and all bills, payments made and correspondence related to Petitioner's May 25, 2007 accident. As of the May 26, 2016 hearing date, there has been no compliance with the subpoena.

The Commission notes that, irrespective of whether Optum is a Medicare/Medicare agent, or a subrogation arm of United Healthcare, there was a tentative reimbursement agreement being finalized before Petitioner's attorney's demand that Optium cease and desist. The Commission finds that the delay in satisfying payment of the medical award has resulted more from the obstructionist behavior of Petitioner's attorney than the Respondent's conduct. Accordingly, the Commission denies Petitioner's Petition for Penalties under §19(k) of the Act and for Attorneys' Fees under §16 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Penalties under §19(k) of the Act and for Attorneys' Fees under §16 of the Act is hereby denied.

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

DATED: SEP 16 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

R: 5/26/16

43

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

☒ 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

Sandra Clayton,

Petitioner,

vs.

16IWCC0573

NO: 07 WC 50766
08WC 42354
08 WC 42355

Pembroke School District #259,

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 affirm Arbitration order 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 15, 2014 is hereby affirmed and adopted.

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

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

16IWCC0573

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

DATED: SEP - 7 2016
KWL/vf
O- 8/30/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)

)

COUNTY OF Mc Henry)

☐ Injured 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

16IWCC0573

Sandra Clayton
Employee/Petitioner

v.

Pembroke School District #239
Employer/Respondent

Case # **07** WC **50766**

,08WC42354 & 08WC42355

The ***petitioner*** filed a petition or motion for **reinstatement** on **date on Motion** , and properly served all parties. The matter came before me on **January 3rd, 2014** in the city of **Woodstock** . 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:

Based upon the facts alleged and the law the Arbitrator denies the Motion 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.

Signature of arbitrator

June 26th, 2014
Date

JUL 15 2014

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

Joshua Garcia,
Petitioner,
vs.

NO: 08 WC 04166

Executive Mailing Service,
Respondent,

16IWCC0621

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 18, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $61,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 8 2016
o092216
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, JOSHUA
Employee/Petitioner

Case# **08WC004166**

EXECUTIVE MAILING SERVICE
Employer/Respondent

16IWCC0621

On 3/18/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE, JAMES P LAW OFFICE
MATTHEW JONES
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
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

JOSHUA GARCIA
Employee/Petitioner
v.

Case # 08 WC 4166

16IWCC0621

EXECUTIVE MAILING SERVICE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth**, Arbitrator of the Commission, in the city of **Chicago**, on **11/18/2015**. 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 1. Prospective Medical; 2. Violation of Two Doctor Rule

FINDINGS

On **01/18/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.
On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
Timely notice of this accident ***was*** given to Respondent.
Petitioner's current condition of ill-being ***is not*** causally related to the accident.
In the year preceding the injury, Petitioner earned $17,416.36; the average weekly wage was $334.93.
On the date of accident, Petitioner was **26** 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 $41,442.04 for TTD, $0.00 for TPD, $0.00 for maintenance, $2,627.60 for PPD advances, and $128,707.12 for medical benefits, for a total credit of $172,776.76.
Respondent is entitled to a credit of $**0.00** under §8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $223.28/week for 163 & 4/7 weeks, commencing 06/28/2008 through 8/17/2011, as provided in §8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $200.95/week for 125 weeks, due to injuries sustained that caused 25% loss of the person-as-a-whole, as provided in §8(d)2 of the Act.

Petitioner failed to prove that he is entitled to any prospective medical care.

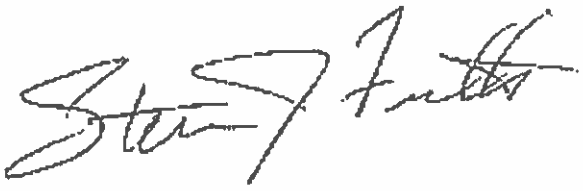
Petitioner did not violate the Two Doctor Rule.

Respondent shall be given a credit of $41,442.04 for TTD, $0.00 for TPD, $0.00 for maintenance benefits, $2,627.60 for PPD advances, and $**128,707.12** for medical benefits, for a total credit of $172,776.76.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day

before the 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 18 2016

INTRODUCTION

This matter proceeded to hearing on November 18, 2015 before Arbitrator Steven Fruth. The disputed issues were: **F:** Is Petitioner's current condition of ill-being causally related to the accident?; **J:** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; **K:** What temporary benefits are in dispute? TTD; **N:** Is Respondent due any credit?; **O:** Is Petitioner entitled to prospective medical care and services? or, alternatively, What is the nature and extent of the injury?; **P:** Did Petitioner exceed the permitted number of treating physicians or healthcare facilities?

Petitioner testified through a translator. Joel Bollero also testified at trial.

This matter was previously tried on a §19(b) Petition before Arbitrator Robert Williams on June 27, 2008. A decision issued by Arbitrator Williams found that Petitioner did suffer an accident arising out of and in the course of his employment with Respondent, and that his condition of ill-being at that time in his lumbar spine and associated radicular complaints was related to his accident at work on January 18, 2008. Temporary total disability benefits were awarded through the date of hearing, and the Arbitrator ordered Respondent to pay certain, but not all, medical expenses claimed by Petitioner at that time. On review the Commission unanimously affirmed Arbitrator Williams' decision and awarded additional medical expenses were awarded.

On administrative review the Circuit Court of Cook County affirmed the Commission. The Appellate Court of Illinois, Workers' Compensation Division, affirmed the holding of the Circuit Court.

STATEMENT OF FACTS

Petitioner testified that he injured his lower back while working in Respondent's shipping department on January 18, 2008. He had complaints of mid back and left leg pain. At the time of trial June 27, 2008 Petitioner was recovering from an IDET procedure. At hearing November 18, 2015 Petitioner testified that his medical treatment continued following the prior §19(b) hearing. Petitioner continued to receive medical treatment at Pain Net Medical Group (PX #12). Following an IDET procedure by Dr. Scott Glaser at Pain Net Petitioner noted 30% relief in pain but continued to complain of left lower back pain radiating to his left hip in the summer of 2008. Dr. Glaser referred Petitioner to Dr. Carl Graf at Pain Net. Petitioner presented to Dr. Graf on October 3, 2008 with complaints of low back pain and bilateral leg pain, left greater than right. Dr. Graf recommended conservative treatment until Petitioner could no longer tolerate the pain, and then Petitioner should consider a lumbar fusion surgery.

Pain Net Medical Group records (PX #12) show chiropractic treatment by Dr. Steve Harvey from February 2008 through May 2011.

Petitioner testified that Dr. Harvey and doctors at Pain Net referred him to Dr. Kevin Jackson, a spine surgeon. Petitioner then began treating with Dr. Kevin Jackson at Pain Net on April 17, 2009 (PX #12). Petitioner complained of low back pain and bilateral leg pain left greater than right. Dr. Jackson noted Petitioner's positive discogram as well as the prior IDET. Petitioner had a positive straight leg raise on the left but negative on the right. Lower extremity reflexes were diminished bilaterally. Dr. Jackson felt Petitioner most likely needed a lumbar fusion at L4–5 and L5–S1. By May 22 Dr. Jackson was convinced Petitioner needed a fusion at L4-5, L5-S1.

Dr. Jackson referred Petitioner for work hardening in June 2009. Work hardening was discontinued in July 2009. At that time Dr. Jackson recommended an H-wave machine which did little to relieve his pain. Dr. Jackson performed a two level lumbar fusion on September 15, 2010. Up to that time Petitioner had not been released to return to work.

Petitioner went to Work Hardening of West Loop (PX #11) on referral by Dr. Jackson. He attended from June 29 through July 20, 2009. Petitioner cancelled 6 of 14 scheduled sessions. He demonstrated the ability to lift 10 lbs. frequently waist to floor and carrying 10 lbs. frequently for 50 feet. He pushed and pulled a slab with 20 lbs. frequently 450 feet. He was able to tolerate 30 min. of cardiovascular exercises. The physical therapist noted "it appears that Joshua has very poor pain tolerance." Continued work conditioning was recommended.

Dr. Jackson performed the L4–5, L5–S1 transforaminal lumbar interbody fusion (TLIF) on September 15, 2010 at Good Samaritan Hospital (PX #10 & PX #15). Petitioner testified that just before surgery he was unable to walk due to back and left leg pain. Petitioner had only short-term relief from the surgery. Postoperatively Petitioner initially complained of severe back pain although his TLSO brace provided comfort (PX #10). On October 29, 2010, Dr. Jackson referred Petitioner to a psychologist because Petitioner was feeling angry and depressed. Dr. Jackson also referred Petitioner for physical therapy. Dr. Jackson expected Petitioner to reach MMI within one year of surgery.

Enrique Gonzalez, Ph.D. (PX #7) is a clinical psychologist affiliated with Prime Care and Michigan Avenue Medical Associates (f/k/a Pain Net Medical Group). Dr. Jackson referred Petitioner to Dr. Gonzalez.

Dr. Gonzalez evaluated Petitioner on November 8, 2010. Dr. Gonzalez noted Petitioner had been experiencing depressed mood and violent thoughts since his surgery. He experienced worry over his finances, crying spells, and feelings of inadequacy. Dr. Gonzalez diagnosed adjustment disorder with depressed mood. Dr. Gonzalez noted Petitioner's complaints of pain over his entire left side. Petitioner had a total of 8 visits with Dr. Gonzalez, the last on August 9, 2011. At that visit, Petitioner

was very upset about a letter he received from Dr. Jackson describing Petitioner's bizarre behavior during their last appointment.

In general Dr. Gonzalez provided cognitive behavioral therapy for Petitioner's depression and anger. These conditions seemed related to Petitioner's chronic pain and lack of financial resources, although Dr. Gonzalez did not state so directly. Dr. Gonzalez did not document any opinion that his care was necessary to cure or relieve any condition related to the underlying accidental injury. Petitioner testified to a few visits with Dr. Gonzalez in 2010 and 2011, which "helped". Petitioner was clear that he was not seeking authorization for additional psychiatric care.

Petitioner followed with Dr. Jackson throughout 2010 and 2011. He referred Petitioner for physical therapy. Petitioner received therapy at Prime Care, affiliated with Pain Net Medical Group, a/k/a Michigan Avenue Medical Associates, and Accelerated Rehabilitation in 2011. Petitioner realized only marginal improvement with physical therapy.

Dr. Edward Goldberg at Midwest Orthopedics at RUSH (PX #21) conducted an IME of Petitioner on May 17, 2010 at the request of Petitioner's counsel.

Dr. Goldberg reviewed Petitioner's clinical history from records from January 19, 2008, including imaging, physical therapy, epidural injections, facet injections, and nerve block injections. Dr. Glaser's discogram on April 10, 2008 was noted as well as Dr. Glaser's IDET procedure on May 8, 2008. Petitioner complained of low back pain with paresthesia in the left leg. He also complained of occasional numbness in the left arm. Petitioner reported he had not worked since the time of his original labor accident. On examination petitioners range of lumbar motion was limited. Muscle strength was normal. There was a negative straight leg raise. Reflexes were normal and no atrophy was noted. Sensation was intact from C5 to T1 and from L3 to S1.

Based on his review of Petitioners records Dr. Goldberg felt that Petitioner had aggravated his degenerative disease. He felt that Petitioner might be a candidate for L4-5 and L5-S1 fusion. Dr. Goldberg further opined that he anticipated Petitioner would achieve MMI within 9 months after surgery. He further opined that Petitioners condition of ill-being was due to the reported accident. He found the Petitioner was able to work with a 10 lb. lifting restriction.

Dr. Ezequiel Mendez (PX #8) is a family practice physician. Petitioner consulted him in 2011 for abdominal pain. In his medical history Petitioner reported lower back problems and pain over the left side of his body from head to knee, along with nausea and weakness. Petitioner reported that his back problems were being treated at Michigan Avenue Medical Associates.

On February 25, 2011 Dr. Jackson noted that Petitioner began noticing dizziness, blurred vision and low blood pressure in physical therapy. Petitioner was also complaining of upset stomach, so Dr. Jackson switched Petitioner's medications. He recommended a CT scan as well which was performed on March 4, 2011 (PX #1). The CT scan revealed the results of the surgery without apparent complications. Although

osseous fusion was not demonstrated, there was no definite evidence of nonunion. There was no apparent operative complication.

In March 2011, Petitioner began making complaints of pain in the entire left side of his body (PX #10). Dr. Jackson noted Petitioner complained of coldness near the left ear and the periauricular area and left eye were noted to be painful. Petitioner reported pain that shot down to his left shoulder and into his left hip and leg. Dr. Jackson noted the CT scan showed no complications from the surgery. Petitioner testified to his continued complaints of pain and symptoms on the entire left side of his body, including chills on only left side. He was discharged from physical therapy at Accelerated Rehabilitation March 14, 2011 at Petitioner's request (PX #16.). The physical therapist noted Petitioner made objective progress but that progress was significantly slow secondary to continued complaints of not feeling well, feelings of nausea, left-sided whole body pain and increased complaints of discomfort after therapy.

Petitioner returned to Accelerated on June 13, 2011 for a reassessment. Petitioner reported the same symptoms as before. He was discharged on June 14 at his request

On April 21, 2011 Dr. Jackson's examination was essentially normal despite an antalgic gait, tenderness on the left side of the S-1 joint, and tenderness in the right hip and thigh (PX #22). Straight leg raise was negative on both the right and the left. Dr. Jackson assessed lumbar disc disease with root symptoms on the left. He recommended that Petitioner wear his TLSO brace and discontinue physical therapy until his medical issues were addressed/resolved. Dr. Jackson noted lacks of mature bridging bone between the vertebral bodies of L4–5 and L5–S1 on review of the March 18 CT scan and that this could be augmented with a short surgical procedure to add more allograft to the lumbar spine. However, he noted this may not address all of Petitioner's issues. He also recommended Petitioner follow-up with his primary care physician due to his abdominal pain, back pain and left hemi-body symptoms and pain and easy fatigue (PX #10).

Pursuant to Dr. Jackson's recommendation, Petitioner again began physical therapy at Accelerated Rehabilitation Centers on June 13, 2011. However, Petitioner was discharged from physical therapy on June 14 at Petitioner's request. He advised the physical therapist he did not feel ready to reinitiate physical therapy secondary to body weakness, nausea, fatigue and "just not feeling to be able to reinitiate physical therapy."

Petitioner resumed medical treatment at Michigan Avenue Medical Associates (f/k/a Pain Net Medical Associates) on June 17, 2011 (PX #9). He testified that Pain Net Medical Group became known as Michigan Avenue Medical Associates. Dr. Rogelio Riera noted Petitioner's multiple complaints on the left side of his body. Petitioner's examination was essentially normal, including a normal neurological examination. Dr. Riera wanted to rule out any type tropical disease, including malaria. On July 26, 2011, Petitioner continued to make the same complaints to Dr. Riera. His examination again

was essentially normal. Dr. Riera noted he had no treatment or medication to offer Petitioner and signed himself out of Petitioner's case.

Both Dr. Jackson and Dr. Riera discontinued physical therapy in June 2011.

Dr. Jackson's last consultation with Petitioner was on June 23, 2011 (PX #22). Dr. Jackson noted Petitioner never had significant improvement of his symptoms. Petitioner's chief complaint at that time was left-sided face pain involving the left ear, and left shoulder pain radiating into his left arm. Petitioner complained that his back hurt and that the left flank area was tender and felt swollen. Petitioner noted abdominal pain. Dr. Jackson did not note any left leg complaints. Petitioner's examination was otherwise normal at that time. Dr. Jackson was of the impression that Petitioner was status post lumbar fusion with continued low back pain and new issues of depression, abdominal pain, left side face/ear pain, and left shoulder/arm pain. He recommended Petitioner continue with his TLSO brace and contact the office if there were any problems. He noted the low back pain could be addressed with a revision surgery, but the surgery would not affect Petitioner's pain issues in his face, shoulder, arm or abdomen. Petitioner was to continue with his current medications and was given restrictions of no lifting over 10 lbs.

Petitioner saw neurologist Dr. Edward Herba at Michigan Avenue Medical Associates on September 15, 2011 (PX #9). Dr. Herba had initially seen Petitioner in 2008 (PX #12). Dr. Herba noted Petitioner's left-sided complaints. He recommended continued treatment with Dr. Gonzalez since much of Petitioner's presentation was compounded by psychological features. Dr. Herba noted the Petitioner felt much better on October 27, 2011 and recommended Petitioner see neurosurgeon Dr. Leonard Kranzler for a second opinion.

Dr. Kranzler first saw Petitioner on November 10, 2011 at Michigan Avenue Medical Associates (PX #9.) Petitioner reported pain over the entire left side of his body and in his back which went into his left leg. Dr. Kranzler noted a DSSEP (dermatomal somatosensory evoked potential) test from Lake County Neuromonitoring (PX #17) showed delays at L4 and L5. Dr. Kranzler diagnosed lumbar radiculopathy at L4 and L5 on the left, recommended a MRI of lumbosacral spine, and recommended surgery.

The MRI was performed on November 14 at Preferred Open MRI (PX #2). The MRI revealed enhancing granulation tissue at L4–5 in the ventral epidural space extending into the left neuroforamen. There was no evidence of recurrent disc bulge. At L5–S1, there was minimal enhancing granulation tissue and no evidence of recurrent disc bulge or disc protrusion. Dr. Kranzler continued to recommend surgery at L3–4 on the left and L4–5 on the left to add screws to augment his fusion.

In 2012 Petitioner continued to complain to Dr. Kranzler of pain over the entire left side of his body. On January 19, 2012 Dr. Kranzler noted that the January 10, 2012 extension/flexion x-rays showed no movement (PX #2 & PX #9). Petitioner continued to complain to Dr. Kranzler of pain over the entire left side of his body in April and May of 2012.

An FCE was performed at Premier Therapy (PX #13) on April 25, 2012. The therapist noted the FCE was valid although there were borderline indications of non-organic findings. The record was noteworthy for Petitioner's markings of a body diagram depicting pain on his left side from head to toe. Petitioner was found at the sedentary physical demand level. The evaluator noted Petitioner's functional capacities were limited due to his complaints over the entire left side of his body, including a feeling of vibration going through his left side. Petitioner tested positive on 3 Waddell's tests for non-organic complaints of pain. Dr. Kranzler noted on May 3, 2012 that Petitioner could return to modified work per the FCE.

On July 12, 2012, Petitioner advised Dr. Kranzler that he was reluctant to consider further surgery. Dr. Kranzler again released Petitioner to work activities pursuant to the FCE.

Petitioner did not receive medical treatment again until a consultation for another opinion with Dr. Robert Erickson on June 14, 2013 at Michigan Avenue Medical Associates (PX #9). Petitioner reported 9/10 pain radiating into his left foot. However, Dr. Erickson noted he presented in mild distress. Petitioner reported that he had been taking very little pain medication. Dr. Erickson noted his difficulty in examining Petitioner due to Petitioner's effort being "somewhat attenuated." Dr. Erickson noted that the November 2011 MRI and the DSSEP were abnormal.

Dr. Erickson recommended another lumbar CT scan and updating the DSSEP. Dr. Erickson noted he was not sure whether Petitioner would benefit from further surgery. He felt this CT scan would help determine if Petitioner achieved final fusion from the prior surgery. Dr. Erickson restricted Petitioner from work and requested Petitioner follow-up on September 6, 2013. Petitioner did not return to Dr. Erickson. The final diagnosis was lumbar radiculopathy.

Petitioner did not seek additional medical care until July 9, 2015, with Dr. Kranzler (PX #23). Petitioner stated that he now wished to undergo surgery. He still complained of the same symptoms and pain on the entire left side of his body including pain in his eyes, face and toes, and numbness on the left side of his body. Dr. Kranzler diagnosed lumbar radiculopathy and recommended another DSSEP test and lumbar spine MRI.

Petitioner has not had medical treatment since July 9, 2015. Currently, he is in a lot of pain in his low back and in his entire left leg. On cross-examination, he admitted he is still has pain and symptoms over the entire left side of his body. This includes pain in the upper body, left upper extremity, left side of his head and face, left eye pain, and chills on entire left side of his body. These left side symptoms were part of the reason he had difficulties with his physical therapy. He testified he has difficulties performing most activities, difficulty bending and difficulty moving and changing positions though he is able to perform activities of daily living. He has not applied for Social Security disability.

Petitioner was terminated by Respondent in 2008. He further testified that he was never offered accommodated work by Respondent.

Petitioner introduced into evidence the report of Steven Blumenthal dated August 27, 2013 (PX #18). Mr. Blumenthal interviewed Petitioner and completed a vocational assessment. He noted Petitioner is an undocumented resident. He completed 9 years of education in Mexico and passed his GED test in 2005. Petitioner is able to utilize a computer but has no formal computer software training. He noted Petitioner's self-reported physical abilities were far below what was documented in the medical records. Mr. Blumenthal recommended Petitioner complete vocational evaluation testing to evaluate his achievement skills and aptitudes note or to better ascertain the degree to which she could obtain employment given direct placement or given formal retraining, regardless of his current undocumented status. It is not clear in Mr. Blumenthal's reports what medical restrictions he relied on for his opinion that the Petitioner cannot return to perform any work he previously performed. He appears to be limiting Petitioner's ability return to work to the sedentary physical demand level based on Dr. Kranzler' s records.

Petitioner testified he did not want vocational rehabilitation. Petitioner testified that he has never returned to work in any capacity since the prior §19(b) hearing. He testified that he worked in factory positions, prior to working for Respondent, where he was not required to lift greater than 15 lbs. He has a forklift certification. He has never looked for work since his accident and has never applied for work anywhere. Petitioner has taken English as a second language courses but has limited command of English.

Respondent presented Joel Bollero as a witness. Mr. Bollero is the risk benefits manager at the Respondent. He had testified at the prior §19(b) hearing on June 27, 2008. His testimony from the prior hearing was adopted by both parties.

Mr. Bollero testified to the duties of a forklift operator. He acknowledged that the description needed to be updated. Forklift operators can operate standing or sitting forklifts and utilize those forklifts in the warehouse to pick up supplies with the forklifts. Forklift operators then bring the supplies to the respective departments. They move completed stock through a mail-processing system. He testified that Petitioner performed a minimal amount of bending and lifting in his work as a forklift operator. The products Petitioner worked with were shrink-wrapped and carried by the forklift during the entire shift. Petitioner never had to lift greater than 25 lbs.

Mr. Bollero prepared Respondent's Exhibit #7, which described the job duties of a forklift operator. Assuming Petitioner had a 30 lb. maximum lifting restriction, could frequently lift 20 Lbs., needed to sit, stand and move throughout the day, and needed to avoid repetitive bending and squatting, Mr. Bollero stated that Petitioner would be able to return to his former position as a forklift operator with Respondent, but for the fact that he had been terminated. If he had not been terminated for no-call/no-show, Respondent would have been able to accommodate any light duty restrictions Petitioner might have.

Mr. Bollero testified in 2008 to Respondent's personnel policies. He testified that Respondent had an Employee Handbook, printed in English, Spanish, and Polish, which was given to each employee at the time of hire. He further testified to the company's no-call/no-show policy for termination. Petitioner was terminated in 2008 for violation of the no-call/no-show policy. He was not offered light duty after termination. Respondent has a policy of no re-hire for job abandonment.

Mr. Bollero also testified that Respondent had light duty available for employees with Workers' Compensation claims, even if on medication. He testified that Respondent had light duty positions "outside of laying down".

Dr. Kranzler gave his evidence deposition on January 8, 2013 (PX #20.). Dr. Kranzler found it noteworthy that Petitioner's postsurgical CT scan from March 4, 2011 did not show any bone graft in the area of the fusion. He also found it relevant that the DSSEP test illustrated sensory loss at the L3-4 and L4-5 levels. Dr. Kranzler found this to be consistent with Petitioner's complaints and physical examination. He testified that the test results confirmed there was pressure on the Petitioner's nerves in his lumbar spine, even though the MRI that was performed on November14, 2011 did not reveal any nerve impingement.

Dr. Kranzler recommended a revision of Petitioner's fusion. He also recommended a decompression as well. He was recommending surgery additionally at the level of L3-4. He claimed that the additional stress at the L3-4 level was caused by the fusion at the lower levels and causally related to the work accident. Dr. Kranzler felt Petitioner could return to modified duty pursuant to the FCE results. He was still recommending surgery at the time of his last treatment of Petitioner on July 12, 2012, but the Petitioner was reluctant to consider further surgery at that time.

Dr. Kranzler diagnosed the Petitioner with lumbar radiculopathy at L4-5 on the left and a failed fusion. He testified that the surgery he has recommended is reasonable and necessary and causally related to the work accident.

On cross-examination, Dr. Kranzler discussed the numerous complaints Petitioner made that appear to be unrelated to the alleged work injury. Petitioner is not only making complaints of lower back pain and pain in his left lower leg, he is also complaining of pain on the entire left side of his body. Dr. Kranzler stated he could differentiate between the complaints. Dr. Kranzler did not treat Petitioner for his upper body left-sided complaints. He did not offer a causal connection opinion with respect to those complaints.

Dr. Kranzler acknowledged that he did not review Dr. Jackson's records or any medical records from prior to November 10, 2011, his first consultation. He did not review Dr. Ghanayem's IME report. But he did agree with Dr. Ghanayem's description that Petitioner symptom complex of pain over the entire left side was bizarre.

Dr. Kranzler testified that a DSSEP can indicate nerve deficit as well as pain. He acknowledged that Petitioner had no right-sided pain when the DSSEP demonstrated .8 at L5 on the right. He admitted that the March 4, 2011 CT scan showed no definitive

evidence of nonunion and that the January 10, 2012 x-ray indicated that the L4-5 and L5-S1 surgery was intact and in alignment.

Dr. Kranzler still opined that Petitioner's complaints were related to his original injury. He reiterated his opinion that Petitioner would benefit from revision of his fusion. He did admit that his opinion with respect to the need for additional treatment is based, at least in part, on Petitioner's subjective complaints.

Dr. Kranzler was cross-examined about the references in the FCE that Petitioner had 3 positive Waddell signs. Dr Kranzler stated that Waddell signs, which may be indicators of symptom magnification, are no longer considered reliable.

On re-direct examination Dr. Kranzler testified too his special insight in identifying malingering. On re-cross-examination Dr. Kranzler noted that Petitioner expressed his aversion to proceeding with revision surgery for his fusion on the last clinical visit in July 2012.

Dr. Ghanayem examined Petitioner at Respondent's request pursuant to §12 of the Act on August 17, 2011 (RX #2). Dr. Ghanayem also reviewed certain of Petitioner's medical records, including imaging studies. Petitioner was complaining of ongoing pain on the left side of his body from the cervical spine to the left flank as well as left by the posterior thigh and calf. He also complained of numbness and pain in the left arm. He had no complaints on the right of the midline.

On examination Dr. Ghanayem observed an abnormal left arm swing with Petitioner's symmetric gait. Lumbar range of motion was limited. Dr. Ghanayem found no focal motor deficits. Petitioner had subjective decreased sensation throughout the entire left leg. Dr. Ghanayem noted Petitioner's bizarre symptom complex, which defied explanation based on MRI scans, the nature of the reported injury, and post-surgical CT scanning. He found no correlation between Petitioner's clinical presentation and objective diagnostic studies. Dr. Ghanayem found the fusion to be solid and that Petitioner did not require additional surgery. Dr. Ghanayem opined that Petitioner could work at a level that would allow him to lift 30 lbs. He further added that Petitioner was at MMI relative to his work injury.

Dr. Ghanayem testified at evidence deposition on January 23, 2013 (RX #1). His CV was admitted in evidence, noting his professorship at Loyola University of Chicago-Stritch School of Medicine and numerous scholarly publications and presentations. He testified consistently with his IME report of August 17, 2011. He further elaborated on his opinions in direct and cross examination.

Dr. Ghanayem reiterated his opinions that Petitioner had a solid fusion and did not need a revision surgery. He noted his review of the March 4, 2011 CT scan and the x-ray report of January 10, 2012, which showed a stable fusion and no change in alignment on flexion and extension. He noted that the surgical screws were not loose or broken. The interbody grafts were not migrating or subsiding; bone was growing through them. He stated that posterior bone bridging would not develop with a TLIF, which is expected. Bony fusion occurs in the interbody. He testified that spinal

movement would occur with loosening or breakage of screws. He disagreed with Dr. Kranzler's opinion that the fusion was not stable.

Dr. Ghanayem also testified that he did not believe a DSSEP is a reliable test in a case such as Petitioner's. As a professor of orthopedic surgery he teaches his students that a DSSEP has no role in lumbar issues. A DSEEP would not be a reliable tool for assessing whether additional surgery was necessary.

Dr. Ghanayem testified that Petitioner's work injury might have caused an aggravation of his underlying lumbar disc disease.

Dr. Ghanayem noted that Petitioner had non-organic findings that he could not relate to Petitioner's spinal issues. He felt Petitioner had a bizarre symptom complex, particularly the reported hemi-body pain and numbness. He stated that the non-organic pain behavior and the bizarre symptom complex may have affected Petitioner's ability to perform during the FCE.

Dr. Ghanayem testified that Waddell signs are reliable in showing non-organic complaints of pain. He noted that the FCE illustrated the Petitioner showed positive Waddell signs on at least 3 tests. Dr. Ghanayem also found signs of symptom magnification on his examination of Petitioner. Based on Petitioner's symptom magnification and his bizarre symptom complex of experiencing pain on the entire left side of his body, Dr. Ghanayem again testified that this likely affected the ability of the FCE to determine the Petitioner's maximum work capacity.

On cross-examination Dr. Ghanayem acknowledged that Drs. Jackson and Kranzler indicated there is not a complete fusion at the L5-S1 level. If patients do not have a complete fusion, they may have no symptoms, or they could have localized low back pain. It is possible that if a patient has symptoms in the low back, a revision surgery can be appropriate. However, Dr. Ghanayem was clear that he did not believe a revision surgery was appropriate in this case.

Dr. Ghanayem gave more specific opinions with respect to Petitioner's work restrictions. He testified that Petitioner could perform a maximum lift at 30 lbs. occasionally and could frequently lift 20 lbs. Dr. Ghanayem found Petitioner would have no issue with sitting, standing, and bending restrictions as noted in the FCE. He stated that Petitioner needed to be fluid at work, meaning he needed to move, walk, and bend throughout the day rather than sitting or standing in the same position all day.

Dr. Ghanayem testified that it was difficult to parse Petitioner's non-organic pain complaints from his potentially organic pain complaints. Some of the pain complaints may have followed a dermatomal pattern from the low back into the left leg. However, Petitioner's complaints covered his entire left leg, his entire left spine, and entire left upper body. Dr. Ghanayem noted that Petitioner should not have leg symptoms after a fusion surgery; there was no evidence of nerve compression on imaging. He again indicated Petitioner may have some residual axial back pain following a fusion surgery.

Respondent introduced into evidence utilization review reports from neurosurgeon Dr. Kimberly Terry dated February 18, 2015 (RX #4) and February 19,

2015, addressed to Dr. Kranzler, (RX #5). Dr. Terry opined that the L3–4 and L4–5 revision fusion surgery, as recommended by Dr. Kranzler, was not medically reasonable and necessary. Dr. Terry noted that Petitioner had not received any medical treatment over one year and there were no current studies to support any additional surgery of any form.

During the trial Petitioner stood up to relieve back stiffness.

IMAGING

2/5/08 lumbar MRI: small disc herniations at L4-5 and L5-S1

4/10/08 post-discogram lumbar CT: extravasation of contrast material at L4-5 and L5-S1

10/8/08 lumbar x-ray: normal lumbar spine

9/3/10 lumbar MRI: mild diffuse bulging and hypertrophy at L4-5 with flattening of thecal sac and mild bilateral neural foraminal stenosis; mild diffuse disc bulging at L5-S1 with small paracentral herniation

12/10/10 lumbar x-ray: posterior fusion fixation in place at L4-S1

1/14/11 lumbar x-ray: posterior fusion fixation in place at L4-S1

3/4/11 lumbar CT: hardware intact at L4-5, bridging bone not demonstrated between L4-5 bodies or posterior elements; posterior bone graft material at L5-S1 without definite mature bridging bone; osseous fusion is not demonstrated but there is no definite evidence of nonunion

11/14/11 lumbar MRI: surgical changes consistent with L4, L5, S1 fusion; normal alignment with normal body heights and disc spaces; enhanced granulation tissue at L4-5 and minimal enhancing granulation at L5-S1

1/10/12 lumbar x-ray: L4-5 and L5-S1 surgery intact and in alignment

CONCLUSIONS OF LAW

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

BACK

The Arbitrator finds that the Petitioner failed to prove that his current condition of ill-being in his low back is causally connected to the January 18, 2008 work accident.

Resolving the issue of causation is often dependent on the credibility of the petitioner. A physician's diagnosis or causation opinion is dependent on the patient's credibility, accuracy, and reliability as a historian of their subjective complaints in addition to their clinical presentation. In addition, Petitioner had a history of poor compliance with regimens of physical therapy ordered by his physicians, requesting discharge more than once before completion of the course of therapy. There was also evidence of symptom magnification. Based on review of all the evidence the Arbitrator found that Petitioner was not an accurate or reliable historian, and is therefore not credible.

Treating and examining physicians have noted Petitioner's bizarre presentation Petitioner has significant, bizarre complaints of left-sided hemi-body complaints of pain and numbness. Treating and examining physicians identified non-organic complaints which defy explanation by accepted anatomy and physiology. The non-organic hemi-body complaints are apparently hysterical in nature and have no relation to Petitioner's underlying back injury from 2008. No treating or examining physician has offered an opinion that the hemi-body subjective complaints are related in any way to the 2008 work injury.

Petitioner did sustain a back injury that led to transforaminal interbody fusion (TLIF) surgery on September 15, 2010 by Dr. Kevin Jackson. Petitioner's post-operative course was a course of ups and downs with regard to his subjective complaints. Post-operative clinical exams, including negative straight leg raising, were essentially normal neurologically and orthopedically. Postoperative imaging did not reveal nerve root compression which would account for Petitioner's subjective left side radicular complaints. Despite this incongruous and contradictory presentation Petitioner's neurosurgeon Dr. Leonard Kranzler diagnosed radiculopathy and the need for revision and extension of Petitioner's fusion.

The Arbitrator does not find Dr. Kranzler's opinions to be persuasive. Dr. Kranzler did not obtain or review Petitioner's medical records from any other healthcare professional other than imaging studies. Dr. Kranzler opined that Petitioner's fusion was not solid and not stable. He therefore recommended revision of the fusion.

The CT scan of March 4, 2011 showed that Petitioners fusion indeed was stable. Although it did not show definitive evidence of bony bridging there was no evidence of nonunion. Further, it showed that the spine was normally aligned. The plain x-rays of January 10, 2012 did not demonstrate any movement during flexion or extension.

In addition Dr. Kranzler relied on the dermatomal somatosensory evoked potential findings as a basis for his opinions. He indicated that the DSS EP could indicate subjective pain. Dr. Kranzler seems to be alone in the field of medicine in believing that pain can be objectively measured by any clinical test or study. In addition to ignoring the obvious findings of the imaging studies in 2011 and 2012 Dr. Kranzler also relied on the reliability of Petitioner's reports of subjective complaints. The arbitrator has previously found that Petitioner is not a reliable historian and therefore not credible.

Petitioner was examined by Dr. Alexander Ghanayem on August 17, 2011. After a thorough clinical examination and review of Petitioner's medical records, including imaging studies, Dr. Ghanayem opined that Petitioner was at MMI relative to his work injury. Dr. Ghanayem noted Petitioner's bizarre symptom complex, particularly the complaints of hemi-body pain and numbness. Dr. Ghanayem believed this overlying, inexplicable presentation complicated Petitioner's status.

In his evidence deposition Dr. Ghanayem I am elaborated on his opinion that Petitioner's TLIF was stable. He noted that posterior bony bridging would not be

expected with this fusion procedure. He noted that the interbody part of the fusion was solid. Dr. Ghanayem also noted that Petitioner's subjective complaints did not correlate with any objective clinical findings, particularly the lack of nerve compression. He also opined that the DSSEP is unreliable for assessing a lumbar case and noted that he does not teach its use to his students. Dr. Ghanayem does not believe Petitioner should have revision of his TLIF.

The Arbitrator notes Dr. Ghanayem's clinical and academic credentials. He is a professor of spine surgery at a respected medical college and has conducted research published in respected medical journals. In light of all the foregoing the Arbitrator finds Dr. Ghanayem's opinions more persuasive than those of any of Petitioner's treating physicians. As such, the Arbitrator finds that Petitioner failed to prove that his current condition of building was causally related to the work place accident on January 18, 2008.

PSYCHOLOGICAL

Further, Petitioner failed to prove that any psychological condition, diagnosis, or problem was causally related to his accidental injury in January 2008.

Neither Dr. Gonzalez nor any of Petitioner's healthcare providers opined that Petitioner's temporary psychological condition was causally connected to the work accident or to the stress of the extensive medical care that followed. The mere fact that Dr. Gonzalez provided cognitive behavioral therapy following Petitioner's accident or following his surgery did not satisfy the burden of proving causal connection.

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

As noted above, Petitioner failed to prove his current condition of ill-being in his low back is causally connected to the work accident. This is based on the Petitioner's lack of credibility, the unpersuasive opinions of Petitioner's treating physicians, and the persuasive opinions of Respondent's expert, Dr. Ghanayem.

Dr. Ghanayem found Petitioner to be at MMI at the time of his exam on August 17, 2011. Petitioner's care thereafter was driven by his clinically inconsistent subjective complaints. Therefore, the Arbitrator finds that Petitioner failed to prove that medical care and treatment after August 17, 2011, other than palliative medications for residual pain, was reasonable or necessary to cure or relieve the effects of the accidental injury sustained on January 18, 2008.

The evidence showed that Respondent paid for Petitioner's low back medical treatment up through Dr. Ghanayem's examination on August 17, 2011, and therefore the Arbitrator finds Respondent has paid for all reasonable, necessary and causally related medical treatment.

With respect to Petitioner's psychological treatment, as noted above, Petitioner failed to prove this treatment was causally connected to the work accident. Respondent is not liable for any of this treatment based on a lack of causal connection.

K: What temporary benefits are in dispute? TTD

The Arbitrator found Petitioner's current condition of ill-being is not causally related to the work-related injury. Therefore, Petitioner is entitled to TTD for the period from June 28, 20§08, the date after the prior §19(b) trial, through August 17, 2011, when he achieved MMI as determined by Dr. Ghanayem.

The Arbitrator notes that Petitioner discontinued physical therapy in March of 2011 at his request due to the bizarre complaints of hemi-body pain and numbness. He again requested discharge from recommended therapy in June 2011. Respondent's attorney wrote to Petitioner's attorney on June 6, 2011 advising that Petitioner needed return to physical therapy, to follow the treatment plan as recommended by his treating physicians, or his TTD benefits would be terminated (RX #8). Petitioner returned to physical therapy for what appears to be one date, but was discharged pursuant to his request. Respondent wrote another letter to Petitioner's attorney on June 20, 2011 (RX #6) and advised that Petitioner's TTD benefits were terminated due to Petitioner's non-compliance with physical therapy. TTD benefits were paid through June 7, 2011 (RX #3).

Dr. Ghanayem noted Petitioner was at MMI at the time of his August 17, 2011 exam. He further opined at his deposition that Petitioner, based on the clinical exam, could return to work within the restrictions of the FCE.

The Arbitrator finds that Petitioner could have returned to work but for his violation of no call/no-show work rules. Joel Bollero testified that Respondent would have accommodated Petitioner's restrictions. He testified that work restriction accommodations were routine. He also testified that normal work duties of a forklift operator did not require lift beyond the FCE restrictions. Petitioner rendered the point moot when he violated work rules requiring calling in or showing up which led to his termination. The Arbitrator found Mr. Bollero to be credible in his testimony.

The Arbitrator finds the vocational report of Seven Blumenthal is not supportive of Petitioner's claim. Mr. Blumenthal's findings are based on inappropriate, sedentary work restrictions and assume Petitioner cannot return to his former employment. Also, Petitioner testified he is not interested in vocational rehabilitation. Petitioner's ability to find work within the FCE restrictions or restrictions placed by various physicians is complicated by his undocumented immigrant status.

Based on the above, the Arbitrator finds Petitioner was entitled to TTD from June 28, 2008 through August 17, 2011; 163 & 4/7 weeks.

N: Is Respondent due any credit?

Based on Respondent's Exhibit Number #3, Respondent is entitled to a credit for benefits paid to date, which includes a $41,442.04 credit for TTD, $2,627.60 credit for PPD advances, and credit for $128,707.12 for medical benefits.

O: Is Petitioner entitled to prospective medical care and services? or, alternatively, what is the nature and extent of the injury?

Based on previous findings the Arbitrator finds that Petitioner failed to prove that he is entitled to the revision and extension of his transforaminal interbody fusion as recommended by Dr. Kranzler. The Arbitrator previously found that Dr. Kranzler's opinion was not persuasive. The Arbitrator also found that Dr. Ghanayem's opinions that Petitioner was at MMI and that revision of the fusion was not medically necessary was persuasive.

As to the nature and extent of Petitioner's injury the Arbitrator notes that Petitioner underwent a 2 level lumbar fusion at L4-5 and L5-S1 with allograft. Petitioner realized improvement following the surgery until he developed unrelated, non-organic symptoms over the entire left side of his body. Further, Petitioner could return to his former employment within the FCE restrictions and as provided by Dr. Ghanayem but for his violation of work rules. This was supported by the testimony of Mr. Bollero.

According to Dr. Ghanayem Petitioner does not require additional medical treatment except for palliative medication. Petitioner may have minor residual complaints of low back pain. Petitioner's claim of ongoing pain is near impossible to evaluate what The Arbitrator cannot reasonably ascribe what complaints are related to the original back injury and what is related to Petitioner's non-organic, entire left-sided complaints of pain, numbness, and chills. The latter are clearly not related to the work injury. His ongoing left leg pain complaints are not likely related to the work accident or the sequelae of surgery because the pain follows no specific dermatomal pattern and there is no radiological evidence of nerve compression.

Based all the evidence, the Arbitrator finds Petitioner is entitled to 25% loss-of-use of person-as-a-whole, pursuant to §8(d)(2) of the Act.

P: Did Petitioner exceed the permitted number of treating physicians or healthcare facilities?

The Arbitrator finds that Petitioner's medical treatment was from a chain of referrals from his original treating physicians. Petitioner did not violate the Two Doctor Rule.

Steven J. Fruth, Arbitrator

March 16, 2016
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SEAN STARKWEATHER,

Petitioner,

16IWCC0586

vs.

No. 08 WC 30919

STATE OF ILLINOIS – MENARD CC,

Respondent.

DECISION AND OPINION ON PETITION UNDER §8(a) OF THE ACT

This matter comes before the Commission on Petitioner's "Petition for Review of Prior Award and Prospective Medical Care Pursuant to §8(a), of the Illinois Workers' Compensation Act." A hearing was held in Mt. Vernon on January 6, 2012 before Commissioner White. The parties were represented by counsel and a record was taken.

In previous proceedings, by decision dated June 8, 2009, an Arbitrator indicated the parties had stipulated to a repetitive trauma accident on July 8, 2008 which caused bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and herniated disc/annular tear at C3-4. Petitioner had surgeries in his wrists and elbows, on August 24, 2008 and September 11, 2008, and on his neck on December 9, 2008. Petitioner was returned to work without restriction on February 24, 2009.

The Arbitrator awarded Petitioner 26&4/7 weeks of temporary total disability benefits, which had been paid, $171,801.46 in medical expenses, 272.95 weeks of permanent partial disability benefits representing loss of 17.5% of each hand, 20% loss of each arm, and 20% loss of the person as a whole, and penalties of $84,062.25 and attorney fees of $33,624.90. Respondent sought review, apparently only on the issue of penalties and fees. The Commission reduced the award of penalties and fees, with one Commissioner dissenting, indicating he would vacate the entire award of penalties and fees.

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Findings of fact & Conclusions of Law

1. Petitioner testified that after his previous testimony on May 13, 2009 he was given an award by the Commission for injuries to his neck and his wrists/elbows bilaterally. Since that award he has continued to have problems with his hands and elbows. He had pain and numbness and tingling in his hand and some in the elbows. He has trouble lifting. Petitioner returned to Dr. Gornet for treatment. He eventually came under the care of Dr. Mall, who administered an injection in his right hand, which did not provide relief. After testing Dr. Mall offered surgery.

2. Petitioner is a corrections officer at Menard Correctional Center. His title and duties have not changed since the original hearing. However, he was moved to the day shift, 7-3, which increased his duties. There is more movement of inmates. He has not suffered any additional injuries to his hands, elbows, or neck since the hearing.

3. Petitioner had an examination pursuant to Section 12 of the Act with Dr. Lange in 2013. Petitioner cooperated with the exam. He did not remember the recommendations Dr. Lange gave regarding treatment. The treatment he has received has helped him continue to work. Petitioner told Dr. Mall that he had some initial improvement after the initial surgeries prior to the arbitration but his symptoms recurred. He does not have diabetes, hyperthyroidism, or gout, and is 5'10" and 185-190 lbs.

4. On cross examination, Petitioner testified that the recurrence of his symptoms occurred a year or a year and a half ago. His surgeries were "several years ago.' He was not doing anything specific when the symptoms returned and he could not ascribe it to any specific activity at work.

5. The medical records indicate that on July 25, 2011, Petitioner presented to Dr. Gornet about 2½ years after surgery on December 9, 2008 which included a disc replacement. He had discogenic neck pain with small broad-based herniation at C3-4. Dr. Gornet noted "he has open medical for this neck issue." Petitioner was working full duty and had some increasing headaches over the last month. A plain CT taken that day showed the hardware was in good position. Petitioner could not have an MRI because of a pacemaker. Dr. Gornet was satisfied with observation and if his symptoms persisted they could obtain a CT-Myelogram. He could continue working full duty.

6. On April 27, 2012, Petitioner complained of increasing neck pain with tension in his neck when he comes home from work. Dr. Gornet's neurological exam was normal but he thought it was prudent to move forward with the CT-Myelogram.

7. On June 21, 2012, Dr. Gornet noted that CT-Myelogram taken that did not show any new problems and successful C3-4 replacement without complication. He kept Petitioner off work for two days because of the test and he would return to work as of June 23rd.

8. On August 6, 2013, Petitioner presented to Dr. Tanaka for evaluation of worsening bilateral hand pain and weakness, right worse than left. He had similar problems in 2007 and had bilateral carpal tunnel/cubital tunnel surgeries. He reported no significant injury which started the symptoms, "but reports that he performs a lot of repetitive upper extremity motions at work that have contributed to this." He noted about 80% improvement in grips strength and sensation after the surgeries. Dr. Tanaka ordered an EMG.

9. The EMG taken by Dr. Philips on August 12, 2013 showed good improvement and compression in the medium and ulnar nerves with no impression of carpal tunnel syndrome or cubital tunnel syndrome. Screening for cervical radiculopathy was also unremarkable.

10. On August 19, 2013, Dr. Tanaka noted the EMG showed significant improvement since the test administered prior to surgery and no evidence of recurrence of recurrent carpal tunnel syndrome or cubital tunnel syndrome. She prescribed medication and some physical therapy and would refer him back to Dr. Gornet for cervical evaluation.

11. By September 30, 2013, Dr. Tanaka characterized Petitioner's condition as resolving symptoms of right medial epicondylitis and bilateral hand numbness. She would reevaluate Petitioner after the evaluation by Dr. Gornet.

12. Petitioner presented to Dr. Gornet on October 21, 2013, reporting some tingling in his hands. Nerve studies showed no recurrence of carpal tunnel syndrome so Petitioner was referred back to Dr. Gornet. "He has no new slips, falls or other issues. This is causally connected to his original treatment." Dr. Gornet indicated he would send him for a CT to see if there were any facet changes. The CT showed no significant issues. Dr. Gornet did not believe it was necessary to go forward with a CT Myelogram. He released Petitioner from treatment.

13. On October 28, 2013, Petitioner returned to Dr. Tanaka noted Dr. Gornet had cleared Petitioner of any cervical pathology. However, he continued to report numbness in his hands and "electrical and nerve" type pain. Dr. Tanaka could not explain his continued bothersome hand numbness and wanted a second opinion from a hand surgeon.

14. At Respondent's request, Petitioner was examined by Dr. Lange pursuant to Section 12 of the Act. Petitioner reported his problems began in 2008 when he developed bilateral numbness and tingling in his hands. He also developed achiness in his neck. He eventually had bilateral carpal tunnel release, cubital tunnel release, and disc replacement surgeries. Petitioner's neck was significantly better after surgery with only occasional very mild achiness/stiffness in the neck. Petitioner's hands also got better after surgery. However, about a year ago he developed recurrent symptoms in his elbows and hands. Dr. Lange's cervical exam was essentially normal. Tinel and Phelan testing "seemed to be benign in the carpal tunnels. He did have equivocal positive Tinel sign over the surgical scar at the right elbow and more definitively to the left."

15. Dr. Lange's diagnoses were history of bilateral carpal tunnel/cubital syndrome, history of disc herniation C3-4, and recurrent arm symptoms, which were peripheral rather than radicular. His peripheral symptoms were likely related to the original bilateral carpal tunnel/cubital syndrome because his current symptoms were not radicular. Evaluation and treatment for his cervical and arm conditions have been necessary and reasonable, but he needed no additional treatment or diagnostics for his cervical condition. He noted that Petitioner presented his condition "in a very credible fashion" and he did exhibit positive Tinel over the elbows.

16. On April 11, 2014, Petitioner presented to Dr. Mall with symptoms similar to those he had in 2007. Over the last year he had worsening bilateral upper extremity symptoms of weakness and tingling in the hands. Despite a negative EMG he presented to Dr. Mall for evaluation of whether his symptoms were the result of recurrent carpal tunnel syndrome. He prescribed a diagnostic injection. If he improved significantly the symptoms could be related to recurrent carpal tunnel syndrome if not he might be referred for pain management.

17. On May 9, 2014, Petitioner reported his symptoms had not changed and he "hurts all the time." He did not benefit from the injection. Dr. Mall was "a little bit perplexed" about Petitioner's symptoms. One does not typically see return of carpal tunnel syndrome symptoms, "especially when seen by a reputable surgeon such as Dr. Brown." Petitioner had bilateral carpal tunnel/cubital symptoms despite negative EMG findings. He would refer Petitioner to Dr. Granberg, a pain specialist.

18. On June 4, 2014, Petitioner presented to Dr. Granberg on referral from Dr. Mall for moderate dull aching, throbbing neck pain into both arms, elbows and hands. However, the pain did not radiate. He had bilateral carpal tunnel and cubital tunnel surgeries in around 2009, as well as disc replacement. He had relief until about two years ago when his symptoms recurred. An injection administered by Dr. Mall provided only nominal relief. Dr. Granberg diagnosed carpal tunnel syndrome and "unspecified heredity and idiopathic peripheral neuropathy" and prescribed a trial of Neurontin.

19. Petitioner continued to treat with Dr. Granberg through December of 2015. He altered prescription medication. Petitioner reported little benefit from the medications.

20. On July 3, 2014, Dr. Sudekum examined Petitioner pursuant to Section 12 of the Act at the request of Respondent. He noted that Petitioner currently complained of constant numbness/tingling in both his hands, which is worse with driving and repetitive activities. He also complained of burning in his elbows, decreased grip strength, and occasional left shoulder pain. Dr. Sudekum also noted a significant resting tremor in both hands, which Petitioner indicated was present for "a few years." Strength was normal bilaterally, Tinel's positive of the right wrist and negative on the left and positive bilaterally at the elbows, and Phalen's was negative in the wrists bilaterally, but at the elbow caused generalized hand pain with no paresthesias.

16IWCC0586

21. Dr. Sudekum indicated that on May 11, 2009, Dr. Gornet noted Petitioner's neck was doing quite well but he still got some residual tingling in his hands. He also noted numbness in Petitioner's hands on June 18, 2009. Petitioner indicated he was comfortable living with the symptoms at the time and would contact Dr. Gornet if he wanted further investigation/treatment. Dr. Sudekum opined that Petitioner's subjective complaints and symptoms were "out of proportion to the findings on physical examination and objective studies and his symptoms were not consistent with typical carpal and/or cubital tunnel syndrome, recurrent or otherwise." He noted that the tremor may be an "*essential tremor*," but it may be indicative of some neurological pathology such as Parkinson's, which potentially could be a cause of the constellation of his arm complaints.

22. Dr. Sudekum recommended evaluation by a neurologist. He thought the possibility that the symptoms were related to postoperative scarring or recurrent compression/irritation of nerves, either spinal or peripheral, was less likely because there was no objective evidence of cervical radiculopathy or peripheral neuropathy.

23. Dr. Sudekum wrote that here was no objective evidence of carpal tunnel syndrome, cubital tunnel syndrome, cervical radiculopathy, tendonitis, or any peripheral neuropathy affecting the arms. His current complaints were not related to his work activities. Petitioner did not need any additional treatment due to any injury or work activities of January 8, 2008 and he had reached maximum medical improvement.

24. On March 2, 2015, Petitioner returned to Dr. Mall and reported his symptoms persisted. "He got some better following his initial surgery" however similar symptoms returned. Dr. Mall's physical exam appears to be normal and Petitioner had normal sensation in all dermatomes. Dr. Mall diagnosed possible complex regional pain syndrome or possible recurrence of carpal tunnel syndrome. He recommended vitamin treatment which may help complex regional pain syndrome. If they had to perform revision carpal tunnel syndrome surgery, it would be more extensive than the previous surgery. He would perform one side first to see it resolved the symptoms.

25. On June 2, 2015, Petitioner thought he was getting worse. Dr. Mall recommended evaluation by a rheumatologist. Nevertheless, they "went ahead and submitted for approval for a carpal tunnel revision." However, they would await the rheumatologist's evaluation.

26. By July 27, 2015, Petitioner reported his symptoms were somewhat worse. Dr. Mall told him he did not have a good explanation for his symptoms. He had nothing to point to a recurrence of carpal tunnel syndrome, other than Petitioner's subjective complaints. He had nothing to offer Petitioner "other than an attempt at surgical decompression and possibly submuscular transposition of the ulnar nerve followed a repeat decompression of the median nerve at the wrist. Obviously, there is a potential that this does not improve his pain or symptoms." Petitioner wanted to proceed nevertheless.

27. Dr. Sudekum testified by deposition on May 14, 2015. Dr. Sudekum was asked to evaluate Petitioner's pathology, possible causes, whether he needed additional treatment, and whether he could return to work. Dr. Sudekum then outlined his physical exam of Petitioner. He also noted that Petitioner's 2008 EMG was interpreted as positive for mild carpal tunnel syndrome and cubital tunnel syndrome, and the 2013 EMG was totally negative. Dr. Sudekum performed his own studies which were consistent with the 2013 study. After his review of medical records and his examination, Dr. Sudekum diagnosed bilateral subjective pain and paresthesias in the arms, ongoing cervical pain, and active treatment of his shoulder, which was subject to previous surgery, post status carpal tunnel/cubital tunnel syndrome/cervical surgeries, and resting tremor. Dr. Sudekum opined that Petitioner's primary and possible recurrent of carpal tunnel syndrome and cubital tunnel syndrome were not related to his job activities.

28. Dr. Sudekum noted that the initial orthopedic surgeon, Dr. Davis, correctly noted that Petitioner had a long and complicated history primarily of neck pain and headaches. Nevertheless, Petitioner was subject to "very aggressive surgical treatment" and "very aggressive diagnoses of surgical pathology." The fact that Petitioner did not get better after the multiple surgeries may indicate incomplete or inaccurate initial diagnoses. Dr. Sudekum was concerned about his persistent symptoms and his tremors could be indicative of a central nervous system condition; which could be treated by a pain management specialist. Petitioner needs "to see a good neurologist," and perhaps even be evaluated for possible "behavior problems." Dr. Sudekum did not believe Petitioner was a surgical candidate. His constellation of complaints was not typical of carpal tunnel syndrome, cubital tunnel syndrome, or cervical neuropathy.

29. On cross examination, Dr. Sudekum testified he did not know whether Petitioner had thoracic outlet syndrome, but that certainly could be one of the differential diagnoses, because he did not improve after nerve decompression surgeries. Dr. Sudekum agreed that he did not specifically mention thoracic outlet syndrome in his report. To the best of his knowledge Petitioner had not been diagnosed with thoracic outlet syndrome or complex regional pain syndrome. However, if he had been seen by a pain management specialist, as recommended by Dr. Mall, those diagnoses would have been considered.

30. Dr. Sudekum also testified that Petitioner's condition improved only "temporarily" after his surgeries; his symptoms returned. He agreed that Dr. Gornet released Petitioner to full duty after his cervical surgery on March 19, 2009. He also agreed that Dr. Tanaka noted a significant improvement in objective nerve condition findings in 2013 from prior to surgery. Dr. Sudekum was aware that Dr. Mall had referred Petitioner to Dr. Granberg but apparently he was not provided Dr. Granberg's records. Dr. Sudekum would not consider his positive examination findings to be objective, except for the tremors, which would be tough to fake.

31. Dr. Mall testified by deposition on September 9, 2015. In April of 2014, Petitioner was sent to him by Dr. Tanaka, his former partner, who "just wanted another set of eyes on him, as he has somewhat of a complex case."

32. Dr. Mall believed he saw her reports as well as those of Dr. Gornet and Dr. Philips. He had bilateral carpal tunnel/cubital tunnel surgery as well as disc replacement. Petitioner improved after the surgeries. Petitioner was then released to full duty and declared to be at maximum medical improvement. However, his symptoms began worsening after that.

33. The EMG/NCV study performed by Dr. Philips showed improvement in the median nerve conduction from the test done prior to surgeries, no evidence of recurrent carpal tunnel of cubital tunnel syndrome, and no evidence of cervical radiculopathy. Dr. Mall testified that EMG/NCV "studies are just one piece of the puzzle" and should not be considered definitive as to the diagnoses of carpal tunnel syndrome, cubital tunnel syndrome, or cervical radiculopathy. On examination, Petitioner exhibited some subjective numbness in his fingers, but the sensory and carpal tunnel findings were negative. He recommended a diagnostic injection. Petitioner reported the injection did not provide much relief, which made the situation a little more complicated. At that time "he did have some positive finings" and Dr. Mall referred Petitioner to Dr. Granberg, a pain management specialist for medication therapy.

34. Petitioner returned to Dr. Mall about a year later in March 2015. He reported the treatment he received from Dr. Granberg did not relieve his symptoms. The failure of nerve-related medication lead Dr. Mall to believe that Petitioner's condition was based more on compression than simply nerve irritation. Despite continued conservative treatment Petitioner's symptoms did not resolve.

35. Dr. Mall then concluded that Petitioner probably had a recurrence of carpal tunnel syndrome and because the initial surgeries had resolved symptoms for a period of time, surgery was the best option, even though he was not 100% sure it would help him. Petitioner has never given him any reason to think he was exaggerating symptoms; "he's always been very pleasant and a very straight shooter." Petitioner's condition was the same as before his surgeries and that was caused by his work activities. The symptoms have now returned, "and therefore these are still related to his job activities."

36. Dr. Mall reviewed the Section 12 reports of Dr. Lange and Dr. Sudekum. Dr. Lange is a cervical spine specialist. He opined that Petitioner's symptoms were coming from his arms and not the cervical spine. Dr. Mall agreed with that assessment. Dr. Sudekum had some findings similar to his. Any variation could be based on the degree of irritation the nerve was under at the particular time of the exam.

37. However, Dr. Mall disagreed with Dr. Sudekum's conclusion that Petitioner got no benefit from the surgeries by Dr. Brown. That conclusion was false, based on Petitioner's report. Therefore, "all of his conclusions are then false."

38. Dr. Mall noted that Dr. Sudekum thought Petitioner should be tested for a neurological condition such as Parkinson's. However, Dr. Mall did not believe that was the cause of Petitioner's symptoms; he "never heard of Parkinson's causing numbness" in the arms. Dr. Mall would not have any objection for Petitioner to see a neurologist; the more minds on a case the better.

39. On cross examination, Dr. Mall agreed that since at least 2013 all compression tests for carpal tunnel syndrome have been negative. However, 15% of all EMG/NCVs have false negative findings. The diagnosis of recurrent carpal tunnel syndrome is not common, probably less than 5%.

40. Petitioner continued to treat with Dr. Mall after his deposition. By December 29, 2015, Petitioner reported his symptoms worsened through the day depending on activity level. Again Dr. Mall continued with the plan of surgery, even though the result of surgery was "still somewhat questionable;" outcomes of revision carpal tunnel syndrome release "are not as well defined.

In these proceedings, Petitioner seeks current and prospective medical expenses arguing "the preponderance of the medical evidence in the record clearly establishes that Petitioner's current condition of ill-being remains causally related to his accidental work injuries of January 1, (*sic*) 2008." He cites the medical opinion of Dr. Mall, was supported by Respondent's initial Section12 medical examiner, Dr. Lange. Dr. Lange, a spine specialist, basically opined that the symptoms appeared to be carpal tunnel/cubital tunnel syndrome related because they were not related to his cervical spine. Respondent argues that Petitioner did not prove he sustained any further injuries from his January 8, 2008 accident. It stresses that there was no objective evidence of Petitioner had any current condition of ill being substantiating his subjective complaints.

Respondent is absolutely correct that there is no objective evidence that Petitioner was currently suffering any peripheral neuropathies, recurrent or otherwise. Throughout the current round of treatment Dr. Mall was fundamentally perplexed by the continuation or recurrence of symptoms Petitioner exhibited. Similarly, Dr. Tanaka could not explain Petitioner's symptoms.

It is certainly within the realm of possibility that Petitioner was never completely symptom-free after his various surgeries, or had only some temporary relief. He complained to Dr. Gornet of persistent symptoms several months after the surgeries and simply indicated that he could live with the symptoms at that time. This scenario could lead either to the conclusion that Petitioner's initial diagnosis was incorrect or incomplete, as suggested by Dr. Sudekum, or that the carpal tunnel/cubital tunnel surgeries ultimately simply failed.

Despite the lack of objective findings, the Commission takes seriously Petitioner's subjective complaints and the opinions of Dr. Mall. Nevertheless, because of the lack of objective findings and Dr. Mall's uncertainty about the benefit of the rather extensive surgeries he recommends, the Commission believes it would be imprudent to order the authorization of such surgeries at this time. In fact, the authorization of any specific treatment is not appropriate and would be speculative because we are not certain of Petitioner's current condition of ill-being.

16IWCC0586

Rather, the Commission believes a more prudent option would be to obtain an objective 3rd party opinion regarding Petitioner's current condition and possible prospective treatment. In the opinion of the Commission the doctor most qualified to render such an opinion is Dr. Brown, the surgeon who performed his carpal tunnel/cubital tunnel surgeries. If for some reason Dr. Brown is unavailable to render such an opinion, the medical opinion should be rendered by a doctor upon whom both parties agree.

Finally, regarding current medical expenses, as noted above the Commission is not certain of Petitioner's current condition of ill-being. Therefore, the Commission cannot determine at this time whether his condition is related to his previous repetitive work-related traumatic injuries. Accordingly, the Commission finds that the award of current medical expenses is inappropriate at this time. We will await further evaluation authorized by this decision and address the issue in any subsequent Petition for relief under Section 8(a), with which Petitioner may choose to proceed.

IT IS THEREFORE ORDERED BY THE COMMMISSION that Petitioner's "Petition for Review of Prior Award and Prospective Medical Care Pursuant to §8(a), of the Illinois Workers' Compensation Act" is granted but only to the extent of ordering Respondent to authorize and pay for an examination by Dr. Brown, or if he is not available, another orthopedic upper extremity specialist mutually agreeable to the parties.

DATED: SEP 13 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-8/16/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Calderon-Burgin,
Petitioner,

vs.

NO: 09WC 23155

Illinois Department of Employment Security,
Respondent,

16IWCC0600

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 10, 2016, is hereby affirmed and adopted.

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

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

DATED: SEP 16 2016
o091316
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CALDERON-BURGIN, MARIA
Employee/Petitioner

Case# **09WC023155**

ILLINOIS DEPT OF EMPLOYMENT SECURITY
Employer/Respondent

16IWCC0600

On 3/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0659 BRILL & FISHEL PC
FRANCINE R FISHEL
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

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

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

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

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

MAR 10 2016

RONALD A. RIOPELLE, 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

Maria Calderon - Burgin
Employee/Petitioner
v.
Illinois Department of Employment Security
Employer/Respondent

Case # **09** WC **23155**

16IWCC0600

An *Application for Adjustment 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 **January 19, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 11, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$51, 190.81**; the average weekly wage was **$1,027.24**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **no** dependent children.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$616.34** week for **15** weeks, because the injuries sustained caused the **3%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

March 10, 2016
Date

ICArbDec p. 2

STATEMENT OF FACTS

Petitioner was employed by the Illinois Department of Employment Security for 33 years. She retired in December of 2010. She testified that on the accident date she was on her way back from lunch when her left foot stuck to the carpet in the hallway leading to her cubicle. She landed on her left elbow and left knee.

Petitioner testified that she felt pain in her left arm, left knee and her shoulder. She sought with her primary care physician, Dr. Alter of Advocate Medical Group. Dr. Alter recommended physical therapy, which she underwent. Petitioner testified that she has returned for follow-up examinations by Dr. Alter.

Petitioner testified that her symptoms have never gone away and affect her activities of daily living.

CONCLUSIONS OF LAW

Petitioner has undergone conservative treatment consisting of medical examinations and physical therapy. She continues to have pain symptoms.

Based upon the evidence in this case, the Arbitrator finds that petitioner has sustained a 3% 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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Ellen Cassano,
Petitioner,

vs.

NO: 09 WC 38253

MacNeal Hospital,
Respondent.

16IWCC0597

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, and 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 July 7, 2015 is hereby affirmed and adopted.

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

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

16IWCC0597

Bond for 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: SEP 16 2016

Joshua D. Luskin

Charles J. DeVriendt

o-09/13/16
jdl/wj
68

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASSANO, MARY ELLEN
Employee/Petitioner

Case# **09WC038253**

MacNEAL HOSPITAL
Employer/Respondent

16IWCC0597

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

If the Commission reviews this award, interest of 0.08% 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:

0412 RIDGE & DOWNES
KARIN CONNELLY
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

0766 HENNESSY & ROACH PC
SUSAN E WALSH
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

Mary Ellen Cassano
Employee/Petitioner

v.

MacNeal Hospital
Employer/Respondent

Case # **09** WC **38253**

Consolidated cases: _____

16IWCC0597

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **October 8, 2014** and **November 14, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0597

FINDINGS

On **October 20, 2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$21,432.32**; the average weekly wage was **$412.16**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

Respondent paid Petitioner **$1,854.72** in non-occupational indemnity disability benefits.

ORDER

RESPONDENT SHALL PAY PETITIONER $247.30/WEEK FOR 10 WEEKS AS PETITIONER HAS SUSTAINED A LOSS OF USE, PERSON AS A WHOLE, TO THE EXTENT OF 2%, PURSUANT TO SECTION 8(d)2 OF THE ACT.

THE ARBITRATOR AWARDS PETITIONER THE MEDICAL BILLS FOR THE REASONABLE, NECESSARY AND CAUSALLY-RELATED TREATMENT THROUGH DECEMBER 5, 2008, PURSUANT TO SECTION 8(a) AND SUBJECT TO SECTION 8.2 OF THE ACT. THE ARBITRATOR DENIES ALL OTHER MEDICAL BILLS. RESPONDENT IS ENTITLED TO A CREDIT FOR MEDICAL BILLS PREVIOUSLY PAID.

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

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

Signature of Arbitrator

July 3, 2015
Date

JUL 7 - 2015

STATE OF ILLINOIS)
)
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mary Ellen Cassano,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 09 WC 38253
	)	
MacNeal Hospital,	)	Arbitrator Brian Cronin
	)	
Respondent.	)	

16IWCC0597

DECISION OF ARBITRATOR

FINDINGS OF FACT:

Petitioner has been employed by Respondent since 1991. She started there as a housekeeper. In 2008, she worked for Respondent as a courier and a parking lot attendant. As a courier, she would go to the post office, pick up things and drop off lunches. As a parking lot attendant, she would work in the booth beside the MacNeal Hospital parking lot and would push a button to raise the gate.

On October 20, 2008, Petitioner was directing traffic because the Kronos machine was broken. Normally, the hospital staff would swipe I.D. badges in the Kronos machine. Petitioner testified that on October 20, 2008, they had to look at each doctor's badge. She and a co-worker had to go to each car to obtain the I.D. badge and then run it through the Kronos machine. She was going back and forth. It was raining that day and Petitioner was wearing rain gear. It was raining all day that day. The area in which the Kronos machine is located is covered but the area in which the

cars pull up to the parking structure is uncovered. Petitioner was walking at a normal pace when she performed these duties. She was not hurrying. While walking back to the parking structure, her legs went up and she was down on the ground. Petitioner did not recall what had happened. She did not know how she fell. Petitioner did not recall precisely where she slipped and fell. She was at Windsor and Euclid. When she slipped and fell, she was holding someone's I.D. badge. The area over which she had been walking, which included the street, the sidewalk and the parking structure, was flat. There was no curb. This was the first time that she had to go outside to the cars, collect the I.D.s and swipe them through the Kronos machine. She performed this activity for a few hours that day. She was out in the rain for a few hours.

Petitioner initially testified that there would have been 10-12 cars in line at that time and later testified that she went to 15-20 cars.

After she slipped and fell, she just lay there. Someone helped her up. One of the officers told her that she had better fill out a report. Petitioner did not notice the pain initially. That evening, Petitioner testified, she told her husband that her neck and arm (and a little bit in her back) felt tight.

Petitioner first sought treatment at MacNeal Healthcare on Cermak on October 21, 2008. (PX 1) She reported that she fell backwards and struck her left elbow and head. She had no complaints of head pain or elbow pain. Her only pain was cervical. She did not have radiating symptoms. She complained of moderate soreness and stiffness in the back and neck that is constant. She stated that the pain is made worse depending on the movement. She rated her pain level at 4/10. Upon examining Petitioner, Daniel Davison, D.O. found that Petitioner's neck was supple with palpable

spasm. He further found cervical side bending, rotation, flexion and extension to be decreased and painful. Spurling's maneuver was negative. No pain with palpation of the midline. Dr. Davison tested Petitioner's upper extremity reflexes. He found that her deltoid, triceps, biceps, wrist flexion and extension and digit extension strength to be 5/5 and symmetrical. He found her upper extremity sensation to be symmetrical and intact. (PX 1)

A preliminary reading of the cervical spine x-rays indicated diffuse degenerative joint disease at C3-C7. (PX 1)

Dr. Davision diagnosed Petitioner with a neck strain, a head injury and a left elbow contusion. He prescribed Naproxen and cold packs to the neck. He released Petitioner to return to regular-duty work. (PX 1)

Petitioner returned to Dr. Davison on October 27, 2008. She rated her pain level at 6/10 and reported that the pain is made worse by moving her head back. Her pain is non-radiating. Examination results did not differ from the October 21, 2008 exam. A final reading of the cervical spine x-rays indicated diffuse degenerative joint disease at C3-C7. Dr. Davison offered the same diagnosis, advised her to continue taking Aleve, begin physical therapy and return to the clinic in 10 days. He released Petitioner to regular-duty work. (PX 1)

Petitioner returned to Dr. Davison on November 10, 2008. She reported a pain level of 4/10 that was non-radiating. She was somewhat improved. Upon examination, Dr. Davison found her neck to be supple with moderate palpable spasm. Otherwise, examination results did not differ from the October 27, 2008 exam. Dr. Davison offered the same diagnosis, advised her to continue taking Aleve, begin physical therapy on

November 13th and return to the clinic in 14 days. He released Petitioner to regular-duty work. (PX 1)

Petitioner returned to Dr. Davison on November 25, 2008. She reported a pain level of 2/10 that was non-radiating. She continued to improve. Upon examination, Dr. Davison found her neck to be supple with mild palpable spasm. Otherwise, the examination results did not differ from the November 10, 2008 exam. Dr. Davison offered the same diagnosis, advised her to continue taking Aleve, continue with physical therapy and return to the clinic in 7 days. He released Petitioner to regular-duty work. (PX 1)

Petitioner returned to Dr. Davison on December 5, 2008. In the HPI section, Dr. Davison wrote the following:

> *"This is a follow-up visit for Mary Cassano, a 60 year-old Courier, whose primary complaint is no pain located in the back and neck. She describes it as good. She considers it to be none. Mary says that it seems to be none. She has noticed that it is made worse by nothing. It is improved with nothing. She feels it is improving very well. He pain level is 0/10. She is now pain free."*

Upon examination, Dr. Davison found her neck to be supple with mild palpable spasm. Otherwise, the examination results did not differ from the November 25, 2008 exam. Dr. Davison offered the same diagnosis and discharged Petitioner to full-duty work. (PX 1)

Petitioner next sought medical care on February 16, 2009 from her primary care physician, Manohar Jethani, M.D., at Health Stop. (PX 4) At that time, Petitioner reported that her right knee has been hurting for 1 month. To the doctor, she reported that she has experienced pain with ambulation for 2 months. No history of trauma. The doctor's impression was patellar tendinitis. (PX 4)

Petitioner returned to Dr. Jethani on February 20, 2009. She complained of a lesion on her right cheek for 4 days as well as a swollen gland. Petitioner complained of no real face pain but painful swelling on the right side of her neck. No trauma reported. Petitioner was worried that she may have been bitten by a bug in her sleep. On examination, Dr. Jethani noted a 1 centimeter diameter red area with pinpoint pustule surrounded by ~ 3 centimeter area of pink swelling on the right that is ~ 3 centimeters lateral to the right nostril. He also found a very large (1-5 centimeter) pre-tonsillar lymph node on the right. Dr. Jethani's impression was infected cyst on the right cheek with cellulitis and lymphadenitis. (PX 4)

Petitioner next sought medical treatment on March 10, 2009. She saw Dr. Jethani for a sore on her lip that is constantly bleeding. Dr. Jethani excised the lesion and ordered a biopsy. (PX 4)

Petitioner next sought medical treatment on July 24, 2009. She saw Dr. Jethani with complaints of pain in her mid-back that radiates down the right side of her arm. She told Dr. Jethani that she has had pain in her upper right back since Monday and that today, she started having a strange feeling radiating down her right arm. She reported that she woke up with pain on Monday. No history of trauma. Following his examination, Dr. Jethani's impression was cervical sprain, examination normal. (PX 4)

On August 21, 2009, Petitioner was evaluated by Dr. Zelby at the request of Dr. Jethani. At the time of the exam, Petitioner complained of neck and right arm pain. Dr. Zelby wrote that she first developed this pain on July 22, 2009, and believes this is due to falling out of a chair the previous day. (RX 4)

Dr. Zelby interpreted a MRI of the cervical spine performed on August 14, 2009 as revealing straightening of the cervical spine. There were broad-based disc/osteophyte complexes throughout which caused complete effacement of the CSF and spinal cord compression at C5-6 greater than C4-5 greater than C3-4 greater than C6-7. There was myelomalacia in the spinal cord from C3-4 to C5-6. The diagnosis was cervical spondylosis with myelopathy. Dr. Zelby recommended surgery. (RX 4)

On October 1, 2009, Petitioner underwent surgery that consisted of an anterior cervical decompression and fusion at C4-5, C5-6, and C6-7. (PX 2, PX 3)

Petitioner underwent a right carpal tunnel release on January 12, 2010. (PX 7)

Due to continuing complaints of neck and right arm pain, on November 30, 2010, Petitioner underwent a second surgery that consisted of an anterior cervical decompression and fusion at C3-4 and a right C7-T1 foraminotomy. (PX 7)

As Petitioner had complaints of right hand pain, she was referred by Dr. Jethani to Patricia A. Hsu, M.D. Dr. Hsu evaluated Petitioner on June 3, 2011 and ordered an EMG of Petitioner's upper extremities. (PX 5)

Petitioner sought treatment from Paul M. Lamberti, M.D. on November 10, 2011. On January 4, 2012, Dr. Lamberti performed a right cubital tunnel release, an extensor pollicis longus exploration and transposition, a volar thumb exploration, an A1 pulley release and tenolysis of the flexor pollicis longus on Petitioner. (PX 6)

In a narrative report from Dr. Zelby dated August 12, 2013 directed to opposing counsel, Dr. Zelby indicated that he first evaluated Petitioner on August 21, 2009. Dr. Zelby wrote:

> *"In reviewing her chart, we have no history or information concerning a Workers' compensation injury from October 2008, and when Ms. Cassano initially came for an evaluation in August 2009, she indicated that her condition arose in July 2009 after falling from a chair. She did not indicate this injury occurred at work *** I have no information to provide a causal connection between any accident or injury in October 2008 and the conditions for which we treated Ms. Cassano. We also have nothing in Ms. Cassano's chart that indicates any specific restrictions that we placed on her following her treatment *** "* (PX 7)

Petitioner testified that she is not the same person that she was before the injury at work. She has weakness in her right hand and arm and does not have full use of her neck. When she tries to use a mouse with her computer, she notices that her right hand locks up. She cannot grasp with her right hand and drops things like her curling iron. She does not hold her grandchildren. She experiences pain in the 4th and 5th fingers of her right hand that travels up her arm. She has pain in her neck, the severity of which depends on the weather.

Petitioner was asked about the July 22, 2009 medical entry that referred to a fall from a chair. Petitioner testified that she never said that she fell out of a chair. She

testified that she was sitting in a plastic lawn chair in which the back of the chair was not locked. She testified that the back of the chair moved back while she was sitting in it, but that she did not fall to the ground. She further testified that she felt that it was important to advise the doctor of everything that had happened to her.

On cross-examination, Petitioner did not recall telling the staff at Health Stop that she woke up with mid-back pain down the right arm and did not recall telling them that there was no history of trauma. Petitioner testified that on December 28, 2013, she hit her neck on the stairs. She did not recall an incident that occurred on July 25, 2014.

On redirect examination, Petitioner testified that since the accident in October 2008, her symptoms have never completely gone away.

CONCLUSIONS OF LAW:

In support of his decision with regard to issue (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", the Arbitrator makes the following findings of fact and conclusions of law:

Clearly, Petitioner was in the course of his employment when she fell while walking from one of the cars in line for Respondent's parking lot and the parking structure. She was performing her job as a parking attendant at the time of the injury. She was holding an I.D. badge of a MacNeal Hospital staff member at the time she fell.

The Arbitrator further finds that Petitioner's injury arose out of her employment.

It is true Petitioner testified that she did not recall what happened and did not know how, or precisely where, she fell. Moreover, Petitioner testified that the surface on which she fell was flat.

Yet, Petitioner testified that it was raining, although lightly, on October 20, 2008. She was wearing rain gear. She was out in the rain for several hours. She was walking back and forth between each of the cars and the Kronos machine.

The Arbitrator draws the reasonable inference that Petitioner slipped and fell on October 20, 2008 due to the wet pavement/sidewalk.

Yet, Respondent argues that Petitioner did not know what caused her to fall and therefore, it was an unexplained fall. Respondent also argues that the surface on which Petitioner was walking at the time she fell was flat and therefore, her employment did not expose her to a greater risk. In support of their position, Respondent cites Caterpillar Tractor Co. v. Indus. Comm'n, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In that case, claimant stepped off a 7-inch curb and onto a driveway and twisted his ankle.

The Supreme Court held that claimant proved that he was in the course of employment at the time of injury, but failed to prove that the injury arose out of his employment. Claimant failed to prove that any defect existed that caused the accident. The Court held that the act of stepping off a curb is a risk common to the general public and thus did not constitute an increased risk of employment. Therefore, the Court reversed and set aside the judgment of the lower court, which affirmed the finding that the employer was liable for the employee's injury.

The Arbitrator finds the case at bar to be more similar to Village of Villa Park v. Illinois Workers' Comp. Comm'n, 3 N.E.3d 885, 378 Ill. Dec. 320 (2d Dist. 2013), although that case involves a fall down a set of stairs. In that case, a community service officer with a previously injured right knee was descending a stairwell at work when his right knee gave out and caused him to fall about 7 stairs and to sustain injuries to his right knee and low back. The evidence established that claimant was required to traverse the stairs at the police station a minimum of 6 times a day. One of the factors that the Appellate Court cited in their holding that claimant's employment placed him in a greater position of falling was the frequency with which he was required to traverse the stairs. The Court affirmed the judgment of the circuit court of DuPage County which confirmed the Commission decision in which they found the injury to be compensable.

In the case at bar, the Arbitrator finds, due to the frequency with which she was required to traverse the pavement/sidewalk in the rain in furtherance of Respondent's interests, that Petitioner slipped and fell, thereby sustaining an accident on October 20, 2008 that arose out of and the course of her employment.

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 makes the following findings of fact and conclusions of law:

On December 5, 2008, Dr. Davison discharged Petitioner from his care and released her to full-duty work. Although he noted a mild, palpable spasm in her neck, he did not note any radiating pain. Petitioner reported that she was pain free at that time.

The Arbitrator notes that at each of Petitioner's 5 visits to Dr. Davison, she was released to regular-duty work.

When Petitioner visited Dr. Jethani, her primary care physician, on February 16, 2009 and March 10, 2009, she voiced no complaints of neck pain or radiating right arm pain.

The Arbitrator notes that one of Dr. Zelby's reports addressed to Dr. Jethani - - the one dated "2/16/2009" is obviously dated incorrectly. (PX 3) Petitioner did not have her initial consultation with Dr. Zelby until August 21, 2009. (PX 3)

When Petitioner visited Dr. Jethani on February 20, 2009, she complained of a lesion on her right cheek and painful swelling on the right side of her neck. Upon examination, Dr. Jethani found a very large (1-5 centimeter) pre-tonsillar lymph node on the right. Dr. Jethani's impression was infected cyst on the right cheek with cellulitis and lymphadenitis. He prescribed Keflex, an antibiotic medication.

Petitioner testified on cross-examination that after Dr. Davison released her from care, she did not seek additional treatment for her neck or back until 8 months later.

Petitioner saw Dr. Jethani on July 24, 2009 with complaints of pain in her mid-back that radiates down the right side of her arm. She told Dr. Jethani that she has had pain in her upper right back since Monday and that today, she started having a strange feeling radiating down her right arm. She reported that she woke up with pain on Monday. There was no history of trauma. Following his examination, Dr. Jethani's impression was cervical sprain, examination normal.

On August 21, 2009, treating physician Andrew S. Zelby, M.D. first examined Petitioner and wrote:

> *"She first developed this pain on July 22, 2009, and believes this is due to falling out of a chair the previous day. The pain is primarily in the neck, but also radiates across the right shoulder and down the posterior aspect of the right forearm. She has numbness in the posterior right forearm which radiates into the third, fourth and fifth fingers of the right hand. She feels her right hand is weak and has been dropping coffee cups with her right hand *** She has had previous episodes of mild neck pain, but never to this severity and never with radiation into her arms."*

Petitioner admitted that she was involved in a lawn chair incident, but denied that she fell to the ground during such incident.

Dr. Zelby performed two surgeries on Petitioner's cervical spine.

On August 12, 2013, Dr. Zelby wrote that he has no information to provide a causal connection between any accident or injury in October 2008 and the conditions for which he treated Ms. Cassano.

The Arbitrator finds that on July 22, 2009, the causal chain was broken when Petitioner sustained a non-work-related injury due to a broken lawn chair. Only after that event did she experience severe neck pain that radiated across the right shoulder and down the posterior aspect of the right forearm. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being of her neck - - cervical spondylosis with myelopathy, herniated cervical disc, history of anterior cervical discectomies and fusions and history of C7-T1 foraminotomy - - is not causally related to the accident of October 20, 2008.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator makes the following findings of fact and conclusions of law:

In National Freight Industries v. Illinois Workers' Comp. Comm'n, 993 N.E.2d 473, 373 Ill. Dec. 167 (5th Dist. 2013), the Court held that despite the existence of an independent, intervening cause that broke the causal connection, claimant should be entitled to seek a permanency award for each accident.

It is true that Petitioner did not seek additional treatment for her cervical strain for ~ 7-1/2 months after she was discharged by Dr. Davison. It is also true that Petitioner did not lose any time from work and was always released to return to her regular duties as a result of the October 20, 2008 accident.

However, following such accident, Dr. Davison ordered a regimen of physical therapy and initially prescribed Naproxen and then Aleve. Although Dr. Davison noted that Petitioner was pain free on December 5, 2008, he found that she had a mild, palpable spasm in her neck.

On August 21, 2009, Dr. Zelby wrote that Petitioner has had previous episodes of mild neck pain, but never to this severity and never with radiation into her arms.

Petitioner testified that since her accident in October 2008, her symptoms never went away completely.

Based on the foregoing, the Arbitrator finds that as a result of the October 20, 2008 accident, Petitioner sustained a cervical strain that resulted in a permanent loss of use of her person as a whole to the extent of 2%, pursuant to Section 8(d)2 of the Act.

The Arbitrator denies Petitioner's claim for TTD benefits.

The Arbitrator awards the medical bills for the reasonable, necessary and causally-related treatment through December 5, 2008, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Respondent is entitled to a credit for medical bills previously paid.

Dated and Entered: July 3, 2015

Arbitrator Brian Cronin

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jeff Petermeyer,

Petitioner,

16IWCC0613

vs.

NO: 09 WC 41291

Alberternst Construction,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, maintenance benefits and penalties and fees and being advised of the facts and law, modifies the Decision of the Arbitrator on the issues of maintenance benefits and penalties and fees as stated below and otherwise affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 44-year-old construction manager, sustained an undisputed injury to his low back on June 2, 2008 while working for Respondent. Respondent initially accepted the claim and paid TTD and medical expenses for evaluations and conservative treatment. Respondent refused to authorize lumbar fusion surgery recommended by Petitioner's treating physician, Dr. Taylor. In January of 2010, Dr. Brett Taylor performed a posterior lumbar fusion from L3 to S1 under by Petitioner's group insurance. In February of 2010, Dr. Taylor completed the anterior portion of the fusion. After a 19(b) hearing on June 28, 2010, the Arbitrator issued a 19(b) Decision awarding the requested TTD and medical benefits. Respondent timely appealed the Decision of the Arbitrator. On May 17, 2011, the Commission affirmed the Arbitrator's decision.

On February 19, 2015 this case was again brought before the Arbitrator. The issues in dispute were causal connection, TTD, nature and extent and penalties and fees. The only issue in dispute regarding causal connection was related to future medical treatment. Respondent did not dispute the reasonableness or necessity of any treatment provided to the date of hearing. Petitioner testified that he

16IWCC0613

was now 51-years-old and had not returned to work for Respondent since the date of accident. As of February 8, 2011 Dr. Taylor found that Petitioner had reached maximum medical improvement from the fusion surgery and released Petitioner to light duty work. The parties stipulated that Petitioner was entitled to TTD benefits from June 3, 2008 through February 8, 2011.

In a Decision dated October 8, 2015, the Arbitrator found that Petitioner was entitled to medical expenses, TTD from June 3, 2008 through February 8, 2011, maintenance from February 9, 2011 through April 24, 2012, and permanent partial disability benefits representing 50% loss of use of the person as a whole. The Arbitrator awarded Section 16 fees and 19(k) penalties for Respondent's failure to pay maintenance benefits from February 9, 2011 through April 24, 2012. Petitioner and Respondent timely appealed the Arbitrator's decision.

After considering all of the evidence, we find that Petitioner failed to prove that he was entitled to maintenance benefits. We modify the Decision of the Arbitrator to strike the award of maintenance benefits from February 9, 2011 through April 24, 2012, and accordingly the award of Section 16 fees and Section 19(k) penalties regarding said benefits.

Petitioner testified that he looked for work on his own after his February 8, 2011 light duty release. He testified the contacts he made were with employers in the construction field because that is the only field in which he has experience. Petitioner did not offer any documentation of his self-directed job search efforts but testified that he was not successful in finding formal employment. Petitioner has a high school degree, earned an associate's degree in refrigeration and air conditioning and a college certificate in Construction Management. He testified that he did not believe that there was any job within the construction field that he could work with light duty restrictions. We do not find that Petitioner proved he performed a diligent yet unsuccessful self-directed job search following his light duty release by Dr. Taylor on February 8, 2011.

Although Petitioner did not secure formal employment, he testified that he began working 10 to 30 hours per week in March of 2011 overseeing the construction of a friend's house. He testified that he helped with blueprints, permits and "getting things lined up" but did not perform any physical labor. He was paid for his services directly from his friend; Petitioner testified that he was paid $5,000.00. Petitioner also began running deliveries for his brother-in-law's business on a part-time basis in the spring of 2012. He testified that he delivered "lightweight" items, such as potato chips, to fast food places. Petitioner estimated that he spent no more than 6 to 8 hours per week making deliveries and received no more than $150.00 during any week he made deliveries. Petitioner offered no corroborating evidence pertaining to either job. Petitioner testified that the house was completed in September of 2012. He continued making deliveries for his brother-in-law until the end of 2013. Despite the evidence that Petitioner was working and receiving compensation, Petitioner claims to be entitled to maintenance benefits during this period.

In March of 2012, Respondent instituted vocational rehabilitation services via Genex. The Genex reports briefly note Petitioner's concurrent part-time work as a new home construction site manager and a courier. Vocational counselling was directed toward assisting Petitioner in finding employment within his restrictions and utilizing his transferrable skills. Petitioner initially cooperated with vocational assistance but eventually became difficult to contact and failed to comply fully with the vocational services provided. Petitioner last met with his vocational counsellor on April 24, 2012. The report from

that meeting indicates that Petitioner refused to sign a vocational rehabilitation plan requiring 10 employer contacts per week. Petitioner testified that vocational counselling helped him create a resume but was otherwise "a joke." Petitioner denied the implication that he was not responsive to his vocational counselor, but the preponderance of the evidence shows that he failed to comply fully with vocational rehabilitation in 2012. Petitioner testified that he stopped looking for any formal work by the end of 2012 and started receiving Social Security Disability benefits with back pay to 2009. For all the reasons set forth above, we conclude that Petitioner was not entitled to maintenance benefits from February 9, 2011 through April 24, 2012 and we modify the Decision of the Arbitrator to strike the award of maintenance benefits for that period as well as the related award of penalties and fees.

All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services of $201,839.34, as provided in Section 8(a) of the Act. Respondent shall be given a credit of $401,639.89 for medical benefits that have been paid, and Respondent is receiving this credit, as provided in Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner temporary total disability benefits of $746.59/week for 140 2/7 weeks, commencing June 3, 2008 through February 8, 2011, as provided in Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $636.15/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.

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

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

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

DATED: SEP 2 6 2016
RWW/plv
o-8/16/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0613

PETERMEYER, JEFF
Employee/Petitioner

Case# **09WC041291**

ALBERTERNST CONSTRUCTION INC
Employer/Respondent

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4888 LAW OFFICE KEITH SHORT
1801 N MAIN
EDWARDSVILLE, IL 62025

2593 GANAN & SHAPIRO PC
HEATHER J RUSSO
411 HAMILTON BLOVD SUITE 1006
PEORIA, IL 61602

16IWCC0613

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

Jeff Petermeyer
Employee/Petitioner

v.

Alberternst Construction, Inc
Employer/Respondent

Case # **09 WC 041291**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **2/19/2015**. 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 _____

16IWCC0613

FINDINGS

On **6/2/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$58,234.28**; the average weekly wage was **$1,119.89**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$103,882.67** for TTD, **$N/A** for TPD, **$N/A** for maintenance. and **$401,639.89** for other benefits (medical), for a total credit of **$505,522.56**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $201,839.34, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $401,639.89 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 $746.59/week for 140 2/7 weeks, commencing 6/3/08 through 2/8/11, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $746.59/week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $636.15/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 to Petitioner penalties of **$9,428.37**, as provided in Section 16 of the Act; **$23,570.92**, as provided in Section 19(k) of the Act; and **$0**, as provided in Section 19(l) 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

9/22/15
Date

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BACKGROUND

Petitioner injured his low back on June 2, 2008 while working for Respondent. Petitioner underwent posterior and anterior lumbar fusions from L3 to S1 on January 15, 2010 and February 5, 2010, respectively. This matter was arbitrated pursuant to §19(b) on June 28, 2010. The Petitioner established causation and was awarded medical expenses subject to the fee schedule as well as temporary total disability benefits for a period of 108 weeks, commencing on June 2, 2008, through June 28, 2010. The decisions of the Arbitrator and Commission are admitted as AX2 & AX3. This matter was then tried on February 19, 2015. The issues in dispute are causation, future medical expenses, TTD, maintenance, nature and extent, and penalties.

FINDINGS OF FACT

Following the §19(b) hearing Petitioner has continued to treat with Dr. Taylor, an orthopedic surgeon, and Dr. Granberg of Millennium Pain Management. Dr. Taylor referred Petitioner to physical therapy post operatively, beginning June 14, 2010 and extending through January 31, 2011. (Px. 8).

Petitioner saw Dr. Granberg, every 2-3 months throughout 2011 and 2012. (Px. 5). Beginning with the June 19, 2012 visit, Petitioner reported increasing pain in his back for which Dr. Granberg offered a trial bilateral sacroiliac joint injection and trigger point injection in the lumbar paraspinous muscles above the level of his fusion. (Px. 5, pp. 314-15). The injections were performed on June 19, 2012 by Dr. Granberg. (Px. 5, pp. 316-17). Petitioner reported some relief from the injections and continued to receive medications from Dr. Granberg. (Px. 5, pp. 318-28). On January 3, 2013, Petitioner's medications were altered with the addition of Gabapentin to his Percocet regimen. The record noted he was previously able to go three months between visits but was having to be seen more frequently. (Px. 5, pp. 329-31). Second bilateral sacroiliac joint injection and trigger point injections were performed May 31, 2013. (Px. 5, pp. 338-42). Again, at the next visit on June 28, 2013, Petitioner reported 80% relief from the injection although he only reported 65% relief from medications. (Px. 5, pp. 343-45). On July 26, 2013, his Percocet dosage was increased. (Px. 5, pp.346-48). Additional trigger point and sacroiliac joint injections were performed on October 7, 2013 and December 30, 2013. (Px. 5, pp. 352-56; 363-67). Injections continued to be performed throughout 2014 in February, April, June, July, September and most recently December 2014. (Px. 5).

On February 8, 2011, Dr. Taylor found Petitioner at maximum medical improvement and deferred future pain treatment to Dr. Granberg. (Px 1, p. 51). The doctor indicated Petitioner could perform in the medium job demand level, however it reportedly caused increased symptoms of back pain and therefore Dr. Taylor recommended light demand activity as more reasonable. (Px. 1, pp. 50-51). At that time, Dr. Taylor placed "social restrictions" of frequent lifting up to 10 pounds, occasional bending, kneeling, crawling, squatting, reaching overhead, reaching above shoulders; frequent sitting, standing, walking; occasional climbing stairs, and then limited vibration, grasping, repetitive motion. (Px. 1, p. 52). Dr. Taylor's testified that as of February 8, 2011 Petitioner had a permanent restriction of duties in the "light demand level." (Px. 1, p. 53). Dr. Taylor testified the functional capacity evaluation was aligned with what he had given Petitioner in terms of permanent restrictions. (Px. 1, p. 54). Dr. Taylor did not note any signs of malingering or somatization as a significant component to Petitioner's presentation during his treatment. (Px. 1, pp. 54-55). At the time of his April 17, 2013 deposition, Dr. Taylor indicated no further surgical treatment was required and Petitioner's medical treatment moving forward would be pain management, although he would defer to Dr. Granberg with respect to any future pain management. (Px. 1, p. 57; 61). In Dr. Taylor's opinion, the medical care provided to Petitioner

has all been related to the original work injury. (Px. 1, p. 58). In his medical record of June 26, 2012, as well as those of November 2, 2012 and April 9, 2013, Dr. Taylor reiterated Petitioner could work within the light duty level. (Px. 3, pp. 162-64; Px. 2, p. 157). When Dr. Taylor saw Petitioner on November 2, 2012, he reported hip pain and groin pain increased with activity and improvement of some pain symptoms following sacroiliac joint injection performed by Dr. Granberg on June 19, 2012. (Px. 1, pp. 59, 61; Px. 5, pp. 314-17).

On December 24, 2012, an FCE was performed at Apex Physical Therapy which noted Petitioner could function at least at the light duty level. (Rx. 7, p. 119).

The next time Dr. Taylor saw Petitioner following November 2, 2012, was on July 16, 2014. (Px. 3; Px. 2, pp. 112-13). On April 9, 2013 Dr. Taylor again indicated Petitioner was capable of performing light duty demand level work. (Px. 2, p. 112; 154). When Dr. Taylor saw Petitioner on July 16, 2014, Petitioner reported his symptoms were significantly worse and reported being markedly limited by his pain symptoms. (Px. 2, p. 115). Petitioner reported his pain medications were providing him with little relief although he did obtain short term improvement after injections from Dr. Granberg. (Px. 2, p. 115). Dr. Taylor's examination findings were substantially similar to the physical findings noted at the November visit. Dr. Taylor testified this is consistent with SI joint pathology bilaterally. (Px. 2, p. 116). An EMG conducted by Dr. Phillips on July 16, 2014 was negative. (Px. 6). Dr. Taylor diagnosed Petitioner with end stage failed back syndrome due to both SI joint and L2-3 adjacent segment issues. (Px. 2, p. 117). Dr. Taylor testified he determined that Petitioner's back condition had deteriorated as of July 16, 2014, based on Petitioner's subjective complaints of pain and the relief Petitioner reported to him from the injections performed by Dr. Granberg. (Px. 1, p. 134). Dr. Taylor testified he denotes "social restrictions" separate from work restrictions. (Px. 1, p. 137). Dr. Taylor placed a work restriction that Petitioner was unemployable based on worsening symptoms. (Px. 2, p. 120). Dr. Taylor also placed sedentary social restrictions indicating lifting at a maximum of 5 pounds, limited bending, kneeling, crawling, squatting, working overhead or reaching above shoulder level. (Px. 2, p. 156). Dr. Taylor indicated he used the term "unemployable" because he felt his overall prognosis would be best if he was not in the work environment, but it does not delineate any physical restrictions. (Px. 1, p. 138). Socially, Dr. Taylor felt Petitioner could function at the sedentary level. (Px. 1, p. 138). Dr. Taylor further indicated the basis for the change in work status between April 2013 and July 2014 was primarily Petitioner's subjective report of symptoms and the description Petitioner gave of his capabilities and limitations. (Px. 2, pp. 139, 142). Dr. Taylor conceded he is not an expert in vocational rehabilitation. (Px. 1, p. 138).

With regard to further treatment, Dr. Taylor testified that as a last resort there is an operation which is extremely morbid and includes extending the fusion into the thoracic spine and past the SI joint into the sacrum, essentially locking the sacrum or pelvis to the thoracic spine. (Px. 2, p. 121). Dr. Taylor does not actually have any plans to perform this procedure on Petitioner. (Px. 2, p. 122). At this point, Dr. Taylor is not recommending Petitioner have the additional fusion procedure. (Px. 1, p. 128). Dr. Taylor has not seen Petitioner again since his July 16, 2014 visit. (Px. 2, p. 128).

Dr. R. Peter Mirkin saw Petitioner pursuant to §12. Dr. Mirkin initially saw Petitioner prior to the 19(b) hearing, on February 9, 2009 with addendums dated July 23, 2009 and April 26, 2010. (Rx. 4). Dr. Mirkin performed another §12 examination on October 24, 2014. He was deposed on November 21, 2014. (Rx. 2; Rx. 1). Dr. Mirkin testified at the time of the independent medical examination Petitioner reported he was doing better than before the surgery, was taking four Oxycodone per day but had complaints of pain in his back and numbness in his legs. (Rx. 1, pp. 8-9). Dr. Mirkin noted positive Waddell sign due to Petitioner's complaint of

pain when he only lightly touched his back. (Rx. 1, p. 10). Petitioner was noted to have 70% range of motion, forward flexion within 15 inches of touching his fingers to the floor, ability to walk on his heels and toes, squat and rise from the squat position, negative straight leg raise test and intact motor and sensory examination. (Rx. 1, p. 10). Dr. Mirkin reviewed x-rays taken in his office which showed an intact fusion with hardware in place from L3 to S1 with the disc above the fusion appearing normal. (Rx. 1, p. 11). Dr. Mirkin agreed with the functional capacity evaluation conducted in October 2012 indicating Petitioner could work at least in the light demand capacity. (Rx. 1, p. 11). In Dr. Mirkin's opinion, there was nothing to indicate progressive pathology of the spine. (Rx. 1, p. 12). Additionally, Dr. Mirkin saw no indication for further surgical procedure as there were no physical findings which supported further surgeries. (Rx. 1, pp. 12-13). Dr. Mirkin noted Petitioner had mild subjective findings and the only objective finding was that he had a prior fusion visible via hardware. (Rx. 1, p. 13). Dr. Mirkin was aware Petitioner was able to, and did work following surgery, and therefore, in his opinion, is employable in some capacity. (Rx. 1, p. 20). Further, in Dr. Mirkin's opinion, Petitioner does not need ongoing medications or a pain specialist. (Rx. 1, p. 37).

Petitioner testified he improved after the surgery and then started declining. In 2011 and early 2012, he began developing hip pain and pain radiating into his legs. In order to do yard work, he utilizes a riding lawn mower, but mostly has his wife and son perform such tasks. (T. 20; 41).

Petitioner completed high school and went to trade school for refrigeration, heating and cooling and also has a degree in construction management from Belleville Area College, now SWIC. Petitioner indicated he did a job search following his release to light duty in 2011 which was marked Petitioner's Ex. 15. He testified he looked for jobs in the construction field because that was all he knew, having worked at Alberternst Construction since the age of 18. Petitioner participated in vocational rehabilitation provided by Respondent. Respondent's counselor first met with Petitioner on March 15, 2012. He indicated there after he was rarely contacted by the vocational counselor and when they did connect it was at times favorable to her. He further testified the vocational counselor provided him a resume which he sent to a few people, only one of which responded, but did not offer him employment. He did not inquire at any residential construction jobs in St. Louis. Petitioner testified he followed up with every lead the vocational rehabilitation counselor sent. Petitioner testified he did not recall the vocational counselor discussing a vocational rehabilitation plan with him. Petitioner testified that in April 2012 he was on light duty, could not tolerate a lot of bending, and lifting anything caused pain or soreness for the next few days.

In 2012 Petitioner worked for a friend who was building a house. His duties included obtaining permits, helping with blueprints, organizing workers and going to the construction site to make sure they were doing the job. (Px. 4; Rx. 10). He did no manual labor. His job duties while working construction management for his friend also included opening and closing the job site as well as supervising what was done throughout the day. (T. 32-33). He could not check anything outside, walk on uneven ground or climb up a ladder to the attic. Petitioner testified he worked between 10 and 30 hours a week in construction management for his friend.

Petitioner also helped his brother-in-law with courier deliveries but he did not pursue that further after working there for approximately a year because he would only deliver smaller items and most of the items they delivered were heavier than 15 pounds, which was his lifting limitation at the time. He assisted with deliveries from May 2012 until late of 2013

Petitioner last actually looked for full time employment at the end of 2012 when he began receiving Social Security Disability. Petitioner testified he would be willing to try to work if there was a job available within his restrictions. Petitioner testified he could not stoop/squat. (T. 58). He testified anything with vibration takes its toll. He avoids bending at the waist, crouching or kneeling and walking over uneven surfaces. (T. 59; Px. 4). He has more functional capability earlier in the day. (Px. 4, p. 215).

Petitioner testified he received changes in his restrictions by Dr. Taylor in 2014. In July 2014 he was placed on a lifting restriction of 5 pounds and told to remain sedentary. Petitioner testified he is limited in terms of functional abilities. He can sit in a comfortable chair for maybe a half hour but then he needs to stand or lie in bed. He can't do much bending, stooping or picking things up. He does not do any yard work now, although he did in 2012. His wife does most of the mowing.

Respondent hired investigators to conduct surveillance of Petitioner. Surveillance was conducted for three days, on August 18, 2014, August 19, 2014 and August 20, 2014. On August 19, 2014, Petitioner was observed and recorded utilizing a leaf blower on the exterior of his home. This went on for approximately 3 to 4 minutes. (Rx, 12). The Arbitrator notes leaf blower did not appear heavy and Petitioner moved at a leisurely pace. That days surveillance showed nothing else of any significance. On August 20, 2014, Respondent's investigator obtained surveillance video of Petitioner from his home to a retail shopping plaza in St. Louis, MO. Petitioner's young niece had been in a minor motor vehicle accident and Petitioner traveled to the scene to assist his brother in law who was trying to repair the girl's vehicle enough that it could be driven home. Petitioner is seen putting gasoline in his truck and cleaning the windows. He is next seen handing tools to his brother-in-law and watching him attempt to make repairs to the vehicle's side-panels. Petitioner is seen using a small power screw driver and lightly pulling a few times on the side panel. He bends and kneels a few times to watch the other man work. The Arbitrator notes the tools do not appear to weigh more than his doctor's limitations. Petitioner is not seen lifting, pulling or pushing more than the few times. Respondent's investigator, Mr. Miller, acknowledged that the total amount of time Petitioner is seen using or handing small hand tools to the other man was about 3 minutes and that he actually used tools for approximately 2 minutes. Mr. Miller agreed that for the vast majority of the video on the 20th Petitioner is simply standing watching someone else work. The Arbitrator finds this to be an accurate description. Finally, the Arbitrator notes that in three days of surveillance Petitioner is seen actually engaged in about 4 to 6 minutes of activity, none of which appears to exceed the restrictions given by Dr. Taylor.

Petitioner retained vocational expert, Stephen Dolan. Mr. Dolan has a bachelor's degree, a Master's in American and English Literature, and took one graduate level coursework in Rehabilitation Counseling. (Px 4, p 196-7; 244). He is a certified rehabilitation counselor. (Px 4, p. 244). Mr. Dolan testified he met with Petitioner once on December 8, 2011 and then spoke to him one time after that on April 8, 2014. (Px. 4, p. 229). Petitioner had a number of transferrable job skills, excellent job history and qualities which Mr. Dolan indicated were beneficial to a prospective employer. (Px. 4, pp. 229-30). Mr. Dolan did not perform a labor market survey because, in his opinion, it was unnecessary due to what he termed "Petitioner's pain problem". (Px. 4, p. 230). Mr. Dolan documented Petitioner's educational history which was significant for graduation from high school, training at a technical school in the St. Louis area and Belleville Area College, where he obtained a certificate in construction management. (Px. 4, p. 206).

Mr. Dolan indicated Petitioner worked in 2011 as a construction consultant in building a new house which was quite large and also worked part time for a company called DZ Trucking as a courier. (Px. 4, p. 208).

Mr. Dolan testified Petitioner discontinued his work activities because they were exacerbating his pain problem. (Px. 4, pp. 208-09). Mr. Dolan reported Petitioner described limitations of being able to sit comfortably for only 10 to 15 minutes before having to change positions; standing for one hour, so long as he can move around; walking for 1.5 miles, although not on rough ground or on a slope; avoiding bending at the waist due to pain; and inability to crouch/squat or kneel. Furthermore, in terms of functional limitations, Petitioner can push and pull lightly, although not with force, and has to keep his low back out of any pushing or pulling. (Px. 1, pp. 213-14). Petitioner gave Mr. Dolan a list of companies he was familiar with from his work at Respondent which he had contacted about employment, but indicated no one was interested. (Px. 1, pp. 220-22). Mr. Dolan is of the opinion that Petitioner is not able to be gainfully employed in any regular and continuous marketplace due to his "pain problem" which requires Petitioner to take prescription pain medication. (Px. 4, pp. 225-26). Mr. Dolan agreed that Petitioner did a number of things as a construction manager which are within the light duty demand level. Those include reading blueprints, allocating manpower, budgeting, and the permitting process. (Px. 1, p. 228). However, Mr. Dolan testified his transferrable skills such as reading blueprints did not make him qualified for any job within the construction environment. (Px. 1, p. 231). Mr. Dolan determined Petitioner is not able to tolerate a regular work schedule, eight hours per day, five days per week due to his poorly controlled pain. (Px. 4, p. 254).

Respondent retained Brenda Latham to provide vocational rehabilitation services to Petitioner. Ms. Latham initially met with Petitioner on March 15, 2012. At that time, Petitioner was working as a construction manager on a new home being built by a friend. He spent approximately 20 hours weekly on the job site supervising and inspecting the work. He also assisted his brother in law as a contract delivery driver for which he usually got called once weekly. Ms. Latham reviewed Petitioner's list of employers he had contacted between April 2011 and January 2012. (Px. 15). Petitioner indicated most employers told him business was "too slow" or work would exceed his physical capabilities. Ms. Latham discussed possible jobs in construction management, "light" driving jobs, security/gate guard work, and sales of construction related equipment with Petitioner. Ms. Latham obtained job leads for Petitioner which she forwarded to him. On March 19, 2012, she provided two job leads for sales associates at Home Depot and transporter positions with Hertz Rent a Car. On March 26, 2012, she provided a lead for a part time insurance inspector. (Rx. 10, p. 150). On April 2, 2012, Petitioner responded to Ms. Latham indicating he had acted on four job leads. Ms. Latham identified additional leads for deck and fence services on April 3, 2012. On April 19, 2012, Ms. Latham provided additional job leads and developed a vocational rehabilitation plan. (Rx. 10, p. 151). Ms. Latham noted she was unable to complete a face to face meeting with Petitioner since the initial meeting on March 15, 2012 due to difficulties in reaching him by phone/email and scheduling conflicts. (Rx. 10, p. 151). On April 24, 2012, Ms. Latham met with Petitioner to review job placement services, at which time they reviewed the rehabilitation plan. (Rx. 10, p. 153). Petitioner indicated he was agreeable to the job goals but requested Ms. Latham to set up appointments with potential employers, as he did not want to "run around" to employers because he was not receiving any benefits. (Rx 10, p. 153-54). It was Ms. Latham's opinion that as of April 24, 2012. Petitioner refused to comply with the vocational rehabilitation plan which required him to contact at least 10 employers per week either via phone, mailing a resume, or by online application. (Rx 10, p. 153-54). On May 18, 2012, Ms. Latham wrote to Petitioner indicating that since he had not provided employer contact records indicating whether or not he was following up on job leads she wished to know whether he was still interested in job placement assistance and reminded him regular contact would be needed to coordinate vocational services. (Rx. 10, p. 156).

Respondent called Kelly Burger to testify at the arbitration hearing. Ms. Burger is a vocational case manager with a bachelor's degree in communications, a master's degree in vocational rehabilitation counseling, and has been a certified rehabilitation counselor since 2007. (T. 110). She reviewed Mr. Dolan's vocational rehabilitation evaluation and various medical records. (Rx. 8, 9). She also reviewed and relied upon the initial vocational evaluation from Brenda Latham, dated March 22, 2012, and her two progress reports dated April 19, 2012 and April 30, 2012. (T. 111). She did not meet with Petitioner. Ms. Burger testified Petitioner has an excellent work history which included supervisory and customer service skills which were transferrable to several light and sedentary positions. (T. 117; Rx. 8, p 134). She conducted a labor market survey which revealed 15 companies, all contacted between August 22, 2014 and August 26, 2014. (Rx. 9). Ten of these 15 companies indicated they were currently hiring or were hiring within the last month. Based on this totality of information, Ms. Burger concluded there was a potential labor market for Petitioner with positions within his work restrictions. She indicated Petitioner is employable in light or sedentary positions including but not limited to: supervisor/manager, supply clerk, inspector, dispatcher, customer service representative, telephone solicitor, chauffeur, front desk clerk, sale representative, hotel clerk, security/surveillance monitor, cashier, host, file clerk, parking lot attendant, bus monitor, office clerk, or light assembly/production. (Rx. 8, p 134). Although Ms. Burger was not aware of the July 16, 2014 restriction of Dr. Taylor to purely sedentary jobs, she testified this would not change her opinion because there are a multitude of factors beyond simply current medical status which she considers when determining employability. (T. 121-22; 128-29). Ms. Burger concluded Petitioner was not motivated to look for employment or participate in job search activities based on his conduct during the vocational rehabilitation efforts conducted in early 2012. (T. 114).

Petitioner was paid temporary total disability benefits by Respondent from the date of accident, June 2, 2008, through February 8, 2011. (Rx 6, p. 104-06).

CONCLUSIONS OF LAW

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

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

The only issue in dispute regarding causal connection is related to future medical treatment. There was future surgery discussed by Dr. Taylor, however that surgery has not been recommended at this time and therefore is not ripe for consideration. Furthermore, Respondent did not place any other causal connection issues in dispute. Further, Respondent does not dispute the reasonableness or necessity of any treatment provided prior to the date of this hearing. As indicated above, since no treatment has been recommended as of this time, the question of the reasonableness and necessity of any potential prospective medical treatment is not ripe for consideration at this time.

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. The respondent shall pay $201,839.34 for medical services, as set forth in Petitioner's exhibits 9 - 14 pursuant to Section 8(a) of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid,

related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. The Arbitrator notes that the parties stipulated that Respondent is entitled to a credit of $401,639.89 for medical bills that have been paid. This amount however includes amounts paid for treatment both before and after the earlier 19(b) hearing.

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

The parties stipulated that Petitioner is entitled to temporary total disability benefits for the period of 6/3/08 through 2/8/11. Respondent terminated benefits following 2/8/11. Thereafter Respondent denies that Petitioner is entitled to any temporary benefits.

On 2/8/11 Dr. Taylor placed Petitioner at MMI. However, Petitioner was not released to his former employment and had significant restrictions that precluded a return to construction. Petitioner has proved that he was incapable of returning to his former employment. He remained disabled and his restrictions have gone from light duty to sedentary duty. Petitioner did conduct a job search following his release but was unable to locate work on his own. Respondent paid no benefits and offered no vocational rehabilitation services. There was no medical opinion contrary to that of Dr. Taylor at that time. Respondent did not have Petitioner re-examined by Dr. Mirkin until 10/24/14. Despite the fact that Petitioner was clearly incapable of returning to his former employment, Respondent did not provide vocational rehabilitation services until Ms. Latham met with Petitioner on 3/15/12. Petitioner initially cooperated with the limited vocational assistance he was provided by Respondent from 3/15/12 through 5/18/12. He eventually became difficult to contact and failed to comply fully with the vocational services provided. As of April 24, 2012, Petitioner was non-compliant as he refused to agree to contact at least ten employers per week via various means.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner is entitled to temporary total disability benefits of $746.59 per week for 140 2/7 weeks, commencing 6/3/08 through 2/8/11, as provided in Section 8(b) of the Act. The Arbitrator further finds Petitioner is entitled to maintenance benefits of $746.59 per week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, as provided in Section 8(a) of the Act.

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

Petitioner seeks a finding of odd lot permanent total disability. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Comm'n,* 77 Ill.2d 482, 487 (1979). A claimant can establish entitlement to permanent total disability benefits under the Act in one of three ways: by a preponderance of the medical evidence; by showing a diligent but unsuccessful job search; or by demonstrating that, because of age, training, education, experience, and condition, there are no available jobs for a person in claimant's circumstance. *Federal Marine Terminals Inc. v. Illinois Workers' Compensation Comm'n,* 371 Ill.App.3d 1117, 1129 (2007). If claimant's disability is limited in nature so he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, the burden is upon the claimant to establish the unavailability of employment to a person in his circumstance. A claimant can satisfy the burden of proving he falls into the odd-lot category in one of two ways; (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market. *Alano v. Industrial Comm'n,* 282 Ill.App. 3d 531, 534 (1996). Once a

claimant meets his burden of proving he falls into the "odd lot" category, the burden then shifts to the employer to prove the claimant is employable in a stable labor market and that such market exists. *Waldorf Corp. v. Industrial Comm'n*, 303 Ill.App.3d 477, 484 (1999).

Petitioner has failed to meet his burden of proving he falls into the permanent total disability category through a preponderance of the medical evidence. Dr. Taylor placed light duty restrictions on Petitioner as of the date of MMI, February 8, 2011. Since that date, the only basis for a change in Petitioner's restrictions were subjective complaints to Dr. Taylor and to Dr. Granberg. There was little change in the physical examination findings, radiographic studies or any objective findings either by Dr. Taylor or by Dr. Granberg. Although Dr. Taylor testified Petitioner's work status was "unemployable," he admitted that Petitioner was capable of work at the light demand level, in line with the FCE performed October 24, 2012.

Dr. Mirkin testified he saw no physical findings to support restrictions beyond the light demand level and specifically that there had been no changes he last examined Petitioner. The Arbitrator finds Dr. Taylor's testimony regarding Petitioner being unemployable in terms of work status yet having sedentary "social" restrictions less persuasive than that of Dr. Mirkin in this regard. If Petitioner is able to function socially at a sedentary level, certainly he is capable of working at least at a sedentary level. Work at the light or sedentary level is in line with the recommendations and opinions of Respondent's vocational rehabilitation counselor as well as the FCE performed in October 2012.

Petitioner has failed to meet his burden of proving he falls into the odd-lot category because he has failed to show either diligent but unsuccessful attempts to find work, or, that because of his age, skills, training, and work history he is not be regularly employable in a stable labor market. Although Petitioner did engage in a limited search for employment, the Arbitrator finds that Petitioner did not engage in diligent attempts to find work. Petitioner indicated he had contacted some companies with which he was familiar from his work for Respondent, but he could provide no documentation of jobs for which he applied. Petitioner's testimony established that he did not even look for work after he started receiving Social Security Disability benefits in late 2012. Petitioner's lack of diligent job search effort is also well-documented in the reports of Respondent's vocational rehabilitation experts, Kelly Burger, and Brenda Latham. Ms. Burger testified Petitioner did not give full effort to the vocational rehabilitation services provided by the Respondent from March 15, 2012 through May 18, 2012 and Petitioner refused to follow the vocational rehabilitation plan of at least ten employer contacts per week.

Mr. Dolan's testimony established Petitioner's excellent transferrable skills, education, training and work history. Petitioner has training and experience in computer software applications including Word and Excel, as well as supervisory and customer service skills which are transferrable to several light or sedentary positions. He has a high school degree, an associate degree in HVAC, and a certificate in construction management. He has a solid work history throughout his adult life. All of these skills are transferrable to light or sedentary work. Although Mr. Dolan testified due to Petitioner's self-described functional limitations he cannot tolerate a full work day, there is no medical evidence to support this assertion. Mr. Dolan did not perform a labor market survey and did not appear to base his vocational opinions on the variety of favorable factors he identified, including transferrable skills and education, but rather relied more on what he described as a "pain problem." Respondent's vocational rehabilitation expert, Ms, Burger, opined that Petitioner is employable at the light to sedentary duty level. The Arbitrator further notes this is in line with the social restrictions placed by Dr. Taylor. The Arbitrator finds the opinions of Ms. Burger more persuasive.

Petitioner points to the inability of vocational services provided by Respondent to secure him employment as support for his position he should be found to fall in the odd-lot permanent total disability category. The Arbitrator finds that the inability to obtain employment during vocational services was due, at least in part, to Petitioner's lack of diligent compliance with the vocational services provided.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has not met his burden of proving he falls into the odd-lot permanent total disability category.

While the possibility exists that Petitioner may have suffered some diminishment of earning capacity which may have entitled him to a wage differential award, the record in this case contains no evidence from which the amount of any such award could be determined.

Based on his medical treatment and his permanent restrictions, the Arbitrator finds Petitioner has proven he suffered a permanent partial disability of 50% loss of his body as a whole, for a total of 250 weeks.

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

On 2/8/11 Dr. Taylor had placed Petitioner at MMI. Petitioner was not released to his former employment. At no time was Petitioner released to return to full duty employment yet TTD stopped when Petitioner reached MMI. Respondent was well aware of significant restrictions that precluded a return to construction. Petitioner has proved that he was incapable of returning to his former employment. Petitioner conducted a job search following his release but was unable to locate work on his own. Respondent paid no benefits and offered no vocational rehabilitation services. There was no medical opinion contrary to that of Dr. Taylor at that time. Respondent did not have Petitioner re-examined by Dr. Mirkin until 10/24/14. Despite the fact that Petitioner was clearly incapable of returning to his former employment, Respondent did not provide vocational rehabilitation services until Ms. Latham met with Petitioner on 3/15/12. Still Respondent paid no maintenance benefits. The Arbitrator previously found Petitioner is entitled to maintenance benefits of $746.59 per week for 63 1/7 weeks, commencing 2/9/11 through 4/24/12, a total of $47,141.83. Respondent has offered no plausible excuse for its failure to offer vocational rehabilitation or pay maintenance benefits for over one year from the date of MMI to 3/15/12. Even after vocational rehabilitation was initiated Respondent persisted in its failure to pay maintenance benefits.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Respondent's refusal to pay maintenance benefits beginning 2/9/11 was vexatious and unreasonable. Respondent shall pay penalties of $23,570.92 pursuant to section 19(k) and attorney's fees of $9,428.37 pursuant to section 16.

County of Winnebago

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION
STATE OF ILLINOIS

Michael Goodwin Petitioner,	)	24849
Vs.	)	10WC~~2486~~, 09WC44211, 09WC44210
Gunite Respondent.	)	Commissioner Kevin Lamborn

AGREED ORDER

The Respondent agrees to pay to Black & Jones, Attorneys at Law, $500.00 (five hundred dollars) in full and final resolution of Black & Jones' Petition for Fees in consideration for which Black & Jones agrees to withdraw their Petition for Fees under Section 16 with prejudice. The underlying cases have previously settled and been paid in full. This settlement is to resolve Black & Jones' claim to attorneys fees and any other claims or issues Black & Jones' may assert therewith.

Gunite retains the right to seek subrogation or reimbursement for the sum paid of $500.00 (five hundred dollars) against Petitioner, Michael Goodwin, directly.

Signed: Dated:

Tracy Jones, Black & Jones Attorneys at Law 8/9/16

Randall Stark, Rusin Maciorowski 8/9/16

APPROVED BY AUTHORITY OF THE
ILLINOIS WORKERS' COMPENSATION COMMISSION
pursuant to the provisions of the
Workers' Compensation and Workers'
Occupational Diseases Acts

Approved by Commissioner Lamborn:
Date: AUG 16 2016

By: Kevin W. Lamborn, Commissioner

AUG 24 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Farkas,

Petitioner,

16IWCC0614

vs.

NO: 10 WC 29987

Illinois Veterans Home,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability benefits and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. At arbitration, the only issue in dispute was the correct wage differential calculation. In a decision dated March 20, 2015, the Arbitrator calculated wage differential benefits based on Petitioner's actual earnings in her new employment. We hereby modify the decision of the Arbitrator because we do not find that Petitioner's actual employment is persuasive evidence of Petitioner's current earning capacity.

Petitioner applied for employment as a sales associate at TJ Maxx and was hired at $8.25 per hour beginning on July 26, 2014. Consistent with her doctor's recommendation, Petitioner filled out her application for employment requesting 30 hours of work per week. Petitioner furthermore indicated that she was available to work Tuesday through Saturday from 8:00 a.m. to 9:00 p.m. While concurrently working at TJ Maxx, Petitioner accepted a job as a clerk for Blessing Hospital for 20 hours per week at $9.95 per hour. After approximately one month, Petitioner resigned from her employment at Blessing Hospital in September of 2014 and continued working at TJ Maxx.

On January 10, 2015 Petitioner filled out a TJ Maxx form changing her availability to

only 20 hours per week. (Respondent's Exhibit #) She indicated that she would be available from 6:00 a.m. to 5:00 p.m. Monday and Thursday and from 6:00 a.m. to 12:00 p.m. on Friday. At arbitration, Petitioner did not explain why she requested reduced hours at that time. However, she testified that she revised the document and added more hours of availability several weeks later. She further testified that she verbally expressed to Respondent that she would work weekends, if asked. There is no evidence corroborating Petitioner's testimony regarding her most recent availability as reportedly communicated to Respondent. Petitioner agreed that she has not made herself available to work all business hours. She admitted that she takes care of her grandchild in her home for a couple of hours two days per week. Petitioner further testified that she prefers to have the weekends off. She testified that her work hours have never been regular since the time she started working for TJ Maxx, which is corroborated by the records in evidence.

Petitioner's Exhibit #1 shows the number of hours per week Petitioner worked at TJ Maxx during the 29 weeks from July 26, 2014 through February 14, 2015. For the majority of the documented period Petitioner worked 10 to 20 hours per week at TJ Maxx, although her weekly hours varied greatly from as few as 5.13 hours to as many as 23.12 hours.

After considering all of the evidence, we modify the Decision of the Arbitrator and find that Petitioner is entitled to a wage differential award pursuant to Section 8(d)1 of $469.46 per week based on Petitioner's present earning capacity of $8.25 per hour (minimum wage) at 30 hours per week. We do not find the number of hours Petitioner actually worked from July 26, 2014 through February 14, 2015 to be persuasive evidence of her current earning capacity. We note that Petitioner initially requested 30 hours of work per week and that this is consistent with her doctor's recommendations. Although for unknown reasons in January of 2015 she requested only 20 hours per week on limited days and at limited times, she testified at arbitration that she subsequently increased her availability. Furthermore, Petitioner's testimony at arbitration indicates that she is currently working more hours at TJ Maxx than what is reflected in Petitioner's Exhibit #1. Petitioner explicitly denied any complaints or problems performing her job duties at TJ Maxx.

In conclusion, the preponderance of the evidence supports a finding that Petitioner's present earning capacity is $8.25 per hour at 30 hours per week. The parties stipulated that the average weekly wage Petitioner would be able to earn in full performance of her duties for Respondent would be $951.69. The difference between $951.69 and Petitioner's present weekly earning capacity of $247.50 is $704.19. A wage differential award of 2/3 of $704.19 equals $469.46 per week for the duration of the disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner permanent partial disability benefits of $469.46 per week, commencing July 26, 2014 and for the duration of the disability, because the injuries sustained caused a loss of earnings as provided in Section 8(d)1 of the Act.

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

16IWCC0614

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

DATED: SEP 26 2016
RWW/plv
o-8/15/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0614

FARKAS, LAURA
Employee/Petitioner

Case# **10WC029987**

ILLINOIS VETERANS HOME
Employer/Respondent

On 3/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
JASON CARROLL
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602-2983

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

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

MAR 20 2015

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

16IWCC0614

STATE OF ILLINOIS)
)SS.
COUNTY OF ADAMS)

- [ ] 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

LAURA FARKAS,
Employee/Petitioner

v.

ILLINOIS VETERANS HOME,
Employer/Respondent

Case # **10** WC **29987**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Quincy**, on **3/4/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [ ] TTD
L. [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 **7/31/10**, 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 **$32,224.82**; the average weekly wage was **$749.42**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits, from 7/26/14-8/16/14, of $552.67/week because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, from 8/17/14-9/27/14, of $417.79/week because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing 9/28/14, of $552.67/week for the duration of the disability, because the injuries sustained caused a loss of earnings, as provided in Section 8(d)1 of the Act.

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

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

Signature of Arbitrator

3/19/15
Date

MAR 20 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

This case was previously heard pursuant to Section 19(b) of the Act on 5/6/13 before Arbitrator Lindsay. The issues in dispute at that time were accident, causal connection, prospective medical care, temporary total disability benefits and petitioner's entitlement to a vocational rehabilitation assessment. Arbitrator Lindsay filed her Arbitration Decision on 5/7/13. She found petitioner sustained an accident that arose out of and in the course of her employment by respondent on 7/31/10; that petitioner's current condition of ill-being as it relates to her cervical spine is causally related to her work accident of 7/31/10; that the medical services provided to petitioner had been reasonable and necessary, and respondent had not paid all appropriate charges; that respondent shall pay reasonable and necessary medical services directly to the petitioner, pursuant to the fee schedule of $3,276.40 for Quincy Medical Group, $481.00 for Springfield Clinic, $66,301.00 for Dr. Michel Malek, $19,413.40 for United Surgical Assistants, $3,097.70 for Professional Imaging, $743.50 for Clinical Radiologists, $47.00 for Joliet Radiological, $10,274.13 for Our Lady of the Resurrection Hospital, and $220.00 for Washington University; that respondent shall pay petitioner temporary total disability benefits of $499.61 a week for 73-4/7 weeks from 8/1/10-1/7/11 and 2/10/11-1/30/12 as provided in Section 8(b) of the Act; that respondent shall pay petitioner maintenance benefits of $499.61 a week from 1/31/12 through 3/6/13 as provided in Section 8(a) of the Act; and that respondent shall authorize and pay for an initial vocational rehabilitation assessment by a certified counselor as provided in Section 8(a) of the Act and the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

The Arbitration Decision was appealed to the Commission by Respondent. On 2/13/14 the Commission issued its Decision and Opinion on Review. The Commission, after considering the issues of accident, causation, temporary total disability, and medical expenses both current and prospective, and being advised of the facts and law, affirmed and adopted the Decision of the Arbitrator. The Commission further remanded the case to the Arbitrator for further proceedings for the determination of a further amount of temporary total disability 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 also denied petitioner's Motion for Sanctions under Supreme Court Rule 137, and penalties under Section 19(k) of the Act, and attorneys fees under Section 16 of the Act.

At the hearing on 3/4/15, the parties submitted their Request for Hearing. The parties stipulated to the periods of temporary total disability benefits and maintenance benefits claimed in the prior 19(b) hearing. Respondent further agreed that petitioner was entitled to additional maintenance benefits through 7/26/14, with respondent paying maintenance benefits through 8/15/14. Both parties stipulate that petitioner was paid a wage

differential pursuant to Section 8(d)1 from 8/18/14 through 2/14/15, but a dispute exists as to whether or not the correct wage differential calculation was paid. That is the basis of this claim. The parties are not disputing that petitioner is entitled to a wage differential, but rather what job and hours that wage differential should be based on.

On 4/4/14 respondent had Charlotte Bishop, MS, CRC, LCPC, of Creative Case Management, Inc., perform a Transferable Skills Analysis/Labor Market Survey. Dr. Malek had restricted petitioner to no lifting more than 10 pounds, no repetitive motion of the neck, no repetitive motion of the upper extremities, no driving or operating of heavy equipment, no work on vibratory equipment, and no work over 3-4 days a week. Upon review of petitioner's work duties, apparent skill set and medical restrictions, Bishop was of the opinion the following occupations appeared to be appropriate occupational alternatives with or without a reasonable accommodation. She noted that this list was not exhaustive of the types of jobs for which petitioner could be a candidate, but rather an illustration of the jobs to which her skills and training could apply. Bishop noted that on-the-job training may be needed to acquire specific skills that are employer specific. She also noted that petitioner may need training in computer fundamentals to become competitive in the job market for some positions. The occupations identified included:

1. Customer service
2. General office clerk
3. Receptionist
4. Personal Assistant
5. Teacher Aide
6. Recreation Aide
7. Appointment/front desk clerk

Bishop performed a labor market survey on the occupations that were obtained from the list of transferable occupations listed above. Bishop identified the following positions in an approximate 40 mile radius from petitioner's home. She identified Customer Service Representative positions at TJ Maxx, Manpower, Bergners, JC Penney Salon Customer Experience Specialist, One Mark Financial Customer Lending Sales Rep, Acceptance Insurance, Charles W. Janes DDS - Dental Assistant, and Check N' Go. All positions were located in Quincy. She also identified miscellaneous positions that included an Opthalmic Assistant, Medical Coder and Patient Service Rep at Quincy Hospital; Ticket/Travel Agent at City Ticket Office; Pharmacy Tech Trainee or Pharmacy Service Associate at CVS; Bank Teller at Manpower; Activity Aide at Beth Haven Nursing Home; Patient Registration Clerk at Hannibal Regional Hospital; Cosmetic Sales Consultant for Estee Lauder at Bergners; Jewelry Consultant at Zales; and Mobility and Tech Sales at Staples. With respect to Wage Information Bishop identified the median annual salary that one could expect to earn in the Quincy, IL area as

$28,842 for customer service; $26,495 for customer service, grocery store; $20,894 for activity aide-nursing home; and $17,722 for a teacher's aide.

Following the completion of this report, Bishop began working with petitioner in an attempt to help her secure alternate employment within the permanent restrictions outlined by Dr. Malek, and incorporated into her report.

Petitioner cooperated with the vocational rehabilitation and on 7/23/14 Bishop emailed respondent's attorney, Diana Wise, and informed her that petitioner had been offered a sales associate job at TJ Maxx, Quincy, IL, and that her training would commence on 7/28/14. Petitioner was initially scheduled to work between 20-30 hours a week. Bishop indicated that petitioner's salary would be $8.25 an hour. On 7/30/14 Bishop informed Wise that petitioner's hours would vary between 12-16 hours a week, with her first two weeks being scheduled for 12 hours each. Bishop informed Wise that petitioner likes the job and hopes to be considered for management trainee once she proves herself as a sales person. Bishop told Wise that petitioner had a headache following her shift but hoped that she would become accustomed to the work and the headache issue would resolve.

On her Application for Employment with TJ Maxx completed 6/13/14 petitioner indicated that she could work 30 hours a week, from 8am-9pm Tuesday through Saturday. On 1/10/15 petitioner completed an hour availability form for TJ Maxx. She indicated that she would like to work 20 hours a week. She indicated that she would be available from 6am-5pm Monday and Thursday, and from 6am-12pm on Saturdays.

On 8/28/14 Bishop emailed Diana Wise and informed her that petitioner had been hired to work 20 hours per week, 4 hours per day, 5 days per week, at Blessing Hospital as a clerk /hostess starting immediately. Her pay was identified as $9.95 and hours. Bishop noted that petitioner indicated that she would be resigning from TJ Maxx.

The Job Description for the Food/Nutrition/Hostess Clerk at Blessing Hospital in the Food and Nutrition Department was offered into evidence by respondent. The job summary indicated that the Clerks are responsible for a variety of tasks in the call center, nourishment area, assigned nursing unit, and kitchen as assigned. It indicated that the Clerks need strong customer service skills, strong communication skills, phone etiquette, the ability to work independently, organizational skills, a willingness to work as part of a team environment, and basic therapeutic diet knowledge. It indicated that Clerks would be on their feet for the majority of a twelve hour shift walking, standing, bending, and lifting. Clerks may also be required to sit at a desk for an entire shift. The physical demands of this job included standing, walking and sitting 1/2 of the time;

using hands to finger, handle or feel, and talk or hear over 1/2 of the time; reach with hands and arms, climb or balance, stoop, kneel, crouch or crawl, and taste or smell under 1/4 of the time. The job also required work at the sedentary and light physical demand level under 1/4 of the time, and medium, heavy and very heavy none of the time. Sedentary was identified as up to 10 pounds occasionally. Light was identified as 20 pounds of force occasionally, and 10 pounds of force frequently.

On 2/9/15 petitioner underwent a Section 12 examination with Dr. Frank Petkovich, at the request of the respondent. Petitioner gave a history of her treatment to date. He reported that petitioner was presently working for TJ Maxx and had, for a period time, worked at Blessing Hospital, but stopped working there because the work was too stressful. Following a record review, history, an examination and x-rays Dr. Petkovich opined that petitioner was status post surgery for anterior cervical discectomy and interbody fusion at C4-C5, C5-C6, and C6-C7, and had been released from care at maximum medical improvement on 1/30/12 by Dr. Malek. He determined petitioner had a 15% whole person impairment. He could not comment as to petitioner's permanent work capabilities. He recommended an FCE. Pending the FCE he was of the opinion that she could work with restrictions of no lifting greater than 10 pounds and occasional overhead work, and no overhead work cumulatively for 10 minutes per hour. He did not preclude her from working full duty, five days a week, and overtime if available. If no FCE was performed Dr. Petkovich was of the opinion that these restrictions would be permanent.

Petitioner offered into evidence petitioner's payroll records from TJ Maxx and Blessing Hospital. Petitioner worked there 8/17/14 through 9/27/14, a period of 6 weeks. During this period she earned $1,214.30. As a result her average weekly wage would be have been $202.38.

Petitioner offered into evidence petitioner's earnings at TJ Maxx and Blessings from 7/26/14 through 2/14/15. (PX1) Petitioner is still working for TJ Maxx. Petitioner worked for Blessing Hospital from 8/17/14 through 9/27/14. Petitioner testified that she quit her job at Blessing because it was in excess of her permanent job restrictions defined by Dr. Malek. She testified that she worked 4 days a week, 4 hours a day. She testified that she sometimes worked on the tray line or got drinks, but most of the time she worked at a desk with two computer screens in front of her, one with patient information on it, and the other had doctor orders, diet, and menu. She testified that when a patient called dietary she would repeatedly have to look back and forth between the monitors. She testified that the repetitive turning of her neck to look from one screen to the other caused her a lot of pain. Petitioner testified that by the end of the day she would go home with such a severe headache that she could only put a heat wrap on her neck, take ibuprofen and/or pain medicine and lay down. Petitioner

testified that she would spend up to 90% of the day on the computer screen. Petitioner denied any such problems with her work for TJ Maxx.

The parties stipulated that the current average weekly wage petitioner could earn in full performance of her duties at Illinois Veterans Hospital if she was still working there as a VNAC would be $951.69. The parties stipulated that this average weekly wage should be used for the calculation of petitioner's wage differential pursuant to Section 8(d)1 of the Act.

Petitioner testified that she never refuses any work at TJ Maxx, and works 4 days a week, up to 6 hours a day. Petitioner watches her grandchild a few hours two days a week.

Having read the job description for Blessing Hospital, the arbitrator finds the job petitioner did exceeded her permanent restrictions outlined by Dr. Malek and Dr. Petkovich in that the job description required work at the light physical demand level which requires lifting in excess of 10 pounds, and petitioner, while working at the desk was required to perform repetitive motion of her neck while looking back and forth between computer screens while taking calls from patients 3-4 hours a day.

The arbitrator finds the job Bishop found petitioner at TJ Maxx is within petitioner's restrictions. Petitioner testified that she is able to perform this job without any problems. The payroll records for petitioner's work at TJ Maxx indicate that from 7/27/14 through 2/14/15, petitioner earned $3,555.84. During this period petitioner worked 29 weeks. Therefore, the arbitrator finds the petitioner earned on average $122.62 per week. This would equate to approximately 15 hours a week. Although Dr. Malek limited to petitioner to 3-4 days a week, he did not limit her hours per day. Nonetheless, the credible evidence shows that petitioner's average hours per week worked was 15, despite the fact that petitioner indicated she could work 30 hours a week when she started and 20 hours a week on 1/10/15. Petitioner testified that she has since changed her requested hours to 3-4 days a week, 6 hours a day.

The arbitrator gives greater weight to the opinions of Dr. Malek, as it relates to petitioner's permanent restrictions, given the fact that he is the one who performed the surgery and monitored her until she was released at maximum medical improvement with permanent restriction in January of 2012. The arbitrator notes that Dr. Petkovich first indicated that he could not comment as to petitioner's permanent work capabilities, and recommended an FCE. He then went on to recommend that pending the FCE petitioner could work with restrictions of no lifting greater than 10 pounds and occasional overhead work, and no overhead work cumulatively for 10 minutes per hour. He did not preclude her from working full duty, five days a week, and overtime if available. If no FCE was performed Dr. Petkovich was of the opinion that these restrictions would

be permanent. Dr. Petkovich provided no credible evidence to support his opinion that petitioner could work fully duty and overtime.

The arbitrator finds the petitioner cooperated fully with respondent's vocational rehabilitation and it was respondent's vocational expert, Bishop, who informed respondent that petitioner had been offered a sales associate job at TJ Maxx, Quincy, IL, and that her training would commence on 7/28/14. The arbitrator finds this was a job that Bishop found for petitioner. Bishop even informed respondent that petitioner's hours would vary between 12-16 hours a week, with her first two weeks being scheduled for 12 hours each. The arbitrator notes that these hours are less than petitioner offered to work. On her Application for Employment with TJ Maxx completed 6/13/14 petitioner indicated that she could work 30 hours a week, from 8am-9pm Tuesday through Saturday. On 1/10/15 petitioner completed an hour availability form for TJ Maxx. She indicated that she would like to work 20 hours a week. She indicated that she would be available from 6am-5pm Monday and Thursday, and from 6am-12pm on Saturdays. Respondent had no objection to petitioner taking this job, that was found for her by respondent's own vocational expert. Respondent also did not object to the hours Bishop told them petitioner would be working for TJ Maxx.

After accepting this job, petitioner continued to look for alternative work where she might be able to earn more. She accepted a job with Blessing Hospital, which she worked concurrently with her job at TJ Maxx. She worked for 6 weeks, but had a lot of complaints with her neck after completing her work day. After reviewing the petitioner's job description at Blessing for the Food/Nutrition/Hostess Clerk position, the arbitrator finds this job clearly did not fall within the permanent restrictions identified by Dr. Malek prior to the 19(b) hearing on 5/6/13. Given this fact, the arbitrator finds the job at Blessing Hospital was not a job petitioner was capable of working.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner is entitled to a wage differential pursuant to Section 8(d)1 of the Act in the amount of $552.67 per week from 7/26/14 through 8/16/14, and 9/28/14 forward. This is based on 66-2/3% of the difference between $951.69 and $122.62. However, for the period 81/7/14 through 9/27/14, when petitioner worked for both TJ Maxx and Blessing Hospital, the arbitrator finds the petitioner is entitled to a wage differential pursuant to Section 8(d)1 of the Act in the amount of $417.79. This is based on the 66-2/3% of the difference between $951.69 and $325.00.

The arbitrator finds the respondent is entitled to a credit for its overpayment of TTD from 7/27/14-8/15/14, and the wage differential it has paid from 8/16/15 through 2/15/15.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Tornabene,

Petitioner,

vs.
State of Illinois Department of Transportation,

NO: 10 WC 31511
16IWCC0622

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 10, 2016, is hereby affirmed and adopted.

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

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

DATED: SEP 29 2016
TJT:yl
o 9/19/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TORNABENE, JOHN
Employee/Petitioner

Case# **10WC031511**

STATE OF ILLINOIS IDOT
Employer/Respondent

16IWCC0622

On 3/10/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1521 FITZ & TALLON
NICHOLAS FITZ
212 W WASHINGTON ST SUITE 2004
CHICAGO, IL 60606

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

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

MAR 10 2016

RONALD A. RASCIA, Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

16IWCC0622

☐ Injured Workers' Benefit 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 Tornabene
Employee/Petitioner

v.

State of Illinois IDOT
Employer/Respondent

Case # **10** WC **31511**

Consolidated cases: **None**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **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 _____

FINDINGS

On **08/12/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**66,881.88**; the average weekly wage was $**1,286.19**.

On the date of accident, Petitioner was **54** 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 $**64,923.88** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**115,841.08** for other benefits, for a total credit of $**180,764.96**.

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 $857.46/ week for 74 weeks, commencing 8/20/2010 thru 01/31/2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/ week for 175.75 weeks, because of the injuries sustained caused 33% loss of use of a person as a whole (165 weeks), as provided in Section 8(d)2, and 5% loss of use of the left leg (10.75 weeks), as provided in Section 8(e) of the Act.

Respondent shall pay $45,449.03 for medical services, as provided in Section 8(a) of the Act. The expenses shall be paid consistent with the medical fee schedule.

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

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

Signature of Arbitrator

3/9/16
Date

MAR 10 2016

16IWCC0622

STATEMENT OF FACTS:

Petitioner, John Tornabene, worked for Respondent, the State of Illinois/ Department of Transportation (IDOT), for over 31 years at the time of his undisputed work injury on August 12, 2010. In his capacity as a heavy equipment operator, Petitioner worked on a bridge crew and ran big jobs using heavy construction equipment; loaded and unloaded construction trucks; set up the proper tools for the job and executed the repairs assigned for the day. The parties stipulated that Petitioner sustained an accidental injury arising out of and in the course of his employment with the Respondent on August 12, 2010. Petitioner testified that when he was preparing for a bridge repair job, and while unloading jack hammers off of a work truck, he slipped and fell off the back of truck with a jackhammer in his hands. Petitioner testified that he fell approximately four (4) feet and landed onto the ground on his left side injuring his left shoulder, right shoulder and neck.

Petitioner was transported from the jobsite to Alexian Brothers Medical Center by a co-worker. Alexian Brothers Medical Center records show Petitioner presented to the emergency room secondary to a fall out of the back of a truck at work. Petitioner reported that he came down on his left hand side with complaints of pain in his neck, left and right shoulders, upper back pain, headaches and sharp pains that radiates down his left arm. Diagnostic imaging in the form of x-rays to the cervical spine and left shoulder were taken. The x-ray of the shoulder revealed no fracture or dislocation and the x-ray of the cervical spine revealed no evidence of fracture or subluxation. Petitioner was diagnosed with shoulder sprain/ strain and cervical sprain/ strain. Petitioner was given Ibuprofen for pain, modified duty work restrictions and instructions to follow-up in clinic the next day. (PX #1)

That same day, Petitioner sought treatment with Dr. Howard Freedberg at Suburban Orthopedics. Dr. Freedberg's initial examination noted that Petitioner reported that he was lifting a jackhammer out of the back of a truck, slipped, fell four (4) feet down from the truck to the ground, and pushed the jackhammer away from him. The doctor noted Petitioner fell backwards with left arm outstretched that sent a shock of pain through his whole upper body; not long afterwards he developed a severe headache which seemed to be radiating from the neck. Petitioner was diagnosed with possible left rotator cuff tear, cervical radiculopathy and cervical strain. The treatment plan included medications, physical therapy, off work duty status and follow-up to clinic in two (2) weeks. (PX # 2)

Petitioner presented himself to Suburban Orthopedics for follow-up visit on August 26, 2010 with complaints of neck and bilateral shoulder pain. It was noted that Petitioner did not start physical therapy as it was not approved by the workers' compensation carrier. Petitioner provided that he was experiencing a new sharp pain in his left elbow and that the medication had helped a little. Due to Petitioner's continual complaints of significant pain, radicular symptoms and shoulder weakness, Dr. Freedberg ordered MRI's of his left shoulder and cervical spine. Dr. Freedberg continued to prescribe a course of physical therapy and kept Petitioner off work until follow-up in two (2) weeks. (PX #2) Petitioner underwent physical therapy at Suburban Orthopedics for his bilateral shoulders and cervical spine from August 31, 2010 thru September 09, 2010. (PX# 2)

On September 09, 2010, Petitioner presented for follow-up with Dr. Freedberg with no change in status since the last visit. Petitioner stated that he gets a headache after physical therapy and was sleeping in an upright chair because he could not lie on either side. Petitioner continued with the sharp pain in his left elbow. Dr. Freedberg noted that because of the significant complaints of pain of Petitioner's bilateral shoulder and cervical spine, MRI's of the left shoulder and cervical spine were needed but had not been approved by the

workers' compensation carrier. Petitioner was advised to continue physical therapy; complete the MRI's, remain off work and follow-up in three (3) weeks. (PX# 2)

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The prescribed MRI of his cervical spine without contrast and an MRI of his left shoulder without contrast was completed on October 27, 2010. The cervical spine MRI noted a small disc protrusion and posterior osteophytes from C4 thought C7 with no significant disc herniation, central canal or neural foraminal stenosis. The left shoulder MRI demonstrated a high-grade partial thickness tear of the supraspinatus tendon, a few residual fibers remain intact on the joint side of the tendon. The labrum and other tendons are intact. (PX# 2)

On November 03, 2010, Petitioner presented for follow-up with Dr. Freedberg to discuss MRI findings and for further evaluation. Petitioner reported worsening headaches, neck and shoulder pain. It was noted that he was getting headaches after therapy and had to stop. Petitioner had right shoulder pain on the top side area with range of motion better than left. He complained that raising increases pain and the left elbow was not improved. Positive findings were discussed as shown in the MRI's. Dr. Freedberg recommended Petitioner undergo surgery to the left shoulder rotator cuff. Petitioner was continued off work in the interim. When Petitioner returned to clinic on December 08, 2010, Dr. Freedberg noted that Petitioner was still awaiting approval for surgery. Dr. Freedberg ordered medications and advised Petitioner to remain off work until follow-up. (PX # 2)

Petitioner presented to St. Alexius Medical Center with Dr. Freedberg for left shoulder surgery on January 21, 2011. The procedure performed consisted of left shoulder arthroscopy, debridement of the labrum, subacrominal decompression, distal clavicle resection, a biceps tenodesis with a rotator cuff repair. This was an outpatient procedure and Petitioner was advised to return to the clinic seven (7) to ten (10) postoperatively. (PX #2)

Petitioner returned to Dr. Freedberg on January 27, 2011 for his first postoperative follow-up visit. It was noted that his left shoulder pain was mild. Petitioner was referred for physical therapy; remain off work and follow-up in four (4) weeks. Petitioner underwent physical therapy at Suburban Orthopedics from January 31, 2011 thru March 3, 2011. (PX# 2)

On March 11, 2011, Petitioner returned for follow-up with Dr. Freedberg status post left shoulder surgery. Petitioner reported that he was not doing well and that his shoulder "doesn't feel right." He reported that he could not sleep on that side and wakes up at night due to the pain. He continued to have pain in the front side of the left elbow. Petitioner also stated that his right shoulder was bothering him more and he has to sleep on his back. Dr. Freedberg continued physical therapy, prescribed medication and kept Petitioner off work. Petitioner underwent physical therapy at Suburban Orthopedics for his bilateral shoulders and cervical spine from March 7, 2011 thru April 6, 2011. (PX #2)

Petitioner returned for follow-up on April 6, 2011. He reported increased right shoulder complaints. Dr. Freedberg ordered an MRI of the right shoulder. Petitioner was to remain off work and follow-up after MRI was completed. (PX# 2)

On May 5, 2011, Petitioner presented to Alexian Brothers Medical Center for right shoulder MRI without contrast. The findings were diffuse tendinopathy of the supraspinatus tendon. (PX #2)

Petitioner returned to Dr. Freedberg on May 11, 2011 to discuss the findings of the MRI. Petitioner reported that his left shoulder felt 50% better, but his right shoulder felt 50% worse. Dr. Freedberg noted that Petitioner had not been in physical therapy as it had not been approved by the workers' compensation carrier. Because of the signs of right rotator cuff pathology, Dr. Freedberg administered a subacromial corticosteroid

injection. Petitioner was to remain off work; attend physical therapy and follow-up in five (5) weeks. Petitioner underwent physical therapy at Suburban Orthopedics from June 1, 2011 thru July 13, 2011. (PX# 2)

Petitioner attended a follow-up visit with Dr. Freedberg on July 13, 2011 for physical examination and follow-up regarding his worsening right shoulder symptoms. Petitioner stated his left shoulder was "wonderful and that he [was] extremely happy." Petitioner reported that he started therapy for his right shoulder and complained that he could not lift his right arm above his shoulder. Petitioner reported that the day prior he was lifting a hammer out of his tool box and he dropped the hammer because it was so painful. Dr. Freedberg opined Petitioner was done treating for his left shoulder. Dr. Freedberg noted that conservative treatment of the right shoulder had failed. Surgery was recommended. (PX #2)

Petitioner underwent the recommended surgical intervention on September 19, 2011. The surgery completed at St. Alexius Medical Center consisted of right shoulder arthroscopy, debridement of the labrum, subacromial decompression, distal clavicle resection, rotator cuff repair and biceps tenodesis. (PX# 2)

On September 29, 2011, Petitioner returned for his first right shoulder post-operative visit with Dr. Freedberg. It was noted that Petitioner experienced complications from the right shoulder surgery as his reaction to the nerve block numbed his lung and Petitioner was hospitalized for approximately three (3) days. It was further noted that there was no permanent impairment to the lung after the nerve block subsided. Petitioner was instructed to start physical therapy for the right shoulder, to remain off work, and follow-up in five (5) weeks. (PX# 2)

Petitioner presented for his second right shoulder post-operative visit with Dr. Freedberg on November 01, 2011. During examination it was noted that Petitioner's shoulder was sore but his range of motion was improving. Petitioner was ordered additional physical therapy for range of motion and joint mobilization techniques. Petitioner was to remain off work, continue physical therapy and follow-up in five (5) weeks. The Petitioner underwent right shoulder physical therapy from November 15, 2011 thru December 5, 2011 at Suburban Orthopedics. (PX #2)

On December 6, 2011, Petitioner returned for follow-up with Dr. Freedberg for his right shoulder symptoms. Petitioner reported that his shoulder was sore, physical therapy was helping and he was not taking any pain medications at this time (Petitioner testified at the time of trial that he did not like taking the pain medications as he did not like the way he felt when he took them). Petitioner also reported that he experienced shooting pains down his right into his arm and fingers and had difficulty with sleep. Dr. Freedberg administered a subacromial corticosteroid injection. Petitioner was continued in physical therapy and kept off work. (PX# 2)

On December 19, 2011, Petitioner returned to Dr. Freedberg due to an injury to his left knee that he sustained in physical therapy on December 15, 2011. It was noted that Petitioner was doing some exercise lifting up crates with weights inside. Petitioner reported that he was doing a couple knee bends and felt a sharp pain in the left knee. Petitioner provided that he tried to walk it off but the pain was persistent. Physical examination of the left knee consisted of pathology of left knee medial meniscus tear. Dr. Freedberg advised that the medial meniscus tear occurred in therapy for his shoulder so it was directly related to the work injury he sustained. An MRI of the left knee was ordered. Petitioner was to remain off work and follow-up after the MRI. (PX# 2)

Petitioner presented to Suburban Orthopedics Radiology for the MRI of the left knee without contrast on December 28, 2011. The impression of the MRI showed evidence of rupture of a small baker's cyst; mild focal insertional partial tearing of the central aspect of the quadriceps tendon, involving less than 10% of the tendon substance; moderate to severe patellofemoral chondromalacia; and medial meniscal degeneration without discrete linear tear. (PX #2)

Petitioner returned to Dr. Freedberg on January 4, 2012. Petitioner reported that his right shoulder was feeling "pretty good" although he could not reach behind his back and still had weakness. The doctor noted that the left knee MRI demonstrated Petitioner had a ruptured baker's cyst. Dr. Freedberg felt that this was not surgical and that Petitioner shall continue physical therapy for the right shoulder, remain off work and follow-up in four (4) weeks. Petitioner underwent physical therapy from January 5, 2012 thru January 19, 2012 at Suburban Orthopedics. (PX# 2)

Petitioner returned to Dr. Freedberg on January 25, 2012 for evaluation. Petitioner reported that he was doing well, and ready to return to work. He provided that he was still very weak and mentioned that he was going to get a trainer to build his strength back up. Petitioner also reported that his knee was doing well and was walking four (4) miles a day. Dr. Freedberg discontinued physical therapy for the right shoulder. Dr. Freedberg noted Petitioner was working on a home based program as he was still deficient with strength and that probably same was permanent although he is working on it. Petitioner was released to return to work full duty on a trial basis until follow-up in approximately four (4) weeks time. (PX #2)

Petitioner testified he returned to work for Respondent for a few weeks and then retired. Petitioner testified that he couldn't perform the required duties of the job and felt that is was best that he retire.

On March 8, 2012, Petitioner returned to Dr. Freedberg for follow-up visit. Petitioner stated that he went back to work for a few weeks and then retired. It was noted that he will be starting a new job at the Addison Park District in April. Petitioner informed the doctor that although he goes to the gym and was working with a trainer who is helping him build strength, there were some exercises that he could not do without a lot of pain. He stated that he still struggled with overhead lifting and movement. Dr. Freedberg noted that Petitioner was continuing with some problems with his knee but not enough to warrant surgical intervention at that time. The doctor indicated Petitioner will need treatment in the future secondary to the injuries he sustained. He indicated Petitioner may even need surgery if the condition worsens as expected in years to come. Dr. Freeberg deemed Petitioner at MMI. Dr. Freedberg noted that Petitioner's shoulders have never and will never approach baseline that he had prior to the injuries he sustained at work. The doctor noted Petitioner had retired and "...one of the significant reasons he did is because he knew the shoulders couldn't withstand long term rigors of his job..." Dr. Freedberg further stated that the conditions of ill being in his shoulders have caused him to retire prematurely; that he will always have some impairment from the injuries and this could continue to progress in the future. Dr. Freedberg stated Petitioner probably will need further treatment in the future which included but was not limited to a total shoulder arthroplasty. The doctor opined that if he needed his shoulders replaced it would be directly causally connected to the accident in question. Dr. Freeberg released Petitioner to return per request needed (PRN). (PX# 2)

Petitioner testified that the job he obtained at the local park district consisted of mowing grass. He indicated that he stopped working at the park district because he felt he could not perform his duties. Petitioner stated that he volunteers for elections in his spare times. He has not seen Dr. Freedberg since March 2012 and was not currently taking any prescription medications.

IN REGARDS TO "J", WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO THE PETITIONER REASONABLE AND NECESSARY?, HAS RESPONDENT PAID ALL APPROPRIATE CHARGERS FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

There is no dispute that Petitioner sustained accidental injuries that arose out of and in the course of his employment on August 12, 2010. Furthermore, there is no dispute that Petitioner's bilateral shoulders, his neck

and left knee conditions of ill-being are causally related to the accident sustained. The Arbitrator finds that all of the medical bills contained in Petitioner's Exhibit #3, which represents all services rendered, are reasonable, necessary and causally related to Petitioner's undisputed work injuries. Respondent to date has paid approximately $115,841.08 in medical bills. Respondent shall pay outstanding medical expenses from Suburban Orthopaedics and all bills shall be paid per fee schedule.

16IWCC0622

IN REGARDS TO "L", WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes that inasmuch as the date of occurrence predates the amendments of the Act (820 ILCS 305/8.1b), an analysis pursuant to said amendment is not appropriate in this matter.

As a result of the accident sustained, Petitioner sustained multiple injuries in this matter. Petitioner sustained an injury to his left shoulder resulting in surgery which included left shoulder arthroscopy, debridement of the labrum, subacromial decompression, distal clavicle resection, a biceps tenodesis with a rotator cuff tear. The post-operative diagnosis included left shoulder anterior labral tear, a biceps tendon tear with type-2 superior labrum anterior and posterior tear, partial tear of the supraspinatus with acromioclavicular degenerative joint disease. Petitioner also sustained an injury to his right shoulder resulting in surgery which included right shoulder arthroscopy, debridement of the labrum, subacromial decompression, distal clavicle resection, rotator cuff repair and biceps tenodesis. The post-operative diagnosis included right shoulder acromioclavicular degenerative joint disease, anterior labral tear, partial tear of the supraspinatus, bicipital tendinitis with bicipital groove stenosis and tearing of the biceps tendon. Petitioner further sustained an injury to his neck resulting in cervical radiculopathy and cervical strain. Lastly, Petitioner sustained an injury to his left knee that occurred in therapy for his shoulder. The left knee shows positive findings for a ruptured Baker's cyst, mild focal insertional partial tearing of the central aspects of the quadriceps tendon and moderate to severe patellofemoral chondromalacia resulting in a severe non-surgical left knee sprain.

Petitioner testified to ongoing problems to his bilateral shoulders, neck and left knee which included stiffness, weakness and soreness, limited range of motion, limited strength and limited overhead lifting. Petitioner testified at the time of trial that he returned to work for Respondent for a few weeks and then retired. Petitioner testified that he couldn't perform the required duties of the job and felt that it was unsafe for him and his co-workers so it was best that he retire as he was told that this current physical state would be as good as he would get. While he has not sought any recent treatment for this pain, he experiences this pain on a daily basis.

Based on all of the foregoing, the Arbitrator finds that Petitioner has sustained 33% loss of use of a person as a whole (bilateral shoulders and cervical conditions of ill-being) under Section 8(d)2 of the Act. The Arbitrator further finds that Petitioner sustained 5% loss of use of the left leg under Section 8(e) of the Act.

IN REGARDS TO "M" SHOULD PENALTIES OR FEES PURSUANT TO SECTIONS 19(K), 19(L) AND SECTION 16 OF THE ACT BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator notes Respondent's conduct in this matter is less than admirable. Nevertheless, the Commission has found that it should accord leniency to governmental bodies in times of financial stress. The Arbitrator takes judicial notice of the budgetary problems affecting the State of Illinois, which are well known to the public. As such, the Arbitrator declines to award penalties in this matter.

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

DREX MCARTHY,

Petitioner,

vs.

NO: 10 WC 44337

WHITE COUNTY COAL CO. LLC / ALLIANCE COAL,

16IWCC0570

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, medical expenses, nature and extent, and "Omission of Respondent's Evidence," and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof, with the clarifications noted below.

The Commission has reviewed the report and deposition of Respondent's Section 12 physician, Dr. Moskal, and finds that the opinions of Dr. Marburger are more persuasive on the issue of whether Petitioner's job duties were a contributing factor in the development of his right elbow arthritis and it becoming symptomatic.

On the issue of medical expenses, we clarify that this decision is not a specific authorization for future treatment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 2, 2015 is hereby affirmed and adopted with the clarifications noted above.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $12,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP - 7 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 8/16/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McAURTHY, DREX
Employee/Petitioner

Case# 10WC044337

WHITE COUNTY COAL CO LLC/ALLIANCE COAL
Employer/Respondent

16IWCC0570

On 7/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5236 CULLEY FIEST KUPPART & TAYLOR
KREIG TAYLOR
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

2742 KEVIN M HAZLETT
1167 FORTUNE BLVD
SHILOH, IL 62269

16IWCC0570

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

Drex McArthy
Employee/Petitioner

v.

White County Coal Co. LLC/Alliance Coal
Employer/Respondent

Case # **10** WC **44337**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **5/13/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/11/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**53,176.76**; the average weekly wage was $**1,022.63**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay to Petitioner permanent partial disability benefits of **$613.58** per week for **19.975** weeks because the injury sustained caused the **7.5%** loss of use of the right arm as provided in Section 8(e) of the Act.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 11, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid 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.

Signature of Arbitrator

6/22/15
Date

JUL 2 - 2015

Drex McArthy v. White County Coal Co., LLC/Alliance Coal
No. 10 WC 44337

FINDINGS OF FACT and CONCLUSIONS OF LAW

This case proceeded to a full hearing before Arbitrator Lee on May 13, 2015. The disputed issues were causal connection, medical bills, future medical and nature and extent.

The Arbitrator finds:

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of March 11, 2009 and that Petitioner sustained repetitive trauma to his right elbow. Respondent does not dispute that Petitioner sustained an accident that arose out of and in the course of his employment but does dispute liability on the basis of causation.

Petitioner testified that he was working for Respondent in March of 2009 and began working for Respondent several years prior to 2009. Petitioner testified at length as to his job duties which consist of hammering and use of his hands and arms regularly throughout his shift. Admitted as Petitioner's Exhibit No. 7 was a hand written job description, which Petitioner testified was consistent with what his job duties consisted of throughout his employment with White County Coal.

Petitioner testified that he noticed pain in his elbow on 3/11/09 while using a sledgehammer at work. Petitioner filled out an accident report and had an appointment to see Dr. James Goris of the Orthopaedic Associates in Evansville on 3/12/09. On that date Petitioner presented with pain, numbness, tingling, weakness, swelling, deformity and radiation of pain in right elbow. Dr. Goris diagnosed Petitioner with osteoarthritis of the elbow, prescribed to Petitioner pain medications and recommended diagnostic studies of the elbow.

Petitioner returned to Dr. Goris on 3/19/09. Petitioner noted on that date that he was improved since his last visit. An elbow x-ray revealed bone spurring and narrowing of the joint consistent with osteoarthritis. Dr. Goris recommended that Petitioner continue with exercises and should the residual symptoms not resolve or become worse a return appointment would be made.

Petitioner followed up with Dr. Goris on 8/12/09 for a recheck of his elbow. Petitioner noted that the pain was not like it was before and that he did not have the motion back in his elbow and depending on the activity he has soreness. Dr. Goris recommended a CT scan to look for loose body in the elbow causing limited motion.

Petitioner continued to have problems with his elbow and returned to see Dr. Goris on 11/19/09 inquiring as to further treatment options. Dr. Goris referred Petitioner to the upper extremity specialist Dr. Marburger for evaluation and treatment options. On that date Dr. Goris injected Petitioner's right elbow with Kenalog for pain relief.

Petitioner first saw Dr. Marburger on 12/23/09. Dr. Marburger noted that he discussed with the Petitioner the etiology, natural history and treatment alternatives of his condition and that based upon the history provided to him and the physical exam findings, it is his medical opinion within a reasonable degree of medical probability that the symptoms are a result of the work related injury as described. It was also noted that he and Petitioner discussed at some length the potential for future surgical intervention.

Petitioner was seen and evaluated on 7/27/10 by Dr. Goris. On this date a repeat injection of the right elbow was performed to relieve the inflammation and discomfort. Petitioner was again referred to Dr. Marburger for treatment.

Petitioner followed up with Dr. Marburger on 4/25/11. It was noted that Petitioner had been employed by White County Coal for 20 years doing heavy use, hammering and other forceful activity. After performing a physical examination, Dr. Marburger provided Petitioner with a third injection into his right elbow.

Following his third injection, Petitioner followed up with Dr. Marburger on 5/10/11 noting that the symptoms had improved but had not resolved. Dr. Marburger recommended that Petitioner be fully active over the next four weeks to see if he remained stable.

Petitioner followed up with Dr. Marburger again on 6/8/11. Petitioner noted on that date that his pain had returned to baseline. Dr. Marburger recommended a CT scan of the right elbow to map out the arthritic changes and indicate where efforts might address his pain. Following the CT scan, Petitioner returned to Dr. Marburger on 8/8/11. The CT scan showed substantial 3 compartment osteoarthritis, marked radial head and RH involvement, flattening and large osteophytes, spurring along both gutters, less so medially at the HU joint. Dr. Marburger noted that he recommended to Petitioner that when ***indicated by his pain***, he proceed with resection of the radial head, implant as indicated. It was noted that Petitioner was to contact him as he wished to proceed. This was the last date that Petitioner was seen by Dr. Marburger.

Dr. Marburger's deposition was taken on 6/5/12 and was admitted into evidence at arbitration. Dr. Marburger opined within a reasonable degree of medical certainty that the symptoms manifested in Petitioner's elbow were at least in part causally related to his work duties. He noted that the type of job activities that Petitioner performed could worsen the symptoms that he has.

Petitioner testified that he has not been back to see Dr. Marburger since 8/8/11 and that he based upon the recommendations of his doctor, he was waiting to undergo surgical intervention until the pain becomes unbearable. Petitioner testified that he still has pain in his right elbow and notices it daily. He testified that he is unable to perform many of the things that he previously could perform such as lifting weights.

Petitioner has continued to work through the pain in his elbow and has not lost time from work. Respondent has paid for the majority of Petitioner's medical bills, although $362.00 remain outstanding.

The Arbitrator concludes:

1. Issue (F) Causal Connection.

   Petitioner's current condition of ill-being is causally related to the accident of 3/11/09. This conclusion is based upon a chain of events, Petitioner's unrebutted testimony, the credible testimony of his treating physician, Dr. Marburger and the medical records. Based upon the testimony of the Petitioner, as well as his handwritten job description, the Arbitrator finds that Petitioner's work duties at least in part contributed to the development of the symptoms in his right elbow for which he continues to experience.

2. Issue (J) Medical Bills/Future Medical.

   Petitioner's medical treatment, as set forth in the records, is reasonable, necessary and causally related to the accident. As a result, Respondent is ordered to pay the medical bills contained in Petitioner's Exhibit number 6 in the amount of $362.00. Respondent is to be given a credit for any medical bills previously

paid by it through its group medical plan for which credit may be allowed under Section 8(j). Based upon the medical records and the testimony of Petitioner, Petitioner's medical rights shall remain open.

3. Issue (L) Nature and Extent.

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 7.5% loss of use of the right arm. In support of this conclusion, the Arbitrator notes that Petitioner has undergone three injections into his right elbow without significant relief. Dr. Marburger has recommended surgery. However, Petitioner is waiting until the pain becomes unbearable. Petitioner still experiences pain in his elbow and is unable to perform many of the things that he could perform previously.

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

Lori McGregor,
Petitioner,
vs.

NO: 11WC004230

Illinois Dept. of Human Services,
Respondent,

16IWCC0583

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 17, 2015, is hereby affirmed and adopted.

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

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

DATED: SEP - 8 2016
MJB/bm
o-8/30/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McGREGOR, LORI
Employee/Petitioner

Case# **11WC004230**

16IWCC0583

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

On 7/17/2015, 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 0.10% 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:

0290 KARCHMAR & STONE
LARRY KARCHMAR ESQ
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
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

JUL 17 2015

RONALD A.RASCIA, 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

Lori McGregor
Employee/Petitioner

v.

Illinois Department of Human Services
Employer/Respondent

Case # 11WC 04230

16IWCC0583

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **June 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ 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. X Other **8 (j) Hold Harmless**

16IWCC0583

FINDINGS

On **May 7, 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 **$31,969.08**; the average weekly wage was **$614.79.**

On the date of accident, Petitioner was **41** years of age, ***single*** with **2** dependent children.

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$409.86** per week for **18 - 5/7 weeks**, commencing **10/1/2010** through **2/11/2011**, as provided in §8(b) of the Act.

Respondent shall be given a §8(j) credit for the medical bills paid by group and shall keep Petitioner safe and harmless from claims or liabilities made against her as provided in §8(j).

Respondent shall pay Petitioner permanent partial disability benefits of **$368.87** per week for **30.75** weeks, because the injuries sustained caused the **15% loss of use of the left hand**, as provided in §8(e) of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 5/7/2010 through 6/12/2014, and shall pay the remainder of the award, 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.

Signature of Arbitrator

July 16, 2015
Date

JUL 17 2015

FINDINGS OF FACT 16IWCC0583

At trial, Petitioner amended the Application for Adjustment of Claim to set forth an accident/manifestation date of May 7, 2010.

Petitioner was employed by Respondent as a human services case worker since January of 2006. Her job duties include the handling of a caseload of about 350 files. Petitioner reviews new files (about 10) daily and types notes in the computer. She reviews existing files and updates them with notes. She types in changes (new data, or removal of data) for the existing files. She talks on the phone and has in person meetings with people. She uses her computer during these contacts (cradling the phone between her neck and shoulder in order to type). Petitioner's work station has a monitor on her desk and the keyboard and mouse are in a tray under her desk. The desk is about 30 inches tall and the keyboard is about 4 inches below the desk. Petitioner did not think that her work station was ergonomic. Petitioner demonstrated her work position for typing at trial. Her wrists are bent up and her elbows were shown to be at about 90 degrees.

Petitioner was allowed 2 fifteen minute breaks per day and also took a lunch (30 minutes?) Sometimes, she would do filing. Petitioner's Exhibit 10 shows that she would typically use her hands for gross manipulation (grasping, twisting, handling) and for fine manipulation (typing) for 4-6 hours per day. Her job tasks are continuous. It is clear that Petitioner must use her hands to type many hours per day. Petitioner has no risk factors for the development of carpal tunnel syndrome, other than she is 41 years old and a female. Petitioner is right hand dominant.

About a month before May 7, 2010, Petitioner began to notice numbness and tingling in her left hand (2 middle fingers) while working. She did not have these problems when not working. Petitioner told her supervisor, Laticia Doe of her complaints and Doe recommended that Petitioner see a doctor. Petitioner tried a wrist brace and modified her work station, but still had hand problems.

Petitioner first sought medical treatment with Dr. Clay Canaday for her hand complaints on May 7, 2010. Petitioner had complaints of left wrist pain running to the elbow, weakness and that she was dropping things. She typed a lot at work. Dr. Canaday thought that Petitioner had possible carpal tunnel syndrome of the left hand. An elbow pad, Medrol Dosepak and Vitamin B-12 were recommended. On August 4, 2010, it was noted that Petitioner had not obtained relief and she was referred to Dr. Anton J. Fakhouri. (PetEx. 5)

Petitioner was first seen by Dr. Fakhouri on August 12, 2010. Dr. Fakhouri diagnosed Left carpal tunnel syndrome and left cubital tunnel syndrome. It was noted that the EMG was negative, as were the glucose and TSH levels. Both the wrist and elbow were injected. Petitioner was seen on September 9, 2010 and it was noted that while the EMG was negative, provocative tests were positive and Petitioner had continued complaints. Accordingly, surgery was offered to relieve the entrapment neuropathies. Petitioner underwent a left carpal tunnel release and a left cubital tunnel release on October 1, 2010. Petitioner underwent a closed manipulation of the left elbow under anesthesia on December 7, 2010. When Petitioner was last seen by Dr. Fakhouri on January 27, 2011 it was noted that she was doing well. She was to return to work in mid February. (PetEx. 3).

Petitioner was off work from the day of the surgery through February 11, 2011. Respondent had no limited duty work available for Petitioner. Petitioner was not paid TTD for the lost time. Petitioner returned to her regular job for Respondent, working the same duties as before, and continues to work as a human services case worker.

Petitioner testified that the surgery helped her. She has left wrist and hand pain. Her elbow locks up if she keeps it bent for 5 minutes. It is hard to straighten the elbow. She has a little bit of numbness and tingling in her fingers. Her arm is tired at the end of her work day.

Petitioner's medical bills were paid by group.

Petitioner was seen by Dr. Irwin Weisman for an IME at the request of her attorney on July 30, 2012. (PetEx. 1 & 2) Dr. Weisman testified via Evidence Deposition. He was of the opinion that Petitioner's carpal tunnel condition was causally related to her work activities of repetitive wrist and hand movement associated with typing and that Petitioner's work activities could aggravate carpal tunnel syndrome. He also thought that Petitioner's cubital tunnel syndrome condition was causally connected to her employment activities, especially typing with the elbows flexed at 90 degrees. Dr. Weisman is a board certified surgeon and plastic surgeon, with an additional designation in hand surgery. (PetEx. 7, 1)

On November 26, 2012, Petitioner was examined by Dr. Michael Vender, a board certified orthopedic surgeon with a concentration in upper extremity surgery, at the request of Respondent for a §12/IME exam. (ResEx. 1 & 3) Dr. Vender testified via Evidence Deposition and at trial. Dr. Vender was of the opinion that Petitioner's carpal tunnel and cubital tunnel syndrome conditions were not causally related to Petitioner's work activities. The experiencing of symptoms while performing an activity does not establish causation. Dr. Vender thought that entrapment neuropathies can be caused by repetitive work activities if they have the appropriate force, intensity and duration. Petitioner's work activities were not sufficiently forceful and they weren't sufficiently repetitive. Hyperflexion is required for the development of cubital tunnel syndrome and that was not shown here. On Cross-Examination, Dr. Vender agreed that long weekly hours of keyboarding could aggravate the symptoms of carpal tunnel syndrome. Dr. Vender did not think that Petitioner's work activities aggravated any pre-existing neuropathy conditions because "there are no risk factors for the conditions". Petitioner's conditions would be considered idiopathic in origin. The deposition was terminated mid way through Cross-Examination and Dr. Vender's testimony resumed before the Arbitrator. (ResEx. 4)

CONCLUSIONS OF LAW

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

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT 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 Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on May 7, 2010, leading to left hand carpal tunnel syndrome with eventual surgical repair, based upon the credible testimony of Petitioner and the medical records and testimony. The left arm cubital tunnel syndrome condition is found to be not causally connected to Petitioner's employment.

Petitioner's testimony and the job description establish that she has a hand use intensive job that involves extensive typing. The Arbitrator is persuaded by Dr. Weisman's credible causation opinion regarding the carpal tunnel condition. Dr. Vender's opinion that there is no causal connection between Petitioner's work activities and the carpal tunnel condition is not persuasive in this case, especially when he concedes that long weekly

hours of keyboarding could aggravate carpal tunnel syndrome, but that is not the case here because Petitioner has no risk factors for CTS (thus, disingenuously, there can be no aggravation and the condition is of unknown origin, thereby failing to address whether a medical condition of unknown etiology could be aggravated).

The manifestation date for this repetitive trauma injury is May 7, 2010, the date on which Petitioner first sought medical treatment from Dr. Canaday for her upper extremity complaints.

The Arbitrator is not persuaded that Petitioner's cubital tunnel condition is causally related to her work activities in this case.

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

The medical services that were provided to Petitioner were reasonable and necessary as they relate to the carpal tunnel syndrome condition.

WITH RESPECT TO ISSUE (K), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Based upon the Arbitrator's finding with respect to the issues of accident and causation and the testimony of Petitioner, Petitioner is entitled to TTD benefits for the time period of October 1, 2010 through February 11, 2011.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that as a result of the injuries sustained (carpal tunnel syndrome of the non-dominant hand with surgical repair and subsequent return to the same job along with mild residual symptoms of pain and occasional numbness and tingling) Petitioner has experienced the loss of use of the left hand to the extent of 15% thereof.

WITH RESPECT TO ISSUE (O) 8 (j) HOLD HARMLESS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's bills were paid by group and Respondent is entitled to a §8(j) credit for the said payments and is obligated to protect and keep Petitioner harmless for claims for reimbursement as is provided in §8(j).

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

Teresa McComas,
Petitioner,

vs. NO: 11 WC 07125

State of Illinois
Fox Developmental Center,
Respondent.

16IWCC0596

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, and 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 July 22, 2015 is hereby affirmed and adopted.

DATED: SEP 16 2016

o-09/13/16
jdl/wj
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

Under the Weather

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McCOMAS TERESA
Employee/Petitioner

Case# **11WC007125**

ST OF IL FOX DEVELOPMENTAL CENTER
Employer/Respondent

16IWCC0596

On 7/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4550 HUNZIKER HECK-SCHNEIDERHEINZE
MICHELLE SCHNEIDERHEINZE
416 MAIN ST SUITE 1600
PEORIA, IL 61602

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH FL
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

JUL 22 2015

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

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

☐ 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

Teresa McComas
Employee/Petitioner

v.

State of Illinois Fox Development Center
Employer/Respondent

Case # **11** WC **7125**

Consolidated cases:
16IWCC0596

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **1/16/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$46,054.00**; the average weekly wage was **$972.87**.

On the date of accident, Petitioner was **43** 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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Petitioner failed to prove that she sustained an accident arising out of and in the course of her employment. Therefore all benefits are denied.

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

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

Signature of Arbitrator

7/20/15
Date

JUL 22 2015

16IWCC0596

FINDINGS OF FACT

Petitioner is claiming an alleged accident on January 16, 2011 involving her right knee. (Arb. Exh. 2) Petitioner is alleging she injured her right knee while cleaning a nurse's station. (Arb. Exh.2) In dispute are the following issues: 1) accident, 2) causation, 3) medical expenses, and 4) TTD.

Petitioner testified she worked for the State of Illinois at Fox Developmental Center as a registered nurse. She worked in that capacity for 3 years. She is no longer employed with Fox Developmental Center and currently resides in Texas.

On January 3, 2011, prior to the date of the accident in question, Petitioner presented to Dr. Alex Crowe. Petitioner stated that her left thigh hurt when she bears weight to walk. [Pet. Ex. A at 63]. Petitioner underwent an x-ray of her left femur. [Pet. Ex. A at 47]. The x-ray showed arthrosis manifested by osteophytosis. [Pet. Ex. A at 47]. Dr. Crowe believed she had facet joint disease. [Pet. Ex. A at 64]. Dr. Crowe recommended that at work Petitioner not bend over because it was aggravating her back which is causing a radiation of pain down into the anterior aspect of her left thigh. [Pet. Ex. A at 64]. She was to return to Dr. Crowe in 2 weeks. [Pet. Ex. A at 64].

Petitioner testified that on January 16, 2011, the date of the alleged accident, she was cleaning up the nurse's station, which included emptying the medication cart and emptying the trash. Around 9:30 p.m., she reached under the desk in the nurse's station and picked up the trash can from under the desk. The trash can was approximately two feet tall and weighed approximately seven pounds. While Petitioner was bending back up with the trash can, she felt a pop in her right knee. Petitioner testified that there was nothing defective in the floor. She testified that she cleaned the nurse's station about three times per day and on this occasion there was nothing unusual or defective. She also takes out the trash at home.

Respondent admitted into evidence the Employee's Notice of Injury. [Resp. Ex. A]. This form, filled out by the Petitioner on the date of the accident, states that she, "was turning around and right knee popped." [Resp. Ex. A].

After the accident, Petitioner presented to St. James Hospital. An x-ray of her right knee showed medial compartment arthrodesis manifest by joint space narrowing and suprapatellar joint effusion. [Pet. Ex. A at 32]. On January 17, 2011, Petitioner presented to AMG Pontiac. [Pet. Ex. A at 27]. Petitioner stated that the day before she was walking along, she tended to pivot, and felt a sharp pain in her right knee. [Pet. Ex. A at 27]. On January 24, 2011, Petitioner returned to Dr. Crowe. [Pet. Ex. A at 11]. Petitioner reported to Dr. Crowe that on the date of the accident, she was emptying the trash and turned to walk and twisted her right knee. [Pet. Ex. A at 11]. Dr. Crowe recommended an MRI and for Petitioner to begin physical therapy. [Pet. Ex. A at 11]. On January 27, 2011, Petitioner underwent an MRI of the right knee without contrast. [Pet. Ex. A at 30]. The MRI revealed detachment, posterior horn and root of the medial meniscus; grade III chondromalacia of the weight-bearing medial femoral condyle; and osteoarthritic change and osteonecrosis at the patellofemoral articulation. [Pet. Ex. A at 31].

On January 31, 2011 Petitioner presented to Dr. Newcomer at Orthopedic & Sports Medicine Center. [Pet. Ex. A at 91]. Petitioner relayed that on the date of the accident, she picked the garbage up, stood, pivoted to turn, and felt a loud pop in her right knee. [Pet. Ex. A at 91]. He recommended proceeding with surgery. [Pet. Ex. A at 91].

16IWCC0596

On February 10, 2011, Petitioner underwent right knee arthroscopic abrasion chondroplasty of the medial femoral condyle, abrasion chondroplasty of the underside of the patella, and removal of cartilaginous loose bodies. [Pet. Ex. A at 95].

Petitioner returned to Dr. Newcomer for a follow-up visit on February 21, 2011. [Pet. Ex. A at 136]. Petitioner was still experiencing some discomfort. [Pet. Ex. A at 136]. Dr. Newcomer recommended that Petitioner remain off work and begin a course of physical therapy. [Pet. Ex. A at 136]. Petitioner continued with physical therapy until April 27, 2011. [Pet. Ex. A at 130]. On April 27, 2011, Dr. Newcomer released Petitioner to work without restrictions. [Pet. Ex. A at 130].

At trial, the parties stipulated that Petitioner's medical treatment and periods of temporary total disability were reasonable and necessary and the only issues were whether that treatment and lost time arose out of a compensable work-related accident and causation.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner failed to meet her burden of proof. In support of this finding, the Arbitrator relies primarily on the Petitioner's testimony and her description of how she allegedly injured herself on the date in question. Essentially, Petitioner claims she injured her knee when she bent over to pick up trash and felt a pop in her knee when she bent back up. The medical records give a slightly different description of accident wherein the Petitioner pivoted and turned before she felt the pop in her knee. In either scenario, there was no evidence that there was defect in the floor, or that the trash was particularly heavy, or that there was the existence of something that would have increased her risk of injury. This case is analogous to Pryor v. Indus. Com'n, 201 Ill.App.3d 1 (Ill.App.Ct. 1990). In Pryor, the claimant, a molder, worked in a job that required him bending over to pick up six to eight pounds of material. Claimant testified that he began experiencing shooting pains in his back and right leg. He was subsequently diagnosed with a herniated disk. After reviewing the evidence, the Commission found that there was insufficient evidence of a compensable injury because the injury could have occurred from any normal daily activity. The Court noted that needing to bend over at work was not unique to the claimant's job, and therefore did not pose a risk greater than those faced outside of work. The Court stated that, "the act of bending over does not establish, as a matter of law, the existence of a risk greater than those faced outside of work." Id. at 6. Similar to the instant case, the Petitioner's mechanism of injury – which was bending over to pick up trash and bending back up, or in the alternative, pivoting and turning – did not present any risk greater than those faced outside of work. Based on the limited facts presented at hearing, the Arbitrator concludes that the Petitioner failed to prove that she sustained and accident arising out of and in the course of her employment on January 16, 2011.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John McBride,
Petitioner,

vs.

NO: 11 WC 9258

16IWCC0588

City of Chicago,
Respondent.

DECISION AND OPINION ON REMAND

Petitioner appealed the decision of Arbitrator Steffen who found Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on February 3, 2011. The Commission affirmed the Arbitrator's decision and addressed some additional issues related thereto. Petitioner sought judicial review of the Commission's decision in the Circuit Court of Cook County. On August 19, 2015, the Circuit Court issued an order reversing the Commission's decision and remanding the case to the Commission.

The Circuit Court issued an order which stated that,

> "The Decision of the Workers Compensation Commission is reversed and this matter is remanded for further proceedings."

The jurisdiction of circuit court to review a decision of the then Industrial Commission (now the Illinois Workers' Compensation Commission) is wholly statutory, and its power, in the exercise of this special statutory jurisdiction, is limited by the provisions of the statute. *Kudla v. Industrial Commission*, 336 Ill. 279. Section 19(f)(2) of the Illinois Workers' Compensation Act, 820 ILCS 305/19F)(2), states in pertinent part:

16IWCC0588

The court may confirm or set aside the decision of the Commission. If the decision is set aside and the facts found in the proceedings before the Commission are sufficient, the court may enter such a decision as is justified by law, or **may remand the cause to the Commission for further proceedings and may state the questions required for further hearing, and give such other instruction as may be proper.** (emphasis added)

Having reviewed the August 19, 2015 Circuit Court's Remand Order, the Commission is at a loss as to whether the Circuit Court found the Commission's decision is contrary to the law or its factual findings are against the manifest weight of the evidence in the record. Without any further specificity or direction from the Circuit Court the Commission is uncertain as to what the Circuit Court wishes us to do. If further clarification is presented to the Commission by the Circuit Court, the Commission will make any and all changes to its decision at that time. Currently, without any further directive, the Commission has reviewed the entire record and finds that its February 27, 2015 Decision and Opinion on Review should stand.

IT IS THEREFORE ORDERED BY THE COMMISSION that its February 27, 2015 Decision and Opinion on Review is the Commission's decision for Claim No. 11 WC 9258.

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

DATED: SEP 14 2016

MB/jm

O: 2/5/15

43

Mario Basurto

David L. Gore

Stephen Mathis

Order **16IWCC0588** (2/24/05) CCG 0002

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

John McBride

v.

Illinois Workers Compensation Commission and City of Chicago

No. 15L050170

ORDER

This cause comes to be heard on plaintiff's writ and statement of error. Due Notice Having been given and this matter being fully briefed and argued, it is ordered

(1) The decision of the Workers Compensation Commission is reversed and this matter is remanded for further proceedings. 4204

Judge Robert Lopez Cepero

AUG 19 2015

Circuit Court - 1627

Atty. No.: 21608

Name: Brian McManus

Atty. for: Plaintiff

Address: 30 N. LaSalle St

City/State/Zip: Chicago - IL

Telephone: 312-346-8210

ENTERED:

Dated:

Judge

Judge's No.

DOROTHY BROWN, CLERK OF THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Myra Jones,

Petitioner,

vs.

No. 11 WC 17132

16IWCC0615

Southern Illinois University at Edwardsville,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission agrees with the Arbitrator that Petitioner's accident is not compensable. Having so found, the Commission strikes as moot the Arbitrator's findings on the issues of causal connection, medical expenses and permanent disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 17, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

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

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

SEP 27 2016

DATED:
o-09/08/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, MYRA
Employee/Petitioner

Case# **11WC017132**

SOI/SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Employer/Respondent

16IWCC0615

On 2/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4562 SCHOEN WALTON TELKEN & FOSTER
MICAH SUMMERS
241 N MAIN ST
EDWARDSVILLE, IL 62025

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

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

FEB 17 2016

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

16IWCC0615

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MYRA JONES
Employee/Petitioner

Case # 11 WC 17132

v.

Consolidated cases: N/A

STATE OF ILLINOIS; SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MICHAEL NOWAK**, Arbitrator of the Commission, in the city of **COLLINSVILLE**, on **5/19/2015**. 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 _____

FINDINGS

On **MARCH 31, 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 **$20,800.00**; the average weekly wage was **$400.00**.

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

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

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

ORDER

Because Petitioner failed to meet her burden of establishing that she sustained accidental injuries which arose out of and in the course of her employment with Respondent benefits are denied.

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

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

Signature of Arbitrator

1/18/16
Date

ICArbDec p. 2

FEB 17 2016

FINDINGS OF FACT

On March 31, 2011, Petitioner, Myra Jones, was employed by Southern Illinois University Edwardsville (SIUE) Head Start as a community worker, performing social services for three and four year olds and working with families. The Petitioner had worked there since March of 2000 and retired in 2013. This work was primarily performed on Respondent's premises in a cubicle which was approximately 7 feet X 5 feet, contained a work desk, computer desk, two filing cabinets, a chair for clients, and the chair which Petitioner used. The Petitioner's office chair swiveled and had wheels which enabled it to easily move around the office. Petitioner's work desk contained drawers which had metal handles. Petitioner would move about the cubicle by rolling from her work desk to her computer desk or filing cabinets and back. She would move between her work desk and computer desk seven to eight times a day. These movements were necessary to properly perform her work duties.

On March 31, 2011, while performing her normal daily work duties, Petitioner struck her right knee on the metal handle of her work desk while moving from her computer desk to her work desk. Upon striking her right knee she immediately felt pain, had swelling, and spent the remainder of the day with her leg elevated. She described the accident as follows:

> While I was at work I guess it was approximately between 11:00, 11:30 a.m., I was sitting at my computer desk working on a computer and I needed to get something from my desk and I swiveled around in the chair to get what I needed and when I swiveled I hit my right knee and banged it on the handle of the desk drawer of my desk. TX 13-14

Petitioner testified that there wasn't anything out of the ordinary with her chair and there wasn't anything behind her that would restrict her movement. TX 54-55. Additionally, Petitioner testified that there wasn't an emergency or any other condition on March 31, 2011 that would have required her to move quickly in her chair. TX 55.

Petitioner was shown a photograph of a steel desk which had a metal drawer in the middle above the space where the chair sits and two drawers on the right side, each with a metal handle. RX 3 Petitioner testified that the desk in the photo looks like the desk that she was sitting at on the date of the accident. TX 37-38.

The Arbitrator notes that Petitioner had extreme difficulty describing the actual layout of her office space. TX 25-49. After an extended period of discussion, Petitioner agreed that a sketch of her office space, labeled as RX 5, was an accurate depiction of her workspace layout on the date of the accident. TX 65-66. Petitioner's computer desk was to the left of the work desk and the drawers of the work desk were on the right. Petitioner's filing cabinets were to the right of the work desk.

Petitioner first sought medical care on April 7, 2011, when she went to Memorial Hospital in Belleville, Illinois. She underwent a right knee x-ray, which showed mild soft tissue swelling, but no other findings. She was diagnosed with "strain right knee/contusion," prescribed vicodin, and told to contact Dr. Marc DeJung for a follow up appointment in 1-2 days. Petitioner was not taken off work or given any restrictions. PX 2.

Petitioner saw Dr. DeJung at Southern Illinois Sports Medicine on April 11, 2011. On her Health History Form, Petitioner noted, "Banged my knee on my desk @ work/lower drawer handle." PX 3, p.4 Dr.

DeJung noted a consistent history of accident. Following examination Petitioner was diagnosed with right anterior knee pain with prepatellar bursitis. She was given medication and an over-the-counter brace. Dr. DeJung did not take Petitioner off work. PX 3.

On April 12, 2011, Petitioner called Dr. DeJung's office indicating she was still in a lot of pain. She requested an MRI of her right knee which Dr. DeJung ordered.

On April 14, 2011 Petitioner saw her primary care physician, Dr. Garner at Belleville Family Medical Associates. Dr. Garner noted, "Myra is a 53-year old black female patient of mine with history of hypertension here for knee injury at work. She claims it is through workman's comp. Apparently, she spun around quickly, striking her knee on the edge of a metal desk, causing immediate pain." Dr. Garner examined Petitioner and diagnosed Petitioner with "right knee pain." He too recommended an MRI. PX 5.

On April 21, 2011, Petitioner had an MRI of her right knee at MidAmerica Imaging, LLC. The impression was: "Edema inferior aspect of the patella is seen as well as along the infrapatellar tendon. This may represent bone contusion or trabecular microfracture. Partial tear involving the infrapatellar tendon would be consideration as well." PX 4.

On June 3, 2011, Petitioner saw Dr. Thomas Meyer at Center for Orthopedic Surgery & Sports Medicine at the referral of Dr. Garner. Dr. Meyer noted, "She turned and hit the handle of a desk drawer at work with the right knee. She had some immediate swelling and bruising that occurred on this, but she was able to continue working. About one week later, she was having enough problems and pain she was seen in the emergency room at Memorial Hospital." PX 1, exhibit 3. Dr. Meyer found Petitioner walked normally and had no effusion, no localized swelling or bruising, no joint line tenderness, intact collateral and cruciate ligaments, unremarkable McMurray's test, and no real patellofemoral crepitation. Dr. Meyer did note "tenderness over the patellar area to palpation and a litte bit on the patellar ligament where it attaches," as well as "pretty good quadriceps outline." *Id.* Dr. Meyer diagnosed Petitioner with "Inferior patellar contusion on the right knee," gave her Voltaren gel samples and released her to full duty work on 6/6/11. PX 1.

Petitioner cancelled appointments with Dr. Meyer on July 1, 2011, July 19, 2011, and July 26, 2011. She finally returned to Dr. Meyer on August 16, 2011. Dr. Meyer noted Petitioner complained of trouble with bent knee activities, but could stand and walk pretty well. Petitioner complained that "once in a while, after being on her feet for a long time, it will cause her some limp," and that she does well at nighttime, but after a lot of bent knee activities, her knee will seem stiffer to her. Dr. Meyer noted "[o]n exam, most of the tenderness today is right at the inferior patella, at het attachment of the patellar ligament." He noted Petitioner had no effusion in the knee, was walking normally and had minimal patellofemoral crepitation. Dr. Meyer discontinued Petitioner's ibuprofen, prescribed her Mobic, ordered physical therapy and told her to return in four weeks. Finally, Dr. Meyer continued Petitioner's full duty, unrestricted release. PX 1. Petitioner did not undergo any physical therapy, nor did she return to Dr. Meyer or any other physician in regard to her right knee. Petitioner testified she has not seen a physician for her right knee since August 16, 2011.

Petitioner testified that she currently takes Ibuprofen and naproxen for her knee. She currently has a lot of stiffness in her knee, especially with standing, as well as pain when she is bending, kneeling or walking long

distances. She testified that her knee pain was currently an average of 7/10, but that it never becomes less pain than a 4/10.

CONCLUSIONS

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

Although Petitioner appeared a bit confused and had difficulty describing the layout of her cubicle she appeared to testify in a credible and forth right manner. The Arbitrator finds that she did strike her right knee on the desk drawer on the date of accident.

The claimant in a workers' compensation case has the burden of proving, by a preponderance of the evidence, all of the elements of his claim, including proof that he suffered an accident which arose out of and in the course of his employment. 820 ILCS 305/2 (West 2008); *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013, 944 N.E.2d 800, 348 Ill. Dec. 559 (2011). 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, 137 Ill. Dec. 658 (1989).

Injuries sustained at a place where a claimant might reasonably have been while performing his work duties are deemed to have been received in the course of his employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57, 541 N.E.2d 665, 133 Ill. Dec. 454 (1989). In this case, it is undisputed that the Petitioner's injuries were sustained in the course of her employment. The only legitimate issue for analysis in this case is whether the claimant's injuries arose out of her employment.

For an injury to "arise out of" the employment, its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. There are three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment: (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116, 881 N.E.2d 523, 317 Ill. Dec. 355 (2007) (citing *Illinois Institute of Technology Research Institute,* 314 Ill. App. 3d 149, 162, 731 N.E.2d 795, 247 Ill. Dec. 22 (2000)).

Employment risks that are "inherent in one's employment" and "include the obvious kinds of industrial injuries and occupational diseases and are universally compensated." *Illinois Institute of Technology Research Institute,* 314 Ill. App. 3d 149, 162. In this case, Petitioner turned or swiveled in her chair and struck her knee on her desk. There is no evidence that the risk of this type of injury is distinctly associated with Petitioner's employment with Respondent. As such, we are not presented with an employment risk. Likewise, this case does not involve a personal risk. There was no evidence that Petitioner's injury was the result of any personal defect or weakness. Indeed, the evidence presented shows that decedent had not experienced any knee problems prior to the accident at issue. Accordingly, the risk associated with her turning or rolling in her desk chair is neutral in nature. See *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Injuries resulting from a neutral risk, such as the injury here, do not arise out of the employment and are not compensable under the Act unless the employee was exposed to the risk to a greater degree than the general public. *Illinois Institute of Technology Research Institute*, 314 Ill. App. 3d at 163. The increased risk may be either qualitative, that is when some aspect of the employment contributes to the risk; or quantitative, such as when the employee is exposed to the risk more frequently than the general public. *Metropolitan Water Reclamation District of Greater Chicago*, 407 Ill. App. 3d at 1014.

Hitting one's knee on a desk is a risk that any member of the general public faces. There is no evidence that there was any defect in the chair that caused Petitioner to strike her desk with her knee or any substance or condition in the work environment that increased the risk she might do so. As such, the Arbitrator finds that Petitioner's injury was not caused by a risk which was increased in the qualitative sense. Likewise the record indicates Petitioner would move from one desk to the other seven to eight times per day. The Arbitrator finds this frequency of movement is insufficient to create a quantitative increase over and above the risk faced by the general public.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that although Petitioner sustained an injury to her knee when she struck it on her desk and that she was in the course of her employment when she did so, her accidental injury may not be said to have arisen out of her employment with Respondent. Benefits are therefore denied

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

There is no evidence in the record indicating Petitioner had any problems or symptoms with her right knee prior to the accident. The Arbitrator finds Petitioners condition of ill-being is causally related to the accident. However, because the accident did not arise out of her employment with Respondent, benefits are denied.

Issues (J) and (K): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? Is Petitioner entitled to any prospective medical care?

Petitioner submitted medical expenses totaling $2,701.00. PX 6-9. The Arbitrator finds these charges are reasonable and necessary to treat Petitioner's right knee condition. However, because the accident did not arise out of her employment with Respondent, benefits are denied.

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

Petitioner was diagnosed with inferior patellar contusion of the right knee. Petitioner testified she has not seen a physician for her right knee since August 16, 2011. Petitioner testified that she currently takes Ibuprofen and naproxen for her knee. She currently has a lot of stiffness in her knee, especially with standing, as well as pain when she is bending, kneeling or walking long distances. She testified that her knee pain was currently an average of 7/10, but that it never becomes less pain than a 4/10. The Arbitrator notes that Petitioner's subjective complaints appear somewhat disproportionate with the objective medical evidence.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability which resulted in the 2% loss of use of her left leg pursuant to §8(e) 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 Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jean R. Hartman,
Petitioner,

vs.

NO: 11 WC 24359

16IWCC0584

Kanoski & Associates,
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 relationship, temporary total disability, medical expenses, and the number of medical providers under Section 8(a), 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.

In further support of the Arbitrator's reasoning, the Commission notes the Appellate Court's decision in the case of *Vill v. Industrial Commission*, 351 Ill.App.3d 798 (1st Dist. 2004). In *Vill*, a claimant was injured while getting out of her car. The Arbitrator found the accident compensable, but the Commission reversed that finding, noting that there was no evidence that the condition of the lot caused any injury and that the act of getting out of the car was not one that was unusual or would have exposed the petitioner to an uncommon risk. The Appellate Court confirmed the Commission's denial of benefits, noting that "the risk of injury that is inherent in the act of exiting a motor vehicle confronts all members of the general public." *Vill* at 804. The analogy to the case at bar is compelling.

The Arbitrator's findings and conclusions regarding the denial of accident are affirmed. As the Arbitrator noted, issues of causal connection, disability, medical expenses and the number of providers under Section 8(a) are thereby rendered moot.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 20, 2015 is hereby affirmed and adopted.

16IWCC0584

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 12 2016

Joshua D. Luskin

Charles J. DeVriendt

o-08/16/16
jdl/jl
68

Ruth W. White

ISBN 0-8058-

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARTMAN, JEAN R
Employee/Petitioner

Case# **11WC024359**

KANOSKI & ASSOCIATES
Employer/Respondent

16IWCC0584

On 7/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

0333 SHAY & ASSOCIATES
TIMOTHY M SHAY
260 E WOOD ST
DECATUR, IL 62523

2871 LOO PATRICIA M CARAGHER
MARY FLANAGAN-DEAN
1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

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

Jean R. Hartman
Employee/Petitioner

v.

Kanoski & Associates
Employer/Respondent

Case # 11 WC 24359

Consolidated cases: n/a

16IWCC0584

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on May 21, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On February 3, 2011, Respondent was operating under and subject to the provisions of the Act.

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

On this date, Petitioner did 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 $32,884.80; the average weekly wage was $632.40.

On the date of accident, Petitioner was 56 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $0.00. Subsequent to trial, the parties stipulated that TTD benefits were paid in full.

Respondent is entitled to a credit of $49,823.64 under Section 8(j) of the Act.

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

June 14, 2015
Date

JUL 20 2015

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained an accidental injury arising out of and in the course of her employment for Respondent on February 3, 2011. According to the Application, Petitioner slipped on snow and ice in a parking lot and sustained an injury to her low back (Arbitrator's Exhibit 2). Respondent disputed liability primarily on the basis that the accident sustained by Petitioner did not occur under circumstances arising out of and in the course of her employment for Respondent. Further, Respondent also disputed liability on the basis of causal relationship (Arbitrator's Exhibit 1).

Petitioner was employed by Respondent as a "Legal Assistant" and worked at Respondent's satellite office in Decatur. Petitioner testified that, for the most part, she was the only employee of the Respondent who was present at the Decatur office on a regular basis. Attorneys employed by Respondent would come to the Decatur office on an as-needed basis to meet with clients. Petitioner testified that she was responsible for conducting interviews with prospective clients and would input data regarding same into Respondent's computer based data system. Petitioner stated that she would many times take work home with her and use her personal computer to access the Respondent's computer system for which she had a password.

Respondent leased office space at a five story office building called Decatur Professional Building. Respondent's office was on the first floor of the building which had a number of other tenants. Photographs of the building and parking lot adjacent to it were received into evidence at trial (Respondent's Exhibit 3).

Petitioner testified that on February 1, 2011, the Decatur area experienced a very heavy snowstorm which resulted in many streets being closed as well as Respondent's Decatur office. Petitioner tendered into evidence a record of the weather for February 1 and 2, 2011, which stated that the Macon County area had received six to nine inches of snow (Petitioner's Exhibit 18).

On February 2, 2011, Respondent's office remained closed because the parking lot was not accessible. Petitioner testified that, on that day, she had papers from the office and that she worked at her residence.

The following day, February 3, 2011, the parking lot adjacent to the building had been plowed and Respondent's office reopened. Petitioner testified that she arrived at the office shortly before 8:00 AM (her normal work hours were 8:00 AM to 5:00 PM). At trial, Petitioner stated that she parked her vehicle in the closest spot to the building. She then stepped out of her vehicle with her left foot and fell landing on her buttocks. At the time of this accident, Petitioner testified she was wearing boots and was holding a plastic bag that contained her shoes and some papers pertaining to work. Petitioner also had her purse over her right shoulder.

Subsequent to the accident, on February 22, 2011, Petitioner gave a recorded statement to the adjuster handling her case. At trial, Respondent tendered into evidence a copy of the transcript of Petitioner's statement. In that statement, Petitioner was asked whether she had anything in her hands at the time she sustained the fall and her response was "Outside of my purse, I don't think

so. Not that day." (Respondent's Exhibit 2; p 13). At trial, Petitioner testified that sometime after she gave recorded statement, she realized that she also had her shoes and work papers when she sustained the fall. Petitioner stated that she attempted to contact the adjuster and left a voicemail message correcting her statement but never received a return call.

Petitioner testified that the parking lot was to the west and south of the office building. Petitioner agreed that she was not directed by Respondent to park in any specific spot. Petitioner further stated that the parking lot was for the use of employees and clients of the various businesses that had offices in the building.

Petitioner's working hours were 8:00 AM to 5:00 PM and Petitioner was not paid for her travel to/from the office. Further, Petitioner agreed that she was never directed by Respondent to take work home with her.

Deborah Krohe, Respondent's HR manager and Petitioner's supervisor, testified on behalf of the Respondent when this case was tried. Krohe testified that Respondent did not own or manage the building and was not responsible for maintenance of either the building or parking lot. This included removal of ice/snow from the parking lot. Krohe stated that other tenants and their clients use the parking lot and confirmed that Petitioner did not have an assigned parking spot.

Krohe also testified that Petitioner was not required by Respondent to take work home with her. However, Krohe agreed that Petitioner did work at home and that she would take papers pertaining to work with her when she did so. She also confirmed that Petitioner had access to Respondent's computer system by use of a password when Petitioner was working at home.

Respondent tendered into evidence a copy of the lease agreement between Respondent and Cardwell Companies (the owner of the building). The lease did not contain a provision regarding the lessor's responsibility for maintenance of and snow/ice removal from the parking lot. However, the agreement did stated "It is understood and agreed that Lessee shall share in common elevators, halls, restrooms, parking lot and lobby on the premises with other tenants of the building. It is further understood and agreed that employees of Lessee shall park in West parking lot." (Respondent's Exhibit 1). Neither Petitioner nor Krohe testified that employees were to park in the West parking lot.

Petitioner testified that she had low back symptoms that pre-dated the accident of February 3, 2011. In March 2010, Petitioner's family physician, Dr. William Franklin, referred her to Dr. Robert Kraus, a neurosurgeon. At that time, Dr. Kraus ordered an MRI and physical therapy. Dr. Kraus also subsequently recommended Petitioner undergo epidural steroid injections, but Petitioner declined to do so. Petitioner stated that she continued to have low back pain up to the time of the accident.

Subsequent to the accident of February 3, 2011, Petitioner had pain in her spine and hips, but she continued to work. On February 14, 2011, Petitioner was sitting at her desk and when she reached down to a desk drawer to get a file, she experienced severe pain running down her left leg. Petitioner testified that this was the first time she ever experienced pain going down her left leg.

Petitioner initially sought medical treatment from Dr. Franklin who saw her on February 14, 2011. Dr. Franklin sent Petitioner to Decatur Memorial Hospital. An MRI was performed on February 15, 2011, which revealed a disc herniation at L5-S1 on the left side. Dr. Franklin subsequently referred Petitioner to Dr. Kraus (Petitioner's Exhibits 1 and 2).

Dr. Kraus performed a microdiscectomy at L5-S1 on February 27, 2011. Petitioner remained under Dr. Kraus' care following surgery and the radicular symptoms gradually improved; however, Petitioner continued to complain of low back pain. Dr. Kraus ordered physical therapy and later referred Petitioner to Millennium Pain Center (Petitioner's Exhibits 3, 4 and 6).

Petitioner testified that, because of her continuing symptoms of low back pain, Dr. Franklin later referred her to several physicians and medical providers, namely, Dr. Matthew Gornet, Dr. William Olivero and Dr. Suzanne Kistner-Davis, a chiropractor. Petitioner also sought treatment on her own from Dr. Christine Becker, a chiropractor.

At trial, Petitioner testified that she still works for Respondent at the same job she had at the time of the accident. Petitioner stated that she still has constant low back pain, primarily on the left side where the surgery was performed. Petitioner rated her pain as being a constant 4/10 which does, on occasion, progress to a 7 or 8/10, depending upon her level of activity.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of her employment for Respondent on February 3, 2011.

In support of this conclusion the Arbitrator notes the following:

There is no dispute that Petitioner sustained an accidental injury on February 3, 2011, when she fell while exiting her vehicle in a parking lot adjacent to an office building where Respondent rented office space. However, for the reasons stated herein, this accident did not occur under circumstances arising out of and in the course of her employment for Respondent.

The evidence is uncontroverted that Respondent did not own or exercise any control over the parking lot and further, was not responsible in any way for the maintenance, including snow/ice removal, of the parking lot where Petitioner sustained the fall.

The parking lot was available for use by both employees and clients of the various businesses that had offices in the building.

Petitioner and Krohe both testified that Respondent did not assign a specific parking spot to Petitioner. While the lease stated that employees were to park in the West parking lot, there was no evidence at trial that this was ever communicated to Petitioner.

Generally, accidental injuries that occur off the employer's premises while traveling to/from work are not compensable. Joiner v. Industrial Commission, 786 N.E.2d 627 (Ill. App. 3rd Dist. 2003).

There are two exceptions to the preceding rule. First, if the employee sustains injuries in a parking lot provided by and under the control of the employer. Second, if an employee's presence at the place where the accident occurred was required in the performance of his duty and the employee was exposed to a risk greater than that of the general public. Illinois Bell Telephone v. Industrial Commission, 546 N.E.2d 603 (Ill. 1989).

The facts of this case clearly mandated conclusion that the first exception is not applicable. Respondent exercised absolutely no control over the parking lot where the accident occurred.

In regard to the second exception, Petitioner was exposed to the same hazards of an accident occurring as a result of ice/snow accumulation that the general public was exposed to at the time she sustained the accident. See Wal-Mart Stores v. Industrial Commission, 761 N.E.2d 768 (Ill. App. 4th Dist. 2001).

The evidence is not clear whether Petitioner was or was not carrying a bag with shoes and work papers at the time she sustained the accident. The transcript of Petitioner's recorded statement and her testimony at trial were inconsistent. However, it is not necessary for the Arbitrator to resolve this conflict because this would only be significant if the evidence established that Petitioner fell because she was carrying the bag with the work papers. There was no such evidence presented at trial.

Finally, Petitioner was not a traveling employee. Even though Petitioner took work home with her from time to time and had access to Respondent's computer system at her home, Petitioner was not required by Respondent to either work at home or travel. See Venture-Newberg-Perini v. Illinois Workers' Compensation Commission, 1 N.E.3d 535 (Ill. 2013).

In regard to disputed issues (F), (J), (L) and (O) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

☐ 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

GRETCHEN MARTINEZ,

Petitioner,

16IWCC0576

vs.

NO: 11 WC 41823

ALTERNATIVE BEHAVIOR TREATMENT CENTER,

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 medical and temporary 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 only with respect to extent Petitioner was found to be temporarily and totally disabled. The Decision of the Arbitrator found Petitioner was temporarily totally disabled from July 18, 2011, the date of Petitioner's accident, through February 21, 2013, the date of Petitioner's arbitration hearing. The Commission finds Petitioner was not temporarily totally disabled beyond April 25, 2012.

Petitioner was the subject of surveillance conducted by Global Options and was observed on March 31, 2012, April 1, 2012, and April 25, 2012, participating in activities inconsistent with the medical restrictions that caused her to be deemed temporarily totally disabled by her treating physician, Dr. Alyssa Stephenson.

16IWCC0576

Dr. Stephenson testified that she had prescribed a Cam walker for Petitioner and also that the Cam walker was to be worn every day during Petitioner's waking hours. She testified further that, as a result of Petitioner's failure to improve despite the utilization of the Cam walker, Petitioner was "to be completely non-weightbearing when she was ambulating with the Cam walker." Earlier in her testimony, Dr. Stephenson had indicated that Petitioner's not being allowed to work in a Cam walker and at a sedentary position as the reason she had prohibited Petitioner from returning to work.

Dr. Stephenson testified that she was unaware of whether Petitioner was compliant about wearing the prescribed Cam walker when not in her presence. The surveillance conducted by Global Options finds on, at least two occasions, Petitioner was not.

On March 31, 2012, and again on April 1, 2012, Petitioner was observed by Global Options walking without a Cam walker on her injured left foot and doing so at a normal pace, with a normal gait and with no signs of pain or discomfort. On both days it was reported that Petitioner as employing non-weightbearing measures to keep pressure off her left foot.

Global Options' surveillance on April 25, 2012, did not observe Petitioner walking as had been observed on March 31, 2012, and on April 1, 2012. Instead, Petitioner, on that day as well as on March 31, 2012, and on April 1, 2012, was observed driving. This is significant as Dr. Stephenson had testified that one cannot drive while wearing a Cam walker. It is inferred, therefore, that Petitioner was not wearing a Cam walker while she was driving on April 25, 2012. It has already been shown that Petitioner had not been wearing a Cam walker on either March 31, 2012, and on April 1, 2012, while out in public.

Petitioner testified that she had reviewed the surveillance report and had seen the surveillance photographs that were taken on March 31, 2012, and on April 1, 2012. She testified further that person in the photograph was her. Her testimony was silent as to why she was not wearing the Cam walker as prescribed on those occasions and did not indicate that her failure to wear the Cam walker on those occasions were isolated incidents.

Petitioner's ambulation without the Cam walker and without assistive devices outside of the home suggests she may not have required the sedentary position and the prescribed Cam walker that Dr. Stephenson prescribed. Petitioner performed activities of daily living without the prescribed Cam Walker or any other assistive device. In so doing, she violated the order of Dr. Stephenson that she be non-weightbearing. The Commission concluded that Petitioner's presentation to Dr. Stephenson regarding the extent of injury and disability was intended to mislead the doctor for secondary gain.

Petitioner on March 31, 2012, and again on April 1, 2012, unknowingly demonstrated that her ability to ambulate was not limited by the injury to her left lower extremity. Accordingly, the Commission finds Petitioner misrepresented the extent of her condition to Dr. Stephenson for the purpose being kept off work. For this reason, the Commission determines Petitioner was temporarily totally disabled from the date of accident through April 25, 2012, the day Petitioner was last under surveillance by Global Options.

16IWCC0576

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 40-3/7 weeks, commencing July 18, 2011, through April 25, 2012, 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 $29,770.70 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent authorize and pay the necessary and reasonable medical expenses associated with the spinal cord stimulator trial as prescribed by Petitioner's treating physicians.

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 in the amount of $13,717.00 for temporary total disability payments paid to 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 $29,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP - 7 2016
KWL/mav
O: 07/11/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0576

Case# 11WC041823

MARTINEZ, GRETCHEN
Employee/Petitioner

ALTERNATIVE BEHAVIOR TREATMENT CENTERS
Employer/Respondent

On 4/2/2013, an arbitration decision on this case was 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:

4595 WHITESIDE & GOLDBERG LTD
BRENT R EARNES
155 N MICHIGN AVE SUITE 540
CHICAGO, IL 60601

1604 STELLATO & SCHWARTZLTD
BRUCE GRON
120 N LASALLE ST 34TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0576

Case # 11 WC 41823

Gretchen Martinez
Employee/Petitioner

v.

Alternative Behavior Treatment Centers
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Waukegan**, on **February 21, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0576

FINDINGS

On the date of accident, **July 18, 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 **$23,920.00**; the average weekly wage was **$460.00**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$13,717.00** for TTD.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$319.00**/week for **83 4/7** weeks, commencing **July 18, 2011** through **February 21, 2013**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **July 18, 2011** through **February 21, 2013**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$13,717.00** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of **$29,770.70**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize, and pay the reasonable, necessary, and causally related medical expenses associated with, the spinal cord stimulator trial as prescribed by the Petitioner's treating physicians.

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

March 27, 2013
Date

11 WC 41823
ICArbDec19(b)

APR 2 - 2013

FACTS:

The parties stipulated that on July 18, 2011, the Petitioner was working in the course of her employment for the Respondent, when she suffered an accident which arose out of and occurred in the course of her employment. The Petitioner testified that on said date, a troubled youth who was a resident of the Respondent either threw or dropped a 100-pound boulder onto the Petitioner's left lower extremity. The Petitioner testified that immediately after the incident occurred, she experienced intense pain in her left foot and ankle. The Petitioner then saw the Respondent's staff nurse. The Petitioner testified that she was treated by the Respondent's staff nurse and was then taken by ambulance to the emergency room at Advocate Condell Medical Center. The parties stipulated that the Petitioner provided notice of her accident as is required under the Workers' Compensation Act.

At the emergency room, the Petitioner gave a consistent history of injury and complained of pain along the lateral aspect of the ankle, lateral malleolus and lateral aspect of the foot, 5th metatarsal. The Petitioner was diagnosed with contusions of the left foot and left ankle and she was prescribed pain medication and instructed to follow up with her podiatrist in Wisconsin.

The Petitioner followed up with Dr. Alyssa Stephenson on July 20, 2011. Dr. Stephenson testified via evidence deposition on August 28, 2012. Dr. Stephenson testified that prior to the subject injury, she had treated the Petitioner for problems related to her right foot and ankle, as well as her left ankle. Dr. Stephenson opined that based upon the fact that the Petitioner was almost completely healed from her prior left ankle injury at the time of the subject accident, any preexisting left ankle treatment had no impact on the Petitioner's post July 18, 2011 condition of ill-being.

The Petitioner gave Dr. Stephenson a consistent history of accident and Dr. Stephenson's examination was reported to demonstrate tenderness over the 5th metatarsal, peroneal tendons, distal fibula and the sinus tarsi over the lateral ankle ligaments. Bruising and edema to the left lower leg, ankle, midfoot and rear foot were also noted. After examination, Dr. Stephenson instructed the Petitioner to wear a Cam Walker boot and she prescribed an MRI of the left foot and ankle took the Petitioner off of work.

The Petitioner returned to see Dr. Stephenson on July 25, 2011. Dr. Stephenson noted pain, bruising and edema in the left ankle, midfoot, rear foot and forefoot. Dr. Stephenson kept the Petitioner off of work and instructed her to continue the Cam Walker boot. Thereafter, the Petitioner continued to follow up with Dr. Stephenson on a regular basis and continued to complain of pain and swelling in her left foot. Dr. Stephenson continued to prescribe pain medication and to keep the Petitioner off work. The Petitioner underwent iontophoresis on several occasions and began a regimen of formal physical therapy at Aurora Medical Center on October 14, 2011. A CT Scan was performed of the Petitioner's left lower extremity on October 18, 2011 and was reported to be suggestive of contusion of the talus and calcaneus and incomplete fracture with hypertrophy of the 2nd cuniform.

At the Respondent's request, the Petitioner saw Dr. George Holmes on November 16, 2011. After examination of the Petitioner and review of the medical records, including the MRI reports and CT scan report, Dr. Holmes opined that the Petitioner had a possible lisfranc fracture or dislocation and possible cuniform fracture. Dr. Holmes suggested that the Petitioner undergo a bone scan and MRI and he opined that if the bone scan was negative for any increased uptake, it would potentially exclude the possibility of a fracture. Dr. Holmes also opined that the Petitioner should be able to return to her usual and customary work duties.

The Petitioner returned to Dr. Stephenson on November 28, 2011 and complain of continued pain in the second metatarsal area proximally and in the Lisfranc's joint and also over the lateral ankle ligaments and the lateral aspect of the left lower leg. Edema to that area was also noted. The Petitioner continued to follow up with Dr. Stephenson and continued to have complaints of tenderness, severe pain and edema across the left lower extremity. Dr. Stephenson discussed the fact that conservative treatment seemed to be failing and, per Dr. Holmes's request, she ordered an MRI of the Petitioner's left lower extremity, as well as a bone scan.

The Petitioner underwent the bone scan of her left foot and ankle on January 6, 2012 and the scan was reported to be positive for abnormal high signal and also some hyperemia. The Petitioner returned to see Dr. Stephenson on January 17, 2012 and was placed in a short leg synthetic cast. Dr. Stephenson ordered an EMG/NCV for the left lower extremity, as well as an MRI of the left foot. The MRI of the Petitioner's left foot was reported to show an abnormal high signal within the proximal third metatarsal and fracture and the EMG/NCV were not undertaken.

On January 9, 2012, the Petitioner received a certified letter from the Respondent indicating that she was terminated due to her failure to return to work following her work-related injury. The Petitioner testified that based upon this letter, she believes that she has been terminated from the Respondent.

The Petitioner continued to follow up with Dr. Stephenson and on February 9, 2012 Dr. Stephenson administered a corticosteroid injection into the 2nd and 3rd metatarsals. On February 21, 2012, Dr. Stephenson referred the Petitioner for a consultation at Advanced Pain Management.

On March 2, 2012 the Petitioner followed-up with Advanced Pain Management. The Petitioner initially saw Dr. Jay Hurh and she reported to Dr. Hurh that her pain was due to a work injury involving a patient throwing a landscaping boulder onto her left foot and ankle. The Petitioner reported continuous pain, which she rated at 7/10 at its best and 9/10 at its worst. Examination of the Petitioner's left foot was noted to demonstrate swelling, erythema and allodyna. Dr. Hurh diagnosed the Petitioner with chronic left dorsal foot pain with chronic regional pain syndrome (hereinafter "CRPS") due to the reported work-related injury of July 18, 2011. The Petitioner was prescribed a regimen of lumbar sympathetic nerve blocks and a new regimen of pain medication. The Petitioner was instructed to continue to follow-up with

her podiatrist to monitor her work status. The Petitioner underwent her first lumbar sympathetic block at left L-3 on March 9, 2012. The Petitioner testified that this nerve block did not resolve her left lower extremity pain.

The Petitioner followed-up with Dr. Stephenson on March 13, 2012 and Dr. Stephenson noted that she agreed with the diagnosis of CRPS. Dr. Stephenson removed the Petitioner from the Cam Walker boot and advised the Petitioner to continue with her treatment at Advanced Pain Management and to remain off of work.

The Petitioner followed-up with Advanced Pain Management on May 1, 2012 and was treated by Dr. Scott Aschenbrener. Dr. Aschenbrener testified via evidence deposition on July 31, 2012. Dr. Aschenbrener concurred with Dr. Hurh's diagnosis of CRPS and he opined that the Petitioner's work accident was a causative factor in her diagnosis of CRPS. Dr. Aschenbrener performed a second lumbar sympathetic block at the Petitioner's left L-4 and he instructed the Petitioner to maintain her regimen of pain medication, and to continue to follow up with Dr. Stephenson. The Petitioner testified that this nerve block did not resolve her left lower extremity pain.

At the Respondent's request, the Petitioner was again seen by Dr. George Holmes on May 9, 2012. Dr. Holmes noted chronic pain over the dorsal aspect of the Petitioner's left foot. Dr. Holmes opined that the Petitioner did not have chronic regional pain syndrome and that she could return to work as a counselor without any formal restrictions.

The Petitioner followed up with Dr. Stephenson on May 15, 2012 complaining of tenderness in the area of the fracture site at the metatarsal. Dr. Stephenson administered another corticosteroid injection into the Petitioner's left foot and ordered her to remain off of work.

The Petitioner followed-up with Dr. Aschenbrener at Advanced Pain Management for a lumbar sympathetic block at her left L-3 level on May 17, 2012. Dr. Aschenbrener indicated that the Petitioner's next step in treatment would be a spinal cord stimulator trial evaluation to include a psychological evaluation. Dr. Aschenbrener instructed the Petitioner to maintain her regimen of pain medication, and to continue to follow up with Dr. Stephenson.

The Petitioner followed up with Dr. Stephenson again on June 5, 2012 and Dr. Stephenson ordered the Petitioner to remain off of work.

On June 14, 2012, Dr. Holmes issued an addendum report after he reviewed the bone scan report, the MRI report, and two surveillance reports of the Petitioner's activities. In reviewing the diagnostic reports, Dr. Holmes noted the MRI which was suspicious for stress induced fractureand the bone scan which was noted to demonstrate uptake in the Petitioner's left midfoot. Dr. Holmes opined that the Petitioner should be able to return to work without any restrictions; that she did not require any further medical treatment; that her prognosis is fair to good; and that she had reached maximum medical improvement with no evidence of any partial permanent disability.

The Petitioner followed-up with Advanced Pain Management on June 22, 2012. Severe functional impairment was noted and it was recommended that the Petitioner proceed with a spinal cord stimulator trial to include psychological evaluation. Dr. Aschenbrener testified that the psychological evaluation is standard medical care prior to a spinal cord stimulator trial, and it is used to confirm that there are no underlying psychological issues which would warrant a spinal cord stimulator trial to be inappropriate.

The Petitioner followed up with Dr. Stephenson on July 31, 2012, complaining of pain in her left lower extremity. Tenderness with palpation and continued edema were noted and the Petitioner was instructed to remain off of work pending the spinal cord stimulator trial.

On referral from Dr. Aschenbrener, the Petitioner followed up with Dr. Itzhak Matusiak, psychologist, on August 8, 2012 and September 5, 2012 for an initial diagnostic evaluation, and individual psychotherapy. Dr. Matusiak opined that the Petitioner is a good candidate for the implantable therapy trial procedure. Dr. Matusiak further opined that there are no contraindications to proceeding with the implantable trial procedure and there are no known drug issues that may prevent proceeding with the implantable therapy trial procedure.

The Petitioner returned to see Dr. Stephenson on October 16, 2012 and December 2, 2012. Dr. Stephenson administered another corticosteroid injection into the Petitioner's left foot and continued to prescribe the Petitioner off of work pending the approval of the spinal cord stimulator trial.

The Petitioner returned to Advanced Pain Management on December 11, 2012 and was noted to have a Oswestry score of 38/60, indicating severe functional impairment. She was once again recommended to proceed with the spinal cord stimulator trial; to maintain her regimen of pain medication; and to continue to follow up with Dr. Stephenson.

Two reports of surveillance conducted on the Petitioner were admitted into the record. The first report purports to be a summary of visual surveillance of the Petitioner conducted for a total of four days, March 31, 2012, April 1, 2012, April 10, 2012, and April 25, 2012. The second report purports to be a social networking investigation of the Petitioner which contains excerpts from the Petitioner's Facebook page.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The parties stipulated that the Petitioner sustained an accident that arose out of and occurred in the course of her employment with the Respondent on July 18, 2011 when a 100 pound boulder was dropped onto her left foot. The evidence demonstrates that immediately

following that accident the Petitioner was taken by ambulance to the emergency room at Advocate Condell Medical Center where she complained of pain along the lateral aspect of the ankle, lateral malleolus and lateral aspect of the foot and was diagnosed with contusions of the left foot and left ankle. Thereafter the Petitioner began a course of conservative treatment with podiatric physician Dr. Alyssa Stephenson. The Petitioner continued that course of treatment, with no relief of her complaints, until she was referred for pain management treatment. The Petitioner was then diagnosed as having chronic left dorsal foot pain with chronic regional pain syndrome and she was prescribed a spinal cord stimulator trial. The Petitioner has undergone the psychological evaluation which is a pre-requisite for the stimulator trial and it has been reported that the Petitioner is a good candidate for the procedure and there are no contraindications to proceeding with the trial stimulator procedure.

Three of the Petitioner's treating physicians, Dr. Hurh, Dr. Aschenbrener and Dr. Stephenson, all opined that the Petitioner is suffering from chronic regional pain syndrome in her left lower extremity related to the July 18, 2011 accident. Dr. Aschenbrener has prescribed a trial of a spinal cord stimulator for the Petitioner and Dr. Stephenson is in agreement with that course of treatment. Additionally, psychologist Dr. Itzhak Matusiak, opined that based upon psychological examination of the Petitioner that she is a good candidate for the implantable therapy trial procedure and that there are no contraindications to proceeding with the implantable trial procedure.

Although Dr. Stephenson had treated the Petitioner for a prior left ankle injury, she testified that any preexisting left ankle treatment had no impact on the Petitioner's post July 18, 2011 condition of ill-being. Dr. Stephenson's reasoning for this opinion was based upon the fact that the Petitioner was almost completely healed from her prior left ankle injury at the time of the subject accident. Dr. Stephenson testified that based upon the failure of every other viable treatment option to address the Petitioner's CRPS, a spinal cord stimulator would be the next step in the Petitioner's treatment. Dr. Asschenbrener also testified that he diagnosed the Petitioner with CRPS and that a spinal cord stimulator would be the next step in the Petitioner's treatment because it is the "common standard" that pain specialists use to treat CRPS of the lower extremity.

Dr. George Holmes, the Respondent's examining physician, opined that the Petitioner does not have chronic regional pain syndrome and that she requires no further treatment. The Arbitrator notes that after the Petitioner's first examination with Dr. Holmes, he diagnosed her with a possible lisfranc fracture or dislocation and possible cuniform fracture and suggested that the Petitioner undergo a bone scan and MRI for further testing. Dr. Holmes opined that if the bone scan was negative for any increased uptake, it would potentially exclude the possibility of a fracture. After the second examination, Dr. Holmes opined that the Petitioner could return to work as a counselor without any restrictions without having reviewed the diagnostic tests which he himself had recommended. Further, when Dr. Holmes issued an addendum to his second report after reviewing the reports of said diagnostic tests, he noted that the bone scan was indeed positive for uptake in the Petitioner's left midfoot, which he originally indicated would be relevant at the Petitioner's initial examination. However, in his June 14, 2012 addendum report, Dr. Holmes summarily dismissed both the bone scan

report and the MRI report without explanation. Dr. Holmes opined that the Petitioner should be able to return to work without any restrictions; that she does not require any further medical treatment; that her prognosis is fair to good; and that she has reached maximum medical improvement with no evidence of any partial permanent disability.

While the Arbitrator notes the qualifications of Dr. Holmes, the Arbitrator finds that, in the instant matter, the opinions of Dr. Aschenbrener and Dr. Stephenson, the Petitioner's treating physicians, are more credible, reliable and persuasive than the opinions of Dr. Holmes. The Arbitrator finds, therefore, that the Petitioner's present condition of ill-being is causally related to the work injury of July 18, 2011.

With regard to the surveillance reports regarding the Petitioner's activities on March 31, 2012, April 1, 2012, April 10, 2012, and April 25, 2012, and her Facebook page, the Arbitrator finds them to be unpersuasive and lacking in probative value.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the July 18, 2011 accident.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Petitioner's Exhibit 1 is a summary of all of the medical expenses from the treatment the Petitioner has received from the date of accident until the date of hearing. At the time of arbitration, the Petitioner submitted medical expenses in the amount of $29,770.70. Based upon the Arbitrator's finding that Petitioner's current condition of ill-being is causally related to the July 18, 2011 accident, the Petitioner has established that she is entitled to satisfaction of her past medical expenses. The Arbitrator hereby awards Petitioner past medical expenses in the amount of $29,770.70 as outlined in Petitioner's Exhibit 1.

Regarding prospective medical care, the medical records of Dr. Stephenson, Advanced Pain Management, and Dr. Matusiak, as well as the testimony of Dr. Stephenson and Dr. Aschenbrener all indicate that the Petitioner is suffering from chronic regional pain syndrome and a spinal cord stimulator trial is the next medically necessary step to address the Petitioner's diagnosis. The Petitioner testified that she wants to proceed with the spinal cord stimulator trial. Thus, based upon the Arbitrator's finding that Petitioner's current condition of ill-being is causally related to the July 18, 2011 accident, Petitioner is awarded the spinal cord stimulator trial prescribed for her by Dr. Aschenbrener and Dr. Stephenson.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that she has been off-work since the date of the accident on July 18, 2011. The Petitioner's employment with the Respondent was terminated on January 9, 2012. The medical evidence demonstrates that the Petitioner has been restricted from working for the Respondent since the date of accident and has been held completely off work by Dr. Stephenson since September 15, 2011.

Based upon the Arbitrator's finding that the Petitioner's current condition of ill-being is causally related to the July 18, 2011 accident and the medical records of Advanced Pain Management and Dr. Stephenson, as well as the testimony of Dr. Stephenson, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits from July 18, 2011 through February 21, 2013 for a period of 83 4/7 weeks. At the Petitioner's temporary total disability rate of $319.00, the Petitioner is entitled to temporary total disability benefits in the amount of $26,659.29. The Respondent is entitled to a credit for temporary total disability benefits previously paid in the amount of $13,717.00.

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

Jacqueline McGuire,
Petitioner,

vs.

NO: 11 WC 46800

16IWCC0589

State of Illinois: Department of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the decision of Arbitrator Lindsay finding that Petitioner sustained an accidental injury arising out of and in the course of her employment on November 2, 2011. As a result Petitioner was temporarily totally disabled from November 2, 2011 through October 27, 2015 for 259-2/7 weeks under Section 19(b) of the Illinois Workers' Compensation Act and is entitled to $362,779.93 in medical expenses under Section 8(a) of the Act. Respondent is entitled to a credit of $71,187.60 for payment of temporary total disability benefits. The issues before the Commission are whether a causal relationship exists between the November 2, 2011 work accident and Petitioner's present condition of ill-being, and if so, the extent of Petitioner's temporary total disability. The Commission, after reviewing the entire file and the record, expands on but otherwise affirms the Arbitrator's decision. The Commission further finds that this case should be remanded to the Arbitrator for further proceedings pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

16IWCC0589

1. Petitioner, a 50 year old right-handed personal assistant, sustained an accident on November 2, 2011 when she was loading a patient's wheelchair into a van. The wind caught the wheelchair and caused Petitioner to fall and do the splits injuring her left hip and right shoulder.

2. On November 6, 2011, Petitioner was seen at Anderson Hospital. Petitioner reported experiencing pain in the left groin. She reported that she had no prior history of hip problems. Petitioner was diagnosed as having a groin pull. She was instructed to follow up with her doctor if her symptoms did not improve over the next couple of weeks. Petitioner's left hip x-ray showed mild osteoarthritis with no acute fractures or dislocations.

3. Petitioner was seen by Dr. Bicalho who diagnosed Petitioner as having a left basicervical femoral neck fracture. On November 15, 2011, Petitioner underwent surgery on the left hip, which consisted of inserting an IM rod into the left hip. The post-operative surgical diagnosis was a left basifemoral femur fracture. After diagnoses of a nonunion and failed hardware were made Petitioner underwent a second surgery on June 28, 2012, which consisted of a total left hip arthroplasty.

4. On January 7, 2013, Petitioner followed up with Dr. Bicalho who noted that Petitioner has a right rotator cuff tear. In terms of the left hip, Dr. Bicalho noted Petitioner is doing well with minimal left hip pain. Dr. Bicalho informed her that she was susceptible to increase wear of her left hip. He further indicated that a possible procedure consisting of a dislocation revision of acetabular component could be warranted. He indicated that Petitioner wished to wait for now and not undergo the procedure since she is doing well at the moment and has minimal problems with the left hip.

5. On March 29, 2013, Petitioner underwent a right shoulder MRI that showed a large full-thickness rotator cuff tear of supraspinatus and infraspinatus with severe fatty atrophy of the muscle bellies, severe subscapularis tendinopathy with moderate fatty atrophy of the muscle belly, severe acromioclavicular joint osteoarthritis and well preserved glenohumeral joint cartilage.

6. On May 12, 2013, Petitioner was seen at Anderson Hospital for her right hip. This condition was unrelated to the workers' compensation claim. Petitioner was diagnosed as having a right hip femoral neck fracture. It was noted at that time that Petitioner was also experiencing left hip pain with passive motion.

7. On May 29, 2013, Petitioner underwent right shoulder surgery consisting of a repair of right rotator cuff with distal clavicle excision. From August 19, 2013 to August 23, 2013 Petitioner underwent post-surgical physical therapy for the right shoulder.

8. On September 13, 2013, Petitioner underwent surgery consisting of a total hip arthroplasty for the non-work related right hip condition. Petitioner's right hip post-operative diagnosis was a right basifemoral neck fracture. During Petitioner's three and a half month post-surgical right hip physical therapy, Petitioner occasionally indicated that she experienced aching in her right shoulder and left hip.

9. On December 20, 2013, Dr. Bicalho indicated that Petitioner has some moderate discomfort with her range of motion. At this time he would recommend non-operative treatment and rehabilitation. However, if the pain gets worse or her range of motion is compromised, she may benefit from reverse shoulder arthroplasty. He indicated he would continue to follow her for her right shoulder condition.

10. Respondent claims that on December 20, 2013 Petitioner reached maximum medical improvement for the conditions related to her November 2, 2011 work accident. Specifically, Respondent claims that after seeing Dr. Bicahlo on December 20, 2013, Petitioner did not see him again until April 27, 2015.

11. On December 31, 2013, Petitioner was erroneously evaluated at Respondent's requests by Dr. Petkovich for her non-work related right hip condition.

12. On January 13, 2014, Petitioner followed up with Dr. Bicalho. At that time she expressed severe left hip pain. She reported that the pain was worsening and was constant. On physical examination, Dr. Bicalho elicited pain both in the left anterior and posterior parts of the hip along with radiating pain down the left thigh. Petitioner reported that the aching, discomforting and throbbing symptoms were aggravated by active movement, ascending/descending stairs, lying down and standing. She reported she was experiencing limping, locking, stiffness, tenderness and weakness. He noted that Petitioner walks well but complains of pain with ambulation. They discussed treatment options including a revision surgery of the acetabular component or implantation of a retaining cup. He noted that Petitioner will decide what she wants to do next and she will contact the office with her decision. She was instructed to follow up with the office in three months.

13. Petitioner again saw Dr. Bicalho on April 24, 2014. At that time she reported that while she can bear weight as tolerated on her right hip, her left hip is still painful. She complained of weakness in her left hip. Her left hip x-rays today showed no further evidence of cup migration. Her let hip hardware was intact and the stem appeared to be seated as well. He recommended that she consider a revision of her acetabular component, which may be loose despite the lack of further migration. He also indicated that there may be a fibrous ingrowth at the cup that would be causing her continuous pain. He explained to her that he was not currently able to perform the revised left hip surgery due to the fact that she is still receiving rehabilitation in regard to her right hip. Lastly, he indicated that Petitioner will be seeing her

workers' compensation doctor and she will then follow up with him to discuss her surgical options.

14. On April 28, 2014, Petitioner was evaluated by Dr. Petkovich for her left hip and right shoulder conditions. He opined that Petitioner left hip condition resulted from the November 2, 2011 work accident and Petitioner's right shoulder was aggravated by the November 2, 2011 work accident. He further opined that Petitioner had reached maximum medical improvement regarding her right shoulder but she had not reached maximum medical improvement regarding her left hip. He recommended that Petitioner undergo further surgery on the left hip in the form of a revision of the acetabular component of the left hip. He based his recommendation on the fact that the acetabular cup had shifted/slipped from her left hip. He opined that after Petitioner underwent the recommended surgery she should be able to reach maximum medical improvement for her left hip condition.

15. On July 24, 2014, Petitioner followed up with Dr. Bicalho. At that time she reported her left hip was doing much better and she only experienced some occasional discomfort in her left hip. She reported that she believes her pain is better since she has been exercising more and strengthening her hip. On examination, Dr. Bicalho noted that Petitioner's pain seems to be resulting from bursitis in the left hip region. He said he observed Petitioner walking today and found she did very well with a minimal Trendelenberg gait. He opined that at this point since she is doing well, it would be reasonable to observe her condition and to further be on the lookout for any additional migration. Dr. Bicalho indicated that he believed that the acetabular component migration has halted and possibly had ingrown. He noted that after discussing the risks of the revision surgery and the possibility of her having a more painful and unstable hip after the surgery, Petitioner indicated she would not like to undergo the recommended surgery at this time. In terms of her right shoulder, Petitioner reported that she is doing well. However, she has experienced an increased pain over the last few weeks. On examination, her symptoms presented themselves as either being consistent with bursitis or tendinitis. Dr. Bicalho recommended that Petitioner receive a cortisone injection in her right shoulder along with physical therapy and that she follow up with his office in three weeks.

16. On August 13, 2014, Respondent's workers' compensation carrier issued a letter concluding there was no employee/employer relationship established between Petitioner and Respondent. Accordingly, they were terminating Petitioner temporary total disability benefits effective August 16, 2014 and they were denying Petitioner's medical claims.

17. From September 11, 2014 through November 3, 2014 Petitioner underwent physical therapy for her right shoulder.

18. On December 19, 2014, Dr. Bicalho noted that Petitioner probably has a recurrent right rotator cuff tear along with arthritis, weakness and discomfort. He recommended that

Petitioner undergo a right shoulder MRI and depending on the outcome she may be a candidate for a possible shoulder replacement.

19. On April 27, 2015, Dr. Bicalho noted that Petitioner is doing well with her left hip. She is only experiencing occasional night pain. She feels no instability. Her left hip x-ray shows her acetabula component is no longer migrating and there is no additional eccentric wear. He opined that at this point that no revision surgery is necessary. However, she may have some eccentric wear in the future and she may need a revision surgery at some point in time. They discussed hip precautions and he instructed her to follow up in six months for repeat x-rays of her left hip.

20. In May of 2015, Petitioner underwent additional physical therapy for her left hip. During some of the sessions Petitioner reported experiencing continued left hip pain along with intermittent locking of her left hip which has caused episodes of falling. It was noted that due to the continued constant left hip pain she was going to follow up with her orthopedist.

21. On September 21, 2015, Petitioner again saw Dr. Bicalho for her left hip. He noted at that time that she is still experiencing pain on her left side, which has intermittently worsened. Currently, Petitioner states the symptoms are severe and they are aggravated by walking and standing but relieved by resting. Dr. Bicalho injected Petitioner's left hip trochanter. He noted that after the injection, Petitioner had no pain or limp and he demonstrated normal ambulation. He instructed her to follow up in six months.

22. At the October 27, 2015 Arbitration hearing, Petitioner testified she is still under Dr. Bicalho's treatment. She last saw him on September 21, 2015 when he gave her a shot in the left hip. Petitioner testified that she does not believe she can perform her job because she cannot lift or bend over. She also occasionally falls for no reason when her hip locks up on her. Currently, her left hip throbs and sometimes when she is standing or sitting too long it goes numb. When she bends over in certain positions, it freezes up. Sometimes she falls when she is walking or bending over low to the ground. She experiences constant pain in her left hip along with numbness and tingling. Approximately 4-5 days a week, she walks with a limp. Her right shoulder hurts mid-air when she tries to hang clothes or get them out of her closet. When she is folding clothes, her shoulder freezes up. She cannot lift groceries, get stuff off of shelves or fix her granddaughter's hair. She has a big indent in her shoulder. While she is right-handed, her left arm is stronger than her right arm. She is up half the night and does not sleep well because of her right shoulder. She has not seen Dr. Bicalho regularly in the last eighteen months because she did not have the money and she is raising her grandchildren. She intends to continue to see Dr. Bicalho. While she only saw Dr. Bicalho two times in 2015, she was advised by Respondent that they would no longer pay for her medical expenses. Petitioner testified that Respondent's indication that it would no longer pay her medical expenses played into whether or not she saw Dr. Bicalho. She also stated she has not looked for any jobs since the 2011 injury and she has not attempted to return to work

for Respondent. Nor has Respondent offered her any work since the November 2, 2011 work accident. Dr. Bicalho only said to come back in six months if she needs addition care. She has not been told to go back to work by any doctor since the November 2, 2011 accident. Dr. Bicalho has kept her on work restrictions.

Based on the above, the Commission affirms the Arbitrator's decision. Specifically the Commission finds that the evidence demonstrates a chain of events of a November 2, 2011 work related accident that resulted in injuries to Petitioner's left hip and right shoulder. Contrary to Respondent's representation, Petitioner continued to treat with Dr. Bicahlo on four separate occasions for both his left hip and right shoulder after December 20, 2013 and prior to April 27, 2015. While Petitioner only saw Dr. Bicalho on two occasions in 2015, Petitioner explained that she was told by Respondent that they would no longer pay for her medical care and she testified that she was not able to afford it herself. As a result of the November 2, 2011 work accident, the evidence demonstrates Petitioner received treatment for her right shoulder through December 19, 2014 and her left hip through the October 27, 2015 Arbitration Hearing. The Commission further notes that on April 28, 2014 Dr. Petkovich evaluated both Petitioner's right shoulder and left hip and he found that both conditions were causally related to the November 2, 2011 work accident. Additionally, he noted that in terms of Petitioner's left hip condition he was recommending that she undergo a further left hip procedure. The evidence further shows that Petitioner's last treatment with Dr. Bicalho took place only a month before the October 27, 2015 Arbitration Hearing and at that time he was still recommending that Petitioner follow up with his office in six months. Accordingly, the Commission finds that Petitioner's current condition of ill-being is causally related to the November 2, 2011 work accident and the Commission affirms the Arbitrator's findings.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $391.56 per week for a period of 259-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, 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 $362,779.93 for medical expenses under §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit in the amount of $71,187.60 for temporary total disability benefits paid to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that this case is remanded to the Arbitrator for further proceedings consistent with this Decision.

DATED: SEP 14 2016

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm

O: 8/4/16

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STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Division,

Petitioner,

vs.

No. 12 INC 00263

Galina Portnoff, Individually & as President
of DIMA Industries, Inc.,

Respondent.

ORDER

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action by and through the Office of the Illinois Attorney General, against the above captioned Respondent, alleging violations of §4(a) of the Illinois Workers' Compensation Act ("Act"). Proper and timely notice was provided to the Respondent via personal service on November 20, 2015, and a hearing was held ex-parte before Commissioner Thomas J. Tyrrell in Chicago, Illinois on February 18, 2016. The Respondent did not appear. Petitioner alleged that Respondent knowingly and willfully lacked workers' compensation insurance coverage during the period of July 20, 2005 to August 20, 2014.

After considering the entire record, the Commission finds that Respondent, Galina Portnoff, Individually and as President of DIMA Industries, Inc., should be held liable as Respondent failed to comply with §4(a) of the Illinois Workers' Compensation Act in that Respondent did not have workers' compensation insurance for the period of November 5, 2005 to December 31, 2008, and January 2, 2010 to April 13, 2012.

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

The Commission finds:

Julio Cesar Reyes filed a claim, case 11 WC 20884, with the Illinois Workers' Compensation Commission ("IWCC") and named DIMA Industries, Inc. as the Respondent, along with the Injured Workers' Benefit Fund ("IWBF"). On May 12, 2015, a decision was entered against DIMA Industries and the IWBF. The IWBF paid an indeterminate amount to the Petitioner, who was awarded medical expenses, temporary total disability, and permanent partial disability.

At the February 18, 2016 hearing on this matter, Don Johnson testified that he is the lead investigator for the Insurance Compliance Unit of the Illinois Workers' Compensation Commission. Investigator Johnson learned of Respondent through the Injured Workers' Benefit Fund case, 11 WC 20884. Petitioner's exhibit 11 is a printout from the IWCC mainframe that shows that Julio Cesar Reyes is the Petitioner in case number 11 WC 20884, and the Respondent is listed as DIMA Industries, Inc.

A notice of non-compliance was sent to the Respondent on August 20, 2014, listing a commencement date of non-compliance of July 20, 2005. Investigator Johnson testified that he could find no proof of insurance coverage by Respondent from July 20, 2005 to August 20, 2014. Investigator Johnson chose the July 20, 2005 date because that is the date the Act changed and the IWBF began. An informal conference with Respondent was subsequently held, but the conference was not successful in terms of negotiating a resolution. Investigator Johnson sent Respondent the Notice of Noncompliance, dated August 20, 2014, which is Petitioner's exhibit 5.

Investigator Johnson verified with the Office of Self-Insurance that Respondent was not self-insured with the State of Illinois. Petitioner's exhibit 4 is a certificate from the Office of Self-Insurance that indicates that Respondent was in fact not self-insured with the State of Illinois.

Investigator Johnson also contacted the National Council on Compensation Insurance ("NCCI") to verify whether or not Respondent had workers' compensation insurance. Petitioner's exhibit 3 is a letter of certification from the NCCI that indicates that Respondent failed to have workers' compensation insurance from November 5, 2005 to December 31, 2008, and January 2, 2010 to April 13, 2012.

Investigator Johnson further confirmed with the Illinois Secretary of State that Respondent DIMA Industries, Inc. was incorporated by Respondent Galina Portnoff, who was also listed as the president of said business. (Petitioner's exhibit 9). Investigator Johnson also obtained income tax returns from the Illinois Department of Revenue with regard to Respondent DIMA Industries, Inc., which showed that Galina Portnoff signed said tax returns as the President of said business. (Petitioner's exhibit 10).

Petitioner's exhibit 8 contains documents obtained from the Illinois Department of Employment Security concerning DIMA Industries that show that Respondent self-reported having various employees through the years at issue. Petitioner's exhibit 11 is a print-out from the IWCC mainframe that indicates that Respondent's employee and injured worker, Julio Cesar Reyes, was to receive an award of $52,095.29 in medical expenses, $3,240.00 in temporary total disability benefits, and $25,821.18 in permanent partial disability benefits.

Neither party in this matter filed a Statement of Exceptions, nor was any evidence offered/ admitted to indicate what the injured worker and Respondent's employee, Julio Cesar Reyes, actually received from the IWBF. Although the Petitioner in this matter did not request that Respondent be fined a specific amount, the Commission finds that the Petitioner has proven that Respondent is liable for failing to obtain workers' compensation insurance for the time period of November 5, 2005 to December 31, 2008, and January 2, 2010 to April 13, 2012. Therefore, the Commission orders Respondent Galina Portnoff, Individually and as President of DIMA Industries, Inc., to reimburse the IWBF for all amounts paid to the injured worker and Respondent's employee, Julio Cesar Reyes.

For violation of §4(a) of the Act, the Commission orders a fine under §4(d) of the Act for non-compliance: $500.00 per day, multiplied by 1,986 total days of non-compliance, which is a sum of $993,000.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent Galina Portnoff, Individually and as President of DIMA Industries, Inc., pay to Petitioner IWCC the full amount of funds paid by the IWBF to Respondent's former employee, Julio Cesar Reyes.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Galina Portnoff, Individually and as President of DIMA Industries, Inc., pay to the Petitioner IWCC the sum of $993,000.00 for violation of §4(a) of the Act as provided under §4(d) of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00.

DATED: SEP 2 3 2016

TJT: gaf
R: 2/18/16
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Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS

) SS.

COUNTY OF WILL

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Panozzo,
Petitioner,

vs.

No: 12 WC 08027

16IWCC0585

BASF Corporation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) has been filed by Respondent, following the Decision of Arbitrator O'Malley filed on July 16, 2015. The Arbitrator determined, *inter alia*, that Petitioner's lower back and right shoulder conditions were related to the claimed accident of October 18, 2011. He awarded temporary total disability benefits for the period of February 22, 2012 through August 5, 2013 (totaling 75 and 6/7 weeks), and temporary partial disability benefits for the period of August 6, 2013 through January 26, 2014 (totaling 24 and 6/7 weeks), and also awarded medical expenses and prospective lumbar fusion surgery as recommended by Dr. Juan Jimenez. Notice of the Petition has been given to all parties.

The Commission, after considering the issues of accident, causal connection, temporary total disability, temporary partial disability, medical expenses, and prospective treatment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission hereby 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).

16IWCC0585

Summary

Petitioner, 43 years old, was employed as a panel board operator at a chemicals manufacturing company. He testified that, while walking through Respondent's facility on October 18, 2011, he stepped on a trench plate that collapsed. His foot dropped into the trench and he twisted his back while also catching himself with his right arm on a tank adjacent to the trench. He was initially diagnosed with lumbar strain and continued working while undergoing physical therapy and taking non-opioid medication. In January 2012, he started taking narcotic pain medication, specifically, Norco, and a muscle relaxant. His pain persisted and by February 22, 2012, he went off-work. It appeared that his ability to perform his job duties was also being compromised at that time by his Norco use.

During the one-and-a-half years that he was completely off-work, he continued treatment for his low back and also his right shoulder (which started hurting about six weeks after the accident). He underwent courses of physical therapy, which proved ineffective. He continued to take Norco throughout this time as well as muscle relaxants (Zanaflex then Soma).

Petitioner returned to work on August 6, 2013 on a part-time, reduced-hours basis. On January 26, 2014, he was placed on full duty, performing work as a bench chemist / laboratory technician. This position allowed Petitioner to alternate between sitting and standing throughout the day. (The panel board operator position was performed mostly while seated.) As to the Norco use, it is apparent that he developed dependency early on. Medical records show that efforts were made to wean him off this drug in mid-2013, but as of the date of hearing (May 12, 2015), Petitioner was still taking it, as well as Soma, among other medications.

The Commission finds that Petitioner reached maximum medical improvement (MMI) as to his lumbar spine by April 30, 2012, pursuant to the opinion rendered by the first independent medical examiner (IME) who examined Petitioner at the request of Respondent, Dr. Gregory Primus. It is noted that Dr. Primus' opinions were supported by Respondent's second IME, Dr. Alexander Ghanayem. In addition, the Commission reverses the Arbitrator's finding that the shoulder injury was related to the accident. The awards of temporary total disability and medical expenses are modified accordingly. The awards of temporary partial disability and prospective surgery are denied.

I. FACTUAL BACKGROUND

A. Petitioner's accident of Oct. 18, 2011

Petitioner, as noted above, was a panel board operator in the control room at Respondent, a chemicals manufacturing company. On the date of accident, he was walking through the facility when he stepped onto a metal plate that covered a trench on the floor. The plate was not sufficiently supported and it gave way. He lost his balance and his leg dropped down into the trench. He testified that he fell to the side and caught himself with his right arm against a tank and used his left hand on the floor to brace himself. He did not actually fall down to the ground.

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(Tr. 14-15). An Accident/Incident Report was completed on November 3, 2011.[1] (PX 1). As he testified, he felt pain in his low back, which he self-treated for a couple of weeks.

B. Petitioner sees company doctor for low back pain through end of 2011

On November 4, 2011, Petitioner went to see the company doctor, Dr. J. Michael Panuska. Dr. Panuska's record of that encounter states:

> "[Petitioner] says he injured his back about 2 weeks ago, which is radiating into his left leg, into his thigh and his calves. He tried using heat, which was of questionable help... He did have back pain 18 years ago. He says he is sleeping okay now and there is no real paresthesias, but there is pain radiating down leg.... He states he kind of slipped and twisted, he did not really fall when this happened."

(PX 3). Lumbar X-rays were viewed by Dr. Panuska as within normal limits. The doctor's impression was lumbar strain. He recommended that Petitioner treat his back pain with heat patches, ibuprofen and other pain relievers and returned Petitioner to regular work. (PX 3).

At a re-evaluation on November 10, 2011, Dr. Panuska noted that Petitioner "says [he is] doing a little better. He is having less problems. This time, sitting knee extension was normal. He was tender to the left lumbar area." Unfortunately, it appears that that Petitioner's condition then stopped improving. On November 22, 2011, "[Petitioner] says [his back] is not really any better. He is about the same... He has no paresthesias, but he is sore to his thighs, both front and back." Dr. Panuska sent Petitioner to physical therapy, which started on November 28, 2011. It was at ATI Physical Therapy, while performing an exercise with his arm involving elastic bands, that Petitioner felt right shoulder pain. (Tr. 37-38, 46). He testified, "The time I really noticed the pain in my shoulder was when I was going to therapy when I was doing that rubber band. That's when I noticed a really sharp pain.... That's when I let the therapist know that something was not right in there." (Tr. 46). As to whether there was any shoulder problem before that time, Petitioner stated, "Probably not, everything was to do with my lower back." (Tr. 46).

A lumbar MRI of December 13, 2011 yielded findings of "disc bulge at L5-S1 that approaches the descending left S1 nerve root" and "disc bulge at L4-5 with questionable tiny left foraminal disc protrusion [with some] bilateral neural foraminal narrowing." Subsequent to the MRI, Dr. Panuska referred him to a consultation with orthopedist Dr. Ashraf Darwish. Dr. Darwish would turn out to be the first of multiple physicians from whom Petitioner would eventually seek care and treatment related to his back and shoulder. Petitioner would see, in

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[1] The Accident / Incident Report states: "Control room operator was helping the field operator troubleshoot a problem in A41 and was walking the line down that runs through the trench in A41 when he stepped on a 2' x 1.5' of steel plating that is used to cover the trench. This particular piece of steel plate was loose and not situated over the opening and when the control room operator stepped on this piece, it gave way and the operator's foot went down causing the operator to lose his balance. The operator caught himself with his arm against the tank adjacent to the trench without falling. The operator told the Care Team Leader about the incident that night and stated to the Team Leader that he felt like he would be okay. The control room operator had some minor pain in his lower back for the next two weeks without it getting better and now has pain in his lower back and down his left leg." (PX 1).

16IWCC0585

addition to Dr. Darwish, neurosurgeon Dr. Juan Jimenez, pain specialist Dr. Jalaja Piska, and internist Dr. Suresh Didwania. As of the date of hearing, Dr. Didwania was serving as Petitioner's primary care physician, and was the prescriber of Petitioner's narcotic and muscle relaxant medications. The treatment connected with these physicians will be referenced below.

C. Petitioner comes under the care of multiple specialists, including Dr. Juan Jimenez and Advanced Pain Specialists

On December 16, 2011, Petitioner saw spine surgeon Dr. Darwish of Oak Orthopedics for his persistent low back pain. On this date, for the first time, complaints of right shoulder pain are mentioned in the medical records. Dr. Darwish wrote, "Since [the injury at work], he has been complaining of severe low back pain that radiates to bilateral buttocks and posterior thigh. He also complains of right shoulder pain as well. He does not have any history of back pain or shoulder pain prior to the injury at work." (PX 5). Dr. Darwish ordered a right shoulder MRI and also referred him to pain specialist Dr. Piska for a possible lumbar epidural steroid injection.

As well, on January 11, 2012, Petitioner presented to neurosurgeon Dr. Juan Jimenez for evaluation of "back pain and lower extremity radiculitis, left greater than right after an occupational injury." The doctor's record stated:

> "[T]here is evidence of loss of disc height at the L5-S1 level as well as a disc herniation with impingement … I suspect that the L5-S1 segment is the primary pain generator. The patient reports persistent pain despite a course of physical therapy. At this point based on the patient's persistent symptoms my recommendation is for evaluation by the pain service for a selective left L5-S1 nerve root injection. If symptoms persist I recommend reevaluation to explore treatment options."

(PX 5). Dr. Jimenez too made a referral to Dr. Piska.

Petitioner did receive lumbar epidural injections, on February 1 and March 7, 2012, from Dr. Piska. However, they provided no relief. On May 23, 2012, Dr. Jimenez noted Petitioner's continued back pain with lower extremity radicultis, and indicated that a micro-discectomy would not fully relieve Petitioner's symptoms. Dr. Jimenez opined that therefore Petitioner was a candidate for a decompression and fusion. (PX 5). Petitioner declined fusion surgery at that time. Dr. Jimenez recommended surgery again on October 13, 2014, when he saw Petitioner for the last time. (PX 5). At hearing, Petitioner testified that he now wishes to undergo the surgery because his symptoms have gotten worse and he "just can't live like this." (Tr. 28-29).

D. Narcotic overuse / dependence becomes apparent; Petitioner goes off-work on Feb. 22, 2012

Regarding Dr. Piska, Petitioner first saw her at Advanced Pain Specialists on January 20, 2012. He reported low back pain and also right shoulder pain characterized as 10/10. Dr. Piska noted that MRIs done on the lumbar spine and shoulder were positive for lumbar disc bulge and sprain/strain. As mentioned above, she administered a lumbar injection on February 1, 2012 at L5 –S1; the post-operative diagnoses were lumbago, lumbar radiculopathy, and disk lumbar

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herniated pulposus. Another injection would be administered on March 7, 2012. The injections provided little to no relief.

During that first visit, Dr. Piska prescribed Norco (5/325 mg three times daily), Zanaflex and Mobic. Petitioner's problematic use of Norco was evidenced soon thereafter. On February 16, 2012, Petitioner was seen by the company doctor Dr. Panuska again, but this time for a fitness for duty evaluation prompted by Petitioner's on-the-job use of Norco, which made him "distracted." In a client encounter report, Dr. Panuska wrote that "much discussion was had about his use of narcotics at work which is prohibited and the fact that he needs to be using other pain medications... He is not to use narcotics at work for pain control."[2]

Petitioner went completely off-work a few days later on February 22, 2012. He continued his use of Norco and, on March 20, 2012, began also taking a muscle relaxant (he was first prescribed Zanaflex, then Soma). While he was off-work, he consistently attended physical therapy as instructed. However, therapy records from throughout the summer of 2013 repeatedly noted that, as was the case with the lumbar injections, relief was not had. Petitioner's use of Norco continued unabated throughout this time, prescribed by Dr. Piska and later by Dr. Suresh Didwania.

Eventually, efforts were made to wean Petitioner off Norco. In a work status report from Dr. Panuska dated July 11, 2013, Dr. Panuska wrote, "He has cut down on narcotics to twice a day, once in the morning and once in the evening, but he has been off work for over a year secondary to his pain, as well as his use of narcotic pain medication." On July 29, 2013, Dr. Didwania indicated that he was "taper[ing] Norco and starting Petitioner on Ultracet as per workman comp." However, on December 23, 2013 (date of the last record provided by Dr. Didwania's office), Petitioner's Norco dosage actually went back up (from 5-325 up to 7-325 every 8 hours as needed). He also continued to take Soma daily. (PX 2).

As mentioned above, as of the date of hearing in May 2015, Petitioner was still obtaining Norco and Soma from Dr. Didwania. He also takes non-narcotic pain relievers.

E. Right shoulder pain and surgery

Petitioner also alleges right shoulder injury caused by the workplace accident. As mentioned above, Petitioner's shoulder pain began some six weeks after the accident. Notably, during Petitioner's visits to Dr. Panuska from November through the end of 2011, Petitioner did not complain of right shoulder pain. As he testified, he started noticing right shoulder pain while he was doing exercises at ATI Physical Therapy, where he was undergoing therapy for his low back. The first documented complaint of right shoulder pain appeared in the medical records of Dr. Darwish on December 16, 2011.

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[2] Two client encounter reports of this visit are found in the medical records. The other report stated, "Apparently, he has a lumbar disk injury. He is in pain. Both legs, feet and toes feel asleep and hot. His left foot is very painful, he says. He is on Norco from his physician, 7.5/325, and he says he gets distracted easily. He is in no acute distress. There is no real exam at this time. We are just discussing his medication use. He can return to work but he is not to take his medications at work on duty. He should follow up with Dr. Piska as arranged. He discharged from my care at this time."

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A right shoulder MRI, ordered by Dr. Darwish, was done on January 5, 2012. The MRI revealed abnormal marrow changes at the cervical neck of the humerus which was suspeicious for a nondisplaced sub-cortical fracture and tendinitis of the supraspinatus. On January 13, 2012, due to persistent shoulder pain, Dr. Darwish sent Petitioner to his colleague at Oak Orthpedics, shoulder surgeon Dr. Michael Corcoran. Dr. Corcoran performed right shoulder arthroscopy on March 26, 2012. Post-operative diagnoses included Grade III chondromalacia of the humerus and glenoid, labral fraying, impingement syndrome, and under-surface tearing of the rotator cuff. On September 19, 2012, Dr. Corcoran diagnosed adhesive capsulitis, but did not recommend additional treatment. (PX 4). It should be noted that Petitioner was prescribed Norco for both back and right shoulder pain.

F. IMEs and Return to work

Petitioner underwent an IME by Dr. Gregory Primus on September 7, 2012 and again on April 30, 2013. He also presented to Dr. Alexander Ghanayem for an IME regarding the lumbar spine only on November 21, 2013. These IMEs will be discussed in further detail below.

Petitioner returned to work on August 6, 2013 on a part-time, reduced-hours basis. On January 26, 2014, he returned to work full-time. At hearing, Respondent presented Larry Nicholls, senior chemist and Petitioner's supervisor (Tr. 50). Mr. Nicholls testified that Petitioner's position is still that of panel board operator, but he currently is assigned the work of a bench chemist or lab technician. As such, Petitioner's duties are sedentary to light, and he is allowed to alternate between sitting and standing. (Tr. 52). Petitioner's restrictions can thus be accommodated indefinitely. He makes the same wages as he did on the date of accident. (Tr. 52).

II. EVIDENCE DEPOSITIONS AND UTILIZATION REVIEW

Evidence depositions were taken of Drs. Jimenez, Primus and Ghanayem. These depositions are discussed below.

Respondent also submitted a utilization review authored by Dr. George Telep, dated July 23, 2012. The utilization review's determinations were that Dr. Jimenez' prospective request for the lumbar fusion surgery was non-certified (citing, *inter alia*, lack of specific documentation of findings), as was Dr. Jimenez' prospective request for a 5-day hospital stay after the prospective fusion. (RX 4).

A. Dr. Juan Jimenez

Dr. Jimenez was deposed on July 31, 2013. Dr. Jimenez testified that his diagnosis was displacement of lumbar intervertebral disc without myelopathy and a herniated disc at L4-5 impinging on a nerve root, which impingement caused Petitioner's left lower extremity complaints. (PX 8 at p. 7-10). According to Dr. Jimenez, fusion surgery was indicated due to loss of disc height in addition to radicular pain. The doctor was defensive regarding his recommendation for pain intervention three months after the date of accident, and resisted giving any opinion as to whether Petitioner's condition was the result of a chronic or acute process, stating, "In terms of looking at the clinical outcome, it's difficult to tease out chronic versus

acute, but my recommendation at the time of the clinical presentation was a holistic one: How can we help the patient with his current clinical pain syndrome? So the recommended treatment is for the condition as a whole." (PX 8 at p. 34).

He opined that Petitioner was not at MMI, insofar as Petitioner was still symptomatic. He disagreed with the utilization review and argued that there were neurological findings on examination. (PX 8 at p. 22). He did not, however, appeal the utilization review's non-certification of the recommended surgery. (PX 8 at p. 36). Interestingly, he did not readily remember that he had recommended a 5-day hospital stay after the surgery, expressing surprise and commenting, "That seems a little bit long." (Tr. 34-35).

As to Petitioner's narcotics use, he several times professed lack of expertise and indicated that his custom was to defer to the judgment of the pain specialist (in this case, Dr. Piska). He was not certain whether seven months was sufficient time to wean a patient off narcotics. (Tr. 39).

B. Dr. Gregory Primus, IME

Dr. Primus examined Petitioner on September 7, 2012 and again on April 30, 2013. He submitted a narrative report and an addendum following these examinations. Dr. Primus was deposed on March 18, 2014 and provided testimony consistent with his written reports. Dr. Primus rendered two main diagnoses: (1) "temporary exacerbation of a preexisting lumbar disc disease with acute work-related strain;" and (2) "right shoulder rotator cuff strain with impingement and associated internal rotation, no deficits, status post arthroscopic debridement." (RX 3 at 11-12).

Regarding the right shoulder, Dr. Primus noted that Petitioner first reported right shoulder pain about six weeks after the accident. Dr. Primus opined that the shoulder condition was not related to the work incident, as otherwise he would have expected an immediate onset of shoulder symptoms. (RX 2 at p. 16). A right shoulder arthrogram of August 17, 2012 was noted to indicate degenerative findings. (RX 2 at p. 9-10). During the second exam of April 30, 2013 with Dr. Primus, Petitioner displayed greater pain in the shoulder, but this apparent deterioration did not change Dr. Primus' causation opinion.

Regarding the low back, Dr. Primus stated that the lumbar spine MRI of December 2011 showed degenerative disc disease as opposed to acute injury from the workplace incident. In particular, there was disc space narrowing at L4-5 and L5-S1, and associated protrusions, but no clear herniation or evidence of nerve root compression. Dr. Primus opined that the work incident caused only a temporary exacerbation, or a lumbar strain, and that Petitioner had since reached MMI. [RX 2 at p. 20]. The doctor opined that lumbar strain in the presence of significant preexisting disease can manifest symptoms "upwards of six months or longer," and in the instant case, he believed the treatment Petitioner received for up to six months after the incident -- that is, up to April 18, 2012[3] -- was related to the temporary exacerbation. (RX 2 at 12-13). However, Dr. Primus did not believe that there was any clear disc herniation or significant worsening radicular symptoms. (RX 2 at p. 14). He did not agree with the recommendation for

[3] This is the date of MMI for the low back as argued by Respondent in its appeals brief.

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a lumbar fusion. Dr. Primus explained that the work incident did not cause any change in Petitioner's anatomy, there were no acute findings, and there was not significant enough natural progression of any preexisting spinal disease that would to lead to symptoms warranting a fusion.

As to Petitioner's current subjective complaints, characterized as "chronic back pain" by Dr. Primus, these were not related to the work incident but arose from preexisting spine disease. For these complaints, the doctor recommended physical therapy and a home exercise program that addressed core strengthening of the spinal muscles. (RX 2 at p. 12, 17-18). He also recommended that Petitioner be weaned off the narcotic and muscle relaxant. In fact, Dr. Primus believed that Petitioner's chronic narcotic and muscle relaxant drug use was the "chief problem" upon Petitioner's first presentation for his IME in September 2012, and that this drug dependence was the issue that "needed intervention more than any surgery or any other therapy or treatment" for Petitioner's claimed back or shoulder conditions. (RX 2 at p. 17-20).

C. Dr. Alexander Ghanayem, IME

Dr. Ghanayem evaluated Petitioner for the lumbar spine only on November 21, 2013. He prepared a narrative report of that date and an addendum on January 2, 2014. He was deposed on August 20, 2014, and provided testimony consistent with his reports. Dr. Ghanayem diagnosed a lumbar strain as a result of the work accident. He stated that the mechanism of injury would be consistent with a strain or sprain and that Petitioner's physical exam was not consistent with anything more significant. The MRI did not reveal a structural change to the spine but only mild, age-appropriate degenerative changes. (RX 3 at p. 11). He also noted symptom magnification, characterizing Petitioner's presentation as a "bizarre" display. As he explained, "when you have somebody, you know, hold their big toe up and they get a pain response with that, that just isn't normal." (RX 3 at 8, 19). [4] Given the absence of acute disc herniations or injuries, absence of nerve compression, the physical exam findings, and the mechanism of injury, Dr. Ghanayem believed that Petitioner had a soft tissue injury of the back, i.e., a lumbar strain. (RX 3 at 11-12). He opined that this injury should have resolved in three or four months. (RX 3 at 14).

Dr. Ghanayem did not feel that the epidural injections were warranted, as there was no evidence of compression, but trigger point injection would have been fine. (p. 12). He was especially adamant that lumbar fusion surgery was not warranted, stating, "His subjective complaints, with his objective physical exam findings and MRI scan -- there's no surgical indication, period. Work injury or not." (RX 3 at 13). In fact, he practically accused Dr. Jimenez of violating the standard of care: "Surgery is not appropriate. No way, shape or form. " (RX 3 at 20-21). Like Dr. Primus, Dr. Ghanayem also believed that Petitioner's use of narcotic pain medication and muscle relaxant was problematic and recommended that he get off those medications. (RX 3 at 22).

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[4] In his IME report, Dr. Ghanayem wrote, "Tension signs result in bizarre reproduction of a lateral thigh and lateral buttock pain with extension. It is not in the same nerve root distribution." (IME report at p. 1).

III. DISCUSSION

The Arbitrator found for Petitioner's case in its entirety. As he stated, he found "the opinions of Petitioner's treating physicians, particularly those of Dr. Jimenez, his neurosurgeon, to be more persuasive than those of Drs. Primus and Ghanayem." (Arbitrator's Decision at p. 9). The Arbitrator noted that both Drs. Primus and Ghanayem concurred that Petitioner sustained acute trauma to his low back due to the October 18, 2011 accident, but they characterized the resulting injury as just a lumbar strain that should have resolved. The Arbitrator went on to note that the medical records document Petitioner's (subjective) complaints of ongoing back pain far beyond the timeline for resolution as expected by these IME physicians, and suggested therefore that the reliability of these physicians' opinions was to be questioned. The Arbitrator did not address Dr. Ghanayem's observation of "bizarre" symptom magnification or the issue of Petitioner's chronic Norco and muscle relaxant use and the potential effect thereof on his symptoms reporting. The Arbitrator, without addressing the delay in the manifestation of right shoulder pain, also found that Petitioner's right shoulder condition was causally connected and awarded all benefits sought regarding same.

The Commission agrees with the Arbitrator that Petitioner sustained a low back injury on the claimed date of accident; however, as to severity of that injury, the Commission holds the opposite impression regarding the credibility of Drs. Jimenez, Primus and Ghanayem. The testimony and written reports of Drs. Primus and Ghanayem were well-reasoned, thorough and, together, also provided a compelling case that Petitioner's chief problem now is his drug dependence. The Commission finds that Petitioner reached MMI as to his low back by April 18, 2012 (pursuant to Dr. Primus' generous determination). The Commission finds that his right shoulder was not injured during or by the accident of October 18, 2011.

IV. CONCLUSION

Petitioner has proven that this injury was, at most, a lumbar strain that resolved no later than six months after the accident, that is, by April 18, 2012. As to the right shoulder injury, Petitioner has not proven that his right shoulder was injured in any way by or during the accident. The record as a whole suggests that, insofar as Petitioner was disabled (totally and then partially) for almost two additional years, his disability is more likely than not the result of an unfortunate dependence on narcotic and muscle relaxant medication that was prescribed imprudently.

Accordingly, the Commission modifies the Arbitrator's award of temporary total disability and medical expenses, reverses the award of temporary partial disability, and reverses the award of prospective lumbar surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on July 16, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 749.29 per week for 8 weeks, for the period commencing February 22, 2012 to April 18, 2012, that being the period of temporary total incapacity for work under § 8(b); Respondent shall be given credit for all amounts paid as temporary total disability payments to date.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. Respondent shall pay only the reasonable and necessary medical expenses incurred for treatment to the lumbar spine up to April 18, 2012, under § 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of temporary partial disability is reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care is reversed.

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 shall pay to Petitioner interest under §19(n) of the Act, if any.

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

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

DATED: SEP 12 2016

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jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

PANOZZO, DAVID
Employee/Petitioner

Case# **12WC008027**

16IWCC0585

BASF CORP
Employer/Respondent

On 7/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% 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:

2208 CAPRON & AVGERINOS PC
STEPHEN SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0560 WIEDNER & McAULIFFE LTD
NICOLE SCHNOOR
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

☐ Injured Workers' Benefit 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)

David Panozzo,
Employee/Petitioner

v.

BASF Corp.,
Employer/Respondent

Case # 12 WC 8027

Consolidated cases: none

16IWCC0585

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **5/12/15**. 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, **10/18/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,954.88**; the average weekly wage was **$1,191.44**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **no** 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 **$61,954.62** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,391.56** for other benefits (PPD advance), for a total credit of **$63,346.18**. (See Arb.Ex.#1).

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 $749.29 per week for 75-6/7 weeks, commencing 2/22/12 through 8/5/13, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $447.69 per week for 24-6/7 weeks, commencing 8/6/13 through 1/26/14, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/19/11 through 5/12/15, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $61,954.62 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services as set forth in PX9, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner is entitled to prospective treatment in the form of surgical treatment recommended by Dr. Jimenez, and Respondent shall pay the reasonable and necessary medical expenses associated therewith pursuant to Section 8(a) and the fee schedule provisions of Section 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

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

Signature of Arbitrator

7/13/15
Date

ICArbDec19(b)

JUL 16 2015

STATEMENT OF FACTS:

The Arbitrator notes that this matter is assigned to the Kankakee venue and proceeded to trial in New Lenox pursuant to §19(b) of the Act.

Petitioner, 43 year old panel board operator, testified that he had worked for Respondent for 17 years and had sustained no previous injuries to his right shoulder or low back. Petitioner testified that on October 18, 2011 he was walking within the plant in an area with trenches containing pipelines. The trenches were covered by metal grates which allowed for the runoff of water. Petitioner testified that there was a steel plating utilized to cover the trench which he had to step on. The steel plate was loose, not situated over the opening and gave way causing him to lose his balance. Petitioner's leg dropped straight down into the trench and he caught himself with his right arm against a tank adjacent to the trench without actually falling to the ground. Petitioner testified that he experienced pain throughout his body but primarily in his low back radiating upwards and his shoulder was sore. Petitioner notified his supervisor of the incident on that day.

Petitioner testified that the pain he was experiencing increased over the next two weeks as a result of which he sought treatment and completed a formal incident report with his employer on November 3, 2011. (PX1). This report corroborates Petitioner's description of the incident and notes that he had begun to experience pain in his lower back radiating down into his left leg.

At the direction of the Respondent, Petitioner was examined by Dr. Panuska at its Occupational Health Clinic on November 4, 2011. (PX3). The history reflects that the pain had been increasing since the accident and was radiating down into his left leg. He was diagnosed with a lumbar strain and prescribed medication and an MRI which was performed on December 13, 2011. This test revealed a bulging disc at L5-S1 approaching the descending left S1 nerve root necessitating a referral to Dr. Darwish, an orthopedic surgeon. In the interim, physical therapy was instituted at ATI. (PX7). Petitioner testified he began to notice increased pain in his right shoulder while performing certain exercises using bands. The records relate that as of December 6, 2011 he was having significant pain in his back and shoulder. (PX7).

Petitioner was first examined by Dr. Darwish on December 16, 2011. (PX4). Petitioner presented with a history of severe low back pain radiating into his bilateral buttocks and posterior thigh together with complaints of pain in the right shoulder as well. Dr. Darwish prescribed an MRI of the right shoulder as he anticipated he may have a torn rotator cuff and referred him to Dr. Piska, a pain management specialist. Petitioner was referred to Dr. Piska for possible epidural steroid injections at L4-L5 and L5-S1 given the diagnosis of lumbar spondylosis with bilateral radiculopathy. (PX4).

Petitioner sought a second opinion from Dr. Juan Jimenez of Neurosurgery Consultants on January 11, 2012. (PX5). Dr. Jimenez's review of the MRI revealed a loss of disc height at L5-S1 as well as herniation with impingement in the lateral recess of the S1 nerve root. Dr. Jimenez diagnosed displacement of the lumbar intervertebral disc without myelopathy and concurred with the L5-S1 selective nerve root injection. When the Petitioner failed to respond to the injections and therapy, Dr. Jimenez felt surgical treatment was indicated but first requested a CT scan to better evaluate the bone anatomy as well as standing flexion/extension films to evaluate motion at L5-S1. Given the results of the scans, Dr. Jimenez did not feel a microdiscectomy would provide full relief of his back pain but rather he was a candidate for decompression and fusion.

On January 13, 2012, Petitioner was reexamined by Dr. Darwish who reviewed the MRI which revealed an intact rotator cuff with abnormal marrow changes which was suspicious for a non-displaced subcortical fracture. Dr. Darwish recommended referral to Dr. Corcoran, a shoulder surgeon for evaluation. (PX4).

Petitioner came under the care of Dr. Corcoran for his right shoulder condition on January 26, 2012. (PX4). Dr. Corcoran felt he may have adhesive capsulitis and some rotator cuff tendonitis and injected him with Kenalog and Marcaine. When Petitioner failed to respond to the injections, it was noted he had failed all conservative treatment and underwent surgery on March 26, 2012 consisting of an arthroscopic subacromial decompression, acromioplasty and debridement. (PX4). Respondent authorized and paid for the surgery.

With respect to his low back symptoms, Petitioner was examined by Dr. Piska of Advanced Pain Specialists on January 20, 2012. Dr. Piska diagnosed Petitioner with lumbar nerve root compression and felt that the cause of his pain and radicular symptoms was lumbar nerve inflammation/irritation secondary to lumbar disc bulging. Dr. Piska performed a lumbar epidural steroid injection under fluoroscopy at the level of L5-S1. On February 14, 2012, Petitioner's pain was noted to be getting gradually worse over time with no relief from the initial epidural steroid injection. (PX6). Dr. Piska confirmed the diagnosis of lumbar nerve inflammation/irritation secondary to the disc bulging and recommended performance of a second epidural steroid injection. Petitioner noted that he experienced a 20% relief from the injection but was still having a lot of tingling in his right leg and pressure in the tailbone area together with numbness, tingling and weakness in the extremities. Due to the lack of response to the injection, Dr. Piska recommended referral to a spine surgeon for evaluation and treatment of spinal issues since he did not respond to conservative therapy. (PX6).

Petitioner returned to see Dr. Piska on May 29, 2012 with ongoing complaints of pain in his lower back and legs. Given his uncertainty about proceeding with surgery, Petitioner continued with pain management and medication under the direction of Dr. Piska at the recommendation of Dr. Jimenez. (PX5; PX6).

Petitioner was re-examined by Dr. Jimenez on November 12, 2012. (PX5). It was noted that he had exhausted conservative treatment for his persistent mechanical type back pain with bilateral lower extremity radiculitis, left greater than right. Petitioner was noted to have objective findings on examination and that the current clinical symptomology occurred following a work related injury. Dr. Jimenez opined that he required an L5-S1 decompression and stabilization procedure and disagreed with the independent medical examiner that surgery was not indicated. (PX5).

Petitioner was last examined by Dr. Piska on January 11, 2013. He continued to have pain in the lower back and bilateral lower extremities and was diagnosed with bulging disc, facet joint syndrome and sacral joint syndrome. It was noted that all treatment to the lower back had been denied by Respondent based upon the results of an independent medical examination where he was deemed to be at MMI. Petitioner complained of ongoing pain and did not know how he would perform his job duties and activities without pain medication. There was no change in his condition with associated burning, numbness, tingling and weakness. Facet joint injections recommended by Dr. Piska were not approved by the Respondent.

Petitioner was last examined by Dr. Jimenez on October 13, 2014. (PX5). He returned with a new MRI that again displayed spondylitic changes in the lumbar spine with loss of disc height at L5-S1 with disc osteophyte complex and nerve impingement. Dr. Jimenez noted Petitioner's failure to respond to conservative treatment and reiterated his recommendation for the L5-S1 lumbar transforaminal interbody fusion. It was further indicated that Petitioner could no longer live with his current pain that was noted to be constant in his low back radiating to his bilateral hips and down into his bilateral lower extremities. He also reported numbness and tingling in his toes bilaterally. Petitioner testified that he desires to undergo the surgical recommendation of Dr. Jimenez but it has never been authorized by the Respondent.

At the direction of the Respondent, Petitioner was examined by Dr. Gregory Primus on September 7, 2012 for the purposes of a §12 examination. (RX2). Dr. Primus opined that Petitioner had sustained an injury to his

lumbar spine which he characterized as a temporary exacerbation of pre-existing lumbar disc disease with acute work related strain. He further felt that Petitioner had sustained a right shoulder rotator cuff strain with impingement and associated internal rotation deficit, status post arthroscopic debridement. He felt the acute lumbar sprain was caused by the accident in question but disputed the causal relationship between the rotator cuff and impingement and subsequent surgery to the work accident in question. With respect to the low back condition, he felt that such a moderate sprain typically resolves in 6 to 12 weeks and there was no objective evidence to substantiate a significant and persistent work related spine injury. He disputed the necessity of the epidural steroid injections and did not agree with any indication to perform a spinal fusion given the results of the MRI and CT scans. Any further treatment to the low back would be to address pre-existing chronic lumbar back disease, not the lumbar strain that was exacerbated during the work related injury. While the imposition of work restrictions was necessitated, he did not attribute those to the work related injury but rather pre-existing spine disease and chronic pain. Any ongoing symptoms and subjective complaints were beyond the work incident and related to the pre-existing lumbar spine condition or other pain factors that are more systemic in nature. Following a repeat examination of April 30, 2013, he reiterated his opinions, including his belief that Petitioner had reached MMI for all conditions related to the work accident as of September 7, 2012. He felt that Petitioner could return to work full time with restrictions based on his current shoulder limitations of weakness and restrictive motion as well as persistent low back pain. He further recommended continuing physical therapy in the form of a home exercise program and to avoid aggravating activities or environments such as whole body vibration, prolonged sitting and heavy lifting that may sprain his lower back. (RX2).

On November 21, 2013, Petitioner was examined by Dr. Alexander Ghanayem at the request of Respondent for the purposes of a §12 examination. (RX3). Dr. Ghanayem concluded that Petitioner was suffering from back and leg pain with the leg pain being worse than his back pain. Given the mechanism of injury and his physical exam findings, he believed Petitioner sustained a lumbar strain for which physical therapy would have been reasonable. He would not have recommended injections and did not feel he was a candidate for any lumbar surgery. He deemed him to be at MMI and recommended a return to regular duty work with regard to his back. (RX3).

On August 6, 2013, Petitioner returned to work part-time in his former capacity as a control panel operator. Given his inability to sit for extended period of times, he was subsequently transferred to the laboratory as a laboratory tech in January 2014 where he has continued to work. Petitioner testified that as of the hearing date the pain and burning sensation in his back has intensified and continues to radiate into his bilateral low extremities. In addition, he described a numbness/tingling sensation that has developed in the skin in the area of his low back. Petitioner testified that he has continued to experience difficulty in performing his job duties due to his inability to stand for extended periods of time. The job description tendered by Respondent confirms that Petitioner is obligated to stand four hours out of each work day. (RX1). Petitioner continues to take Soma, Hydrocodone at night and on the weekends and Tramadol during the day in an attempt to reduce his pain. Petitioner testified that his condition continues to deteriorate. He indicated that he can no longer tolerate the pain and desires to have the surgery recommended by Dr. Jimenez given his lack of response to the conservative treatment prescribed by his physicians and the §12 examiners.

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:

Petitioner testified that on October 18, 2011 he was walking on the premises of the Respondent during his regular workday. At that time, he stepped on steel plating that was used to cover a trench. The steel plate was

loose and not situated over the opening, giving way and causing him to lose his balance. He testified that his leg foot went down into the trench and he fell to the side. He noted that he reached up and caught himself with his right arm against a tank adjacent to the trench without falling. Petitioner notified his supervisor of the incident on that day.

On November 3, 2011, Petitioner completed an accident/incident report in accordance with Respondent's policy. (PX1). The events described within that document corroborate his testimony at arbitration. Respondent's Exhibit 6, the employer's form 45, confirms Petitioner's testimony and the fact he sustained injuries to his low back area when his foot was fell into a trench. Respondent produced no evidence to rebut the testimony of Petitioner and the contents of these incident reports.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds 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 on October 18, 2011.

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

Petitioner alleges that he sustained injuries to his right shoulder and low back necessitating medical treatment and the imposition of restrictions as a result of the accident on October 18, 2011. Respondent has disputed the causal relationship between any current conditions and the work accident.

At the time of the accident, Petitioner testified that as he was falling into the trench he reached up and caught himself on a nearby tank using his right arm. Petitioner testified that he had never sustained an injury to his right shoulder prior thereto.

Following the incident, Dr. Panuska prescribed physical therapy following his visit of November 22, 2011. (PX3). Petitioner testified that while performing band exercises, he experienced severe shoulder pain which prohibited him from doing the therapy. The therapy record of December 2, 2011 corroborates Petitioner's complaints of pain in the right shoulder and as of December 6, 2011 it was noted certain exercises were withheld secondary to significant shoulder pain. (PX7).

On December 16, 2011, Petitioner was noted to be experiencing right shoulder pain by Dr. Darwish who recommended obtaining an MRI to delineate the cause of the pain as he anticipated he may have a torn rotator cuff. (PX4). The MRI was suspicious for a non-displaced subcortical fracture and Dr. Darwish recommended referral to Dr. Corcoran, a shoulder surgeon for evaluation.

Dr. Corcoran examined Petitioner on January 26, 2012, noted his work injury of October 2011 and believed that the biggest symptoms at that juncture may be adhesive capsulitis and possible rotator cuff tendonitis and recommended injections which failed to resolve the pain. Given these findings, Dr. Corcoran recommended a right shoulder arthroscopy for evaluation of the rotator cuff as well as subacromial decompression which was performed on March 26, 2012. Petitioner underwent a course of physical therapy thereafter together with two cortisone injections. There is no history of Petitioner having injured his shoulder between the subject accident and surgery.

On December 13, 2012, Petitioner underwent a functional capacity evaluation at the direction of Dr. Corcoran and was noted to have given a maximum response and consistency effort. (PX4). Petitioner was noted to be

unable to successfully return to all of the physical demands of his former job. Petitioner testified that he has sustained no other injuries or trauma to his right shoulder since the date of the subject accident.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's current condition of ill-being with respect to his right shoulder is causally related to the accident on October 18, 2011. The evidence shows that Petitioner suffered acute trauma to his right shoulder on the date of the incident or at a minimum sustained an aggravation of a pre-existing degenerative condition. Along these lines, the Arbitrator finds the opinions offered by Dr. Primus, Respondent's §12 examining physician with respect to the shoulder, to be unpersuasive. Dr. Primus was of the opinion that Petitioner was suffering from a "chronic scenario" as opposed to an acute injury to the shoulder. However, there is no evidence to show that Petitioner had received any treatment to his right shoulder before the accident or was restricted or incapable of performing his job duties during the period leading up to the incident in question.

With respect to Petitioner's claimed lumbar spine condition, Petitioner noted that he experienced an immediate onset of back pain that increased in intensity over the following two weeks. On November 4, 2011, he sought treatment for his back condition with Respondent's occupational health physician, Dr. Panuska. (PX3). The records reveal a history of no prior back pain with the exception of an incident occurring 18 years earlier. Following the incident in question, Petitioner was diagnosed with a lumbar strain and a course of physical therapy was instituted. Following the performance of an MRI, a bulging disc at L5-S1 approaching the descending left S1 nerve root was noted resulting in a referral by Dr. Panuska to Dr. Darwish, an orthopedic surgeon. (PX3).

On December 16, 2011, Petitioner was examined by Dr. Darwish of Oak Orthopedics at which time he was diagnosed with lumbar spondylosis without myelopathy with bilateral radiculopathy and referred for pain management and possible epidural steroid injections at L4-L5 and L5-S1. (PX4).

On January 11, 2012, Petitioner was examined by Dr. Jimenez who diagnosed a displacement of the L5-S1 lumbar intervertebral disc without myelopathy as well as bilateral spondylosis. (PX5). A CT scan subsequently confirmed the diagnosis, and given Petitioner's lack of response to conservative measures, Dr. Jimenez felt Mr. Panozzo was a candidate for decompression and fusion. Petitioner was not in favor of surgery at that time and it was recommended that he follow up with pain management and Dr. Piska. (PX5).

Petitioner was first examined by Dr. Piska on January 20, 2012. At that time, Dr. Piska diagnosed lumbago, nerve root compression, lumbar disc displacement/herniation with his symptoms attributable to lumbar nerve inflammation/irritation. Based upon these findings, Dr. Piska performed two lumbar epidural steroid injections.

On February 19, 2013, Petitioner was examined by Dr. Didwania, his family physician. Dr. Didwania acknowledged his complaints of back and shoulder pain due to injuries at work with tingling going down to his toes. He diagnosed Petitioner with lumbago and has continued to monitor his pain medication through the present. (PX2).

On September 7, 2012, Petitioner was examined by Dr. Primus at the request of the Respondent. Dr. Primus acknowledged that Mr. Panozzo sustained an injury to his lumbar spine with the accident of October 18, 2011. He felt the mechanism of injury was plausible for an acute lower back strain with a slip and loss of balance, coupled with an outreach of the right arm for support. (RX2).

On November 21, 2013, Petitioner was examined by Dr. Ghanayem at the request of the Respondent. (RX3). Dr. Ghanayem felt that Petitioner had back and leg pain with the leg pain being worse than his back pain.

Given his mechanism of injury and physical exam findings, along with positive Waddell signs, Dr. Ghanayem's diagnosis was a lumbar strain. (RX3).

Petitioner was last examined on October 13, 2014 by Dr. Jimenez. At that time it was noted that Petitioner had exhausted conservative treatment including therapy and spinal injections. He had objective findings upon his examination and continued with constant low back pain radiating to his bilateral hip and down his bilateral lower extremities. Pain was noted to be seven out of ten characterized as a constant dull ache with numbness and tingling into his toes bilaterally. (PX5).

Petitioner testified that he has sustained no injuries or trauma to his low back since the accident. Furthermore, while Dr. Primus opined that any conditions associated with the work-related injury Petitioner sustained would have resolved within six to twelve weeks, the evidence suggests that has in fact not occurred. Indeed, even Dr. Primus indicated that based on Petitioner's subjective complaints and mild leg symptoms, work restrictions were necessary including minimized prolonged sitting and whole body vibration due to the negative impact it would have on his lumbar spine. (RX2). Regardless, Dr. Primus was of the opinion that Petitioner's ongoing symptoms and need for restrictions were attributable to a "pre-existing spine disease and chronic pain" as opposed to the acute work related injury. The Arbitrator finds Dr. Primus' opinions along these lines to be unpersuasive, based on the medical records taken as a whole and the findings and opinions of treating physicians Drs. Panuska, Darwish, Piska and Jimenez, as well as Petitioner's credible testimony as to the nature of the injury and his ongoing complaints.

The Arbitrator likewise is unpersuaded by the opinion of Dr. Ghanayem who examined Petitioner on one occasion and felt he had sustained an acute lumbar strain resulting in back and leg pain. Dr. Ghanayem opined that injections and surgery were not indicated in the absence of nerve root compression. Once again, this opinion is in sharp contrast to the opinions of treating physicians Drs. Panuska, Darwish, Piska and Jimenez who felt that the objective symptoms present in Petitioner necessitated therapy, injections, a surgical recommendation and the imposition of restrictions.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that both his right shoulder and lower back conditions are causally related to the accident on October 18, 2011.

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 initially sought treatment with Dr. Panuska, Respondent's occupational health physician. When his back symptoms failed to resolve, Dr. Panuska referred him to Dr. Darwish at Oak Orthopedics for evaluation on December 16, 2011. (PX4). Dr. Darwish referred Petitioner to Dr. Piska, a pain management specialist for evaluation of possible epidural steroid injections at L4-L5 and L5-S1. In addition to the back symptoms, Dr. Darwish's initial evaluation refers to complaints of right shoulder pain necessitating a referral to Dr. Corcoran for evaluation of a rotator cuff tear. (PX4).

When back surgery was indicated, Petitioner sought treatment from Dr. Jimenez of Neurology Consultants who in addition to recommending a surgical procedure also referred Petitioner to Dr. Piska for epidural steroid injections. (PX6). Dr. Piska concurred with a diagnosis of lumbar disc displacement/herniation together with

nerve root compression and concurred with the recommendation for lumbar epidural steroid injections under flouroscopy given the symptoms and the nature of his lesions.

At the request of Respondent, Petitioner was examined by Dr. Primus. Dr. Primus disagreed with the indications that led to the epidural injections as he did not feel Petitioner had a true conservative period with adequate time and therapy to address his lumbar spine pain. He further felt that Petitioner did not present with symptoms significant enough to warrant the injections in the absence of clear objective evidence in the diagnostic testing performed. However, Dr. Primus also acknowledged that Petitioner did not respond to the extensive treatment rendered and continues to suffer from chronic low back pain, which Dr. Primus attributed to pre-existing degenerative disc disease. (RX2). However, once again, the record shows that Petitioner had never been previously diagnosed with or sought treatment for said condition prior to the accident in question.

Dr. Ghanayem, who also examined Petitioner at the request of Respondent, likewise felt Petitioner sustained a traumatic lumbar strain requiring nothing more than physical therapy by way of treatment. Unlike Dr. Primus, however, he felt the degenerative changes in Petitioner were age appropriate. (RX3, pp.10-11). Dr. Ghanayem would not have recommended injections for leg symptoms where there was no neurologic compression present in the neurodiagnostic films.

On the other hand, Petitioner's primary treating neurosurgeon, Dr. Jimenez, testified that Petitioner presented with a classic radicular type pain in the distribution of the L5-S1 nerve. His physical examination produced objective findings, including diminution to pinprick in the left L5 distribution that he noted corroborated Petitioner's pain and radicular symptoms. (PX8, pp.7-8). Dr. Jimenez also reviewed the MRI which revealed a tear in the L4-5 disc together with herniation and impingement in the lateral recess of the S1 nerve root. Regardless of the terminology used, Dr. Jimenez felt there was disc material compressing on Petitioner's L5-S1 nerve producing the concordant physical findings in the left lower extremity symptoms. (PX8, pp.9-10). Given that Petitioner had already undergone a course of physical therapy without pain resolution, Dr. Jimenez felt that the next logical step to follow in a patient with radiculopathy is assessment by a pain management physician for performance of epidural injections. Accordingly, Petitioner was referred to Dr. Piska, a regional pain consultant, for evaluation of the necessity of the injection. Dr. Jimenez then deferred to Dr. Piska as to the determination of the necessary pain medication to address his complaints.

Petitioner underwent the epidural steroid injections without relief. Given his failure to respond to these injections, Dr. Jimenez prescribed additional diagnostic tests consisting of CT scan and flexion extension films to visualize the bone anatomy in order to provide a recommendation for the definitive surgical treatment. (PX8, pp.14-15). Those diagnostic tests specifically identified facet disease and discogenic degenerative disease. These conditions were in addition to displacement of the lumbar disc identified in the MRI resulting in his recommendation of a lumbar interbody fusion at the level of L5-S1. (PX5).

Based on the above, and the record taken as a whole, the Arbitrator finds the opinions of Petitioner's treating physicians, particularly those of Dr. Jimenez, his neurosurgeon, to be more persuasive than those of Drs. Primus and Ghanayem. Both Dr. Ghanayem and Dr. Primus concur that Petitioner sustained acute trauma to his low back but characterized the resulting injuries as nothing more than a lumbar strain which should have resolved. However, the medical records as well as Petitioner's credible testimony suggests that Mr. Panozzo continues to experience ongoing complaints relative to his lower back. The Arbitrator further finds that the medical expenses incurred as a result of treatment relating to both his right shoulder and lower back injuries were reasonable and necessary under the circumstances.

Accordingly, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses as set forth in PX9, including out-of-pocket expenses, pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

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

Respondent submitted into evidence a utilization review report dated July 23, 2012. (RX4). This report indicated that the "... request for L5-S1 transforaminal posterolateral arthrodesis, laminectomy, facetectomy for decompression, posterior instrumentation interbody device and autograft and five days of hospital in-patient stay is not certified." (RX4). The Arbitrator notes that this report was prepared approximately 22 months prior to the hearing without the benefit of the reviewer ever having examined Petitioner. Furthermore, the reviewer did not have the benefit of more recent diagnostic films and/or updated medical records and documentation. In addition, Dr. Jimenez disputed the conclusions contained therein as he found clear neurological findings on his examination which were pathognomic for nerve root compression. In addition, he noted that the loss of disc height and the presence of a disc both are going to contribute to foraminal narrowing which in turn is evidence of compression of the nerve root. It was further unclear from the contents of the report as to whether the reviewer actually evaluated the diagnostic films or relied on the radiologist's interpretation that can vary from practitioner to practitioner. As a result, the Arbitrator finds the utilization review non-dispositive on the issue of the proposed surgery.

Furthermore, as previously noted, the Arbitrator finds the opinions of Drs. Panuska, Jimenez, Piska and Didwadia to be more persuasive than those offered by Respondent's §12 examining physicians, Drs. Primus and Ghanayem as they relate to the diagnosis of Petitioner's low back injury as prospective treatment recommendations. The record shows that Petitioner has exhausted all conservative forms of treatment consisting of therapy, injections and pain management. Petitioner's symptoms continue to deteriorate and he testified he can no longer tolerate the pain and desires to undergo the decompression and fusion procedure recommended by Dr. Jimenez.

Accordingly, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to accident and causation (issues "C" and "F", supra), the Arbitrator finds that Petitioner is entitled to prospective medical treatment in the form of the surgery recommended by Dr. Jimenez, and Respondent shall be liable for the reasonable and necessary medical expenses associated therewith pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND/OR TEMPORARY PARTIAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner alleges that he was temporarily totally disabled for the period from February 22, 2012 through August 5, 2013 when he returned to work for Respondent as a control panel operator. The parties stipulate that the Respondent paid all temporary total disability benefits during said time period. However, Respondent disputes liability for any temporary disability benefits thereafter.

The Arbitrator notes that pursuant to *Interstate Scaffolding v. Illinois Workers' Compensation Commission*, 236 Ill. 2d 132, 142 (2010), the determining factor as to whether an individual is entitled to temporary total

disability benefits is whether the claimant's condition has stabilized, *i.e.* whether the claimant has reached maximum medical improvement.

In the present case, Petitioner testified that on August 6, 2013 he returned to work for Respondent as a control panel operator but was subsequently transferred to the laboratory given his inability to stand for extended periods of time. Petitioner has continued to work for Respondent in a full time capacity since January 26, 2014.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's condition has not stabilized and as a result he has not yet reached maximum medical improvement. Indeed, Dr. Jimenez, Petitioner's primary treating neurosurgeon, testified that Petitioner has yet to reach MMI and is in need of a decompression and fusion surgery in order to address the injuries sustained in the accident. Therefore, the Arbitrator finds that Petitioner was temporarily totally disabled from February 22, 2012 through August 5, 2013, at which time he returned to work for the Respondent, for a period of 75-6/7 weeks (including the extra leap year day in February of 2012), as provided in Section 8(b) of the Act.

With respect to Petitioner's claim for temporary partial disability benefits, the record shows that Petitioner returned to work for the Respondent on August 6, 2013 on a part-time reduced capacity basis. On January 26, 2014 he was placed on full duty while working as a laboratory technician. Petitioner's Exhibit 11 consists of Petitioner's paystubs for the period extending from August 6, 2013 through January 26, 2014, or a period of 24-6/7 weeks. These pay records show that Petitioner earned $12,923.10 during the period in question, or an average of $519.90 per week ($12,923.10 ÷ 24.857 weeks).

The parties stipulated that Petitioner's average weekly wage for the year preceding the accident was equal to $1,191.44. (Arb.Ex.#1). Thus, the difference between what Petitioner would have earned on a weekly basis in the full capacity of his job ($1,191.44) and what he earned on a weekly basis in his part-time position ($519.90) equaled $671.54, or a weekly temporary partial disability (TPD) rate of $447.69 (2/3 x $671.54).

Therefore, based on the above, and the record taken as a whole, Petitioner is entitled to temporary partial disability benefits of $447.69 per week from August 6, 2013 through January 26, 2014, for a period of 24-6/7 weeks, as provided in Section 8(a) of the Act.

WITH RESPECT TO ISSUE (N), IS THE RESPONDENT DUE ANY CREDIT, THE ARBITRATOR FINDS AS FOLLOWS:

Respondent shall be given a credit of $61,160.33 for TTD as stipulated between the parties. (Arb.Ex.#1).

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patrick O'Kane,

Petitioner,

vs. No. 12 WC 08827

City of Chicago,

16IWCC0619

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission agrees with the Arbitrator's Decision in all respects, except the extent of Petitioner's disability. The Commission finds the injuries sustained caused permanent disability to the extent of 25 percent of the person as a whole. In so finding, the Commission notes that Petitioner, then a 63-year-old laborer, sustained a large full thickness rotator cuff tear with a long head biceps tendon rupture. Petitioner obtained a good result with the surgery. Dr. Heller imposed restrictions after Petitioner stated he did not think he could perform heavy work duties on a regular basis. Dr. Heller was concerned about Petitioner returning to work as a laborer, given his age and general state of health, including preexisting osteoarthritis. Dr. Heller was also concerned that Petitioner might reinjure his shoulder. However, that was not the main reason for the restrictions.

The Commission agrees with the Arbitrator that Petitioner did not show good faith cooperation with Respondent's subsequent efforts at vocational rehabilitation and he deliberately

limited himself to working a low paying job close to home. The Commission agrees with the Arbitrator that Petitioner failed to prove he is entitled to wage differential benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 11, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $938.67 per week for a period of 61 4/7 weeks, from August 17, 2011, through October 23, 2012, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $695.78 per week for a period of 125 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 25 percent of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit of $67,047.86 for temporary total disability benefits, $13,142.51 for temporary partial disability benefits and $73,216.26 for maintenance benefits paid to Petitioner.

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

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

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

DATED: SEP 27 2016
o-08/25/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

O'KANE, PATRICK
Employee/Petitioner

Case# **12WC008827**

16IWCC0619

CITY OF CHICAGO
Employer/Respondent

On 1/23/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

2731 SALVATO & O'TOOLE
CARL S SALVATO ESQ
53 W JACKSON BLVD SUITE 1750
CHICAGO, IL 60604

0010 CITY OF CHICAGO
MICHELLE S BRYANT
30 N LASALLE ST - 8TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

16IWCC0619

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Patrick O'Kane
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12** WC **8827**

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 **Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **November 24, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0619

FINDINGS

On **8/15/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$73,216.00**; the average weekly wage was **$1,408.00**.

On the date of accident, Petitioner was **63** 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 **$67,047.86** for TTD, **$13,142.51** for TPD, **$73,216.26** for maintenance, and **$0** for other benefits, for a total credit of **$156,406.62**.

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

ORDER

Respondent shall pay Petitioner $938.67 per week for 61 4/7 weeks from August 17, 2011 through October 23, 2012, for temporary total disability, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner $844.80/week for 75 weeks as the injury caused 15% loss of use of a person, pursuant to Section 8(d)2 of the Act.

Respondent shall be given a credit of $67,047.86 for temporary total disability paid to Petitioner; $13,142.51 for temporary partial disability benefits paid to Petitioner; and $73,216.26 for maintenance benefits paid to Petitioner pursuant to Sections 8(a) and 8(b) 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.

16IWCC0619

STATEMENTS OF FACT

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) temporary total disability; 4) temporary partial disability; 5) nature and extent; 6) maintenance and 7) whether the petitioner is entitled to a wage differential. *See,* AX1.

Mr. Patrick O'Kane, ("Petitioner,") testified that he sustained a work related injury on August 15, 2011 while working for the City of Chicago, ("Respondent"). He is presently the sixty-six (66) years old. Petitioner testified that he worked for the respondent for sixteen (16) years as a cement mixer. He testified that his duties included assisting the finisher, pouring concrete, loading and unloading boards, and filling holes.

Petitioner testified that on August 18, 2011, while working for the respondent, he was throwing stones into a big hole when he heard a popping sound in his left shoulder and it began to throb. He continued to work, but when he got home his left shoulder felt weird and when he reported to work the next morning, he reported the pain to his supervisor and asked to see a doctor. Petitioner testified that he completed and signed an accident report, then went to MercyWorks for an evaluation.

The accident report was completed on August 16, 2011 and Petitioner wrote that he had pain in his arm from wrist to shoulder, from repetitive jarring motion while striping a retaining wall, using a scraper. RX1.

While at MercyWorks, Petitioner was evaluated by Dr. Homer Diadula; and instructed to remain off work and to follow-up for re-evaluation on August 19, 2011. During the August 19, 2011 follow-up visit, petitioner presented with persistent left shoulder pain. Dr. Diadula ordered an MRI of the left shoulder.

On September 14, 2011, Petitioner underwent an MRI, which was read to show "severe tendinopathy of the supraspinatus tendon with partial thickness partial width tears, involving the anterior half of the supraspinatus tendon". There was also a "full width, partial-thickness undersurface tear of the infraspinatus tendon and tendinopathy of the subscapularis tendon with a full-thickness, partial width gap within the central portion of the subscapularis tendon measuring 9mm". There was also a "large amount of fluid distending the subacromial/subdeltoid bursa." Dr. Diadula diagnosed the petitioner with a rotator cuff tear and referred him to an orthopedic specialist.

On September 23, 2011, Petitioner had an initial examination with Dr. William Heller, an orthopedic specialist at Midland Orthopedic Associates. Petitioner provided a personal, medical history of pain in his left shoulder, onset date of August 15, 2011. When answering the question, "how long has it bothered you?" the petitioner wrote "since 5-30-11". With regards to whether this was a work-related injury, Petitioner wrote that the injury occurred on 8/15/11 and in answer to the question "how long

have you had this problem?" the petitioner answered "3 months". Petitioner went on the say that "because of the constant movement, jarring, pulling, reaching, and general stress from the work, in detail something pulled or popped". Dr. Heller reviewed the MRI and recommended arthroscopic repair. PX2

On October 26, 2011, Dr. Heller performed arthroscopic repair of the left rotator cuff, performing a longhead biceps tendon resection, an arthroscopic subacromial decompression and left shoulder glenohumeral joint arthroscopy, with extensive debridement.

Following his surgery, Dr. Heller evaluated Petitioner and noted that at the time of surgery, Petitioner had some full thickness cartilage defect and osteophytes, indicative of osteoarthritis. Petitioner underwent post-operative, physical therapy and work hardening.

On May 4, 2012, Dr. Heller noted that Petitioner felt as though he had plateaued and the petitioner did not think he could perform heavy work duties. Dr. Heller noted that Petitioner was functioning at medium level and given his age, the doctor opined that Petitioner would probably function at a medium level on a permanent basis. Dr. Heller ordered a functional capacity evaluation ("FCE") to determine permanent restrictions.

On June 19, 2012, Petitioner underwent an FCE with his job title listed was laborer, which is characterized as heavy-level work. The Arbitrator notes that the accident report, as well as other documents, identifies the petitioner as a cement mixer.

On June 29, 2012, Dr. Heller placed the petitioner at maximum medical improvement ("MMI") and gave him the following permanent restrictions; lifting 35 pounds occasionally; 20 pounds frequently; bi-lateral lifting of 38 pounds, floor to waist; and 23 pounds waist to above shoulder. Dr. Heller also ordered minimal carrying of approximately 43 pounds bilaterally and 20 pounds with the left arm.

On October 23, 2012, Dr. Heller evaluated Petitioner for occasional left arm burning and tingling and prescribed a Medrol dose pack, muscle relaxants and placed the petitioner at MMI; with the same restrictions provided on June 29, 2012.

On June 23, 2014, approximately three years post-surgery, Dr. Heller evaluated petitioner for an unspecified reason. During this examination, Dr. Heller noted that petitioner is doing nicely, i e. able to use his left arm on a full-time basis and not having any significant pain complaints.

Petitioner testified that Respondent was unable to accommodate the restrictions provided by Dr. Heller, but he was told that he needed to look for work within his restrictions. Petitioner testified that he began looking for work outside of the City of Chicago in September 2012.

Petitioner testified that he met with a vocational expert from Genex Services on or about August 8, 2012, and provided his educational background and work history. Genex provided a transferable skill analysis, which identified ten (10) prospective jobs that fit within petitioner's work restrictions. RX2

During the initial meeting with Ms. Donna Cullen, the Genex consultant, petitioner was advised that he needed to fully comply with the terms and the conditions of the vocational rehabilitation program, which included in-person contacts and pursuing job leads, sent by Genex. Ms. Cullen immediately began sending to the petitioner, job leads for positions within his restrictions. On August 22, 2012, during his monthly progress session with Ms. Cullen, Petitioner expressed his opinion that he doubted that an employer would hire a 64-year-old person. Petitioner failed to apply for several jobs Ms. Cullen sent to him because he felt that they were too far away or in a dangerous area. RX2, Genex rpt. #1.
Petitioner testified that he was fully compliant with Genex and the requests made by Ms. Cullen. Ms. Cullen's reports demonstrate that Petitioner failed to follow-up on many of the leads, failed to submit applications or his resume and provided incorrect or invalid information for prospective employers. RX2, Genex rpts. #5, 6, 7, 10, 11, 14 and 15.

Petitioner testified and the vocational progress reports indicate that the petitioner did not apply to job leads because he does not drive however; he testified that he does take public transportation.

On cross-examination, Petitioner was queried regarding two specific, prospective employers that he refused to apply with, the restaurant, Fogo de Chao and AMC theaters. Petitioner testified that he did not recall being asked to apply for these jobs, but conceded the point when he was shown two letters addressed to him from Genex. RX3.

Ms. Cullen also recommended that the petitioner participate in a computer-training program. On August 28, 2013, Petitioner was contacted by MedVoc Rehabilitation, Ltd. ("MedVoc") to initiate a more structured vocational program; which included computer training. The introductory letter explained the vocational process and included various authorizations and releases. RX2.

During his initial meeting with Ms. Natalie M. Maurin, a MedVoc rehabilitative consultant, Petitioner reported that he was not currently active in the union. While working with MedVoc, Petitioner did not applying to all job leads or complete the job applications. Petitioner testified that some of the leads were in a "seedy" area" or difficult to get to. RX2, rpt. 12/16/13.

On January 9, 2014, Ms. Egle, a MedVoc representative, accompanied Petitioner to a prospective employer, to assist him in completing an application. The report states that while waiting to complete the application, Petitioner made disparaging comments about the employer, within earshot of the receptionist, as she was approaching the front desk. RX 2, rpt 1/27/14.

MedVoc also noted inconsistencies with Petitioner's reported employer contacts, specifically, petitioner's job leads for December 9, 13, 16 and 20, 2013. RX2, rpt. 1/27/14.

On November 4, 2013, MedVoc identified twenty-one (21) prospective employers that indicated that they would consider hiring the petitioner, given his education, work history and work restrictions. Their wages ranged from $8.25-$14.25 and the mean wage is $10.58. The petitioner did not apply for any of these jobs identified in this labor market survey. RX2, Market Survey dated 11/4/13.

On September 12, 2014, MedVoc identified fifteen (15) prospective employers willing to hire Petitioner given his education, work history and work restrictions. The positions varied in wage and the mean wage was $11.12 per hour. Petitioner testified that he did not apply to any of the jobs identified in this labor market survey.

Petitioner testified that in March 2014, he found a job as a delivery person at Sit Down Restaurant. He testified that he earns $8.25 per hour and that he is currently working full-time. He takes the bus to work and it takes him approximately 40 minutes to an hour to get there.

Petitioner testified that he was a member of union local 76 and he had personal knowledge that the laborers for Respondent currently earn $38.00 per hour. However, he agreed that there is no way for him to know how much he would be making today if he still worked for the respondent. Petitioner is seeking a wage differential award.

CONCLUSIONS OF LAW

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

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In

addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

While Petitioner's testimony regarding mechanism of injury is not crisp, in reviewing the medical records, it is apparent that the petitioner injured himself while at work therefore, the Arbitrator finds that the petitioner has proven, by a preponderance of the evidence, that his accident arose out of and in the course of his employment by Respondent.

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

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).

Following the petitioner's arthroscopic repair, Dr. Heller evaluated him and noted that at the time of surgery he had full thickness cartilage defect and osteophytes, indicative of osteoarthritis.

On May 4, 2012, Dr. Heller noted that petitioner was functioning at a medium level and given petitioner's age, the doctor opined that Petitioner would probably remain functioning at a medium level, on a permanent basis.

The Arbitrator finds that the petitioner's current condition of ill-being is related to his osteoarthritis, age and exacerbated by the work-related accident.

K. What temporary benefits are in dispute?"

The Petitioner claims to be entitled to further TPD benefits from June 28, 2014 through November 30, 2014; and maintenance benefits from December 29, 2012 through June 27, 2014. The Arbitrator finds that petitioner failed to substantially comply with vocational rehabilitation services that were provided by the respondent; and failed to provide a diligent job search. The Arbitrator finds that the petitioner essentially sabotaged some of his job search efforts and therefore, interfered with his ability to secure adequate and gainful employment. As such, Petitioner is not entitled to further maintenance or TPD benefits.

Petitioner testified that he was notified by the respondent that his restrictions could not be accommodated, but he did not provide any evidence to suggest that from June 29, 2012 through August 8, 2012, he looked for work.

The Commission has found that in the absence of "good faith" cooperation with vocational rehabilitation efforts, the termination of temporary total disability benefits is justified. *Hayden v. Industrial Commission,* 214 Ill.App.3d 749, 574 N.E.2d 99, 103, 158 Ill.Dec. 305 (1st Dist. 1991).

The Supreme Court has held that, it is the petitioner's obligation to make "good-faith efforts to cooperate in the rehabilitation effort." *Archer Daniels Midland Co. v. Industrial Commission,* 138 Ill.2d 107, 561 N.E.2d 623, 149 Ill.Dec.253 (1990).

The Commission has held that when the petitioner lacks the intent to return to work... the employee is (was) not entitled to benefits and was not permanently, totally disabled. *Schoon v. Industrial Commission,* 259 Ill.App.3d 587, 630 N.E.2d 1341, 197 Ill. Dec 217 (3d Dist. 1994).

As such, Petitioner did nyot show good faith cooperation with the respondent's efforts at vocational rehabilitation therefore, he is not entitled to maintenance or TPD benefits. Respondent shall receive a credit for maintenance benefits paid.

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

The petitioner has not proven. By a preponderance of the evidence, that he is entitled to a wage differential, as provided in Section 8(d)1 of the Act. The petitioner has failed to satisfy the second prong of 8(d)1 "and the average amount which he is earning or is able to earn in some suitable employment or business after the accident." The petitioner failed to make a good-faith effort to co-operate with the vocational rehabilitation services provided by Respondent. When presented with

employment opportunities by the respondent, the petitioner either sabotaged his efforts or made no effort at all, to seek employment with those employers provided to him. As a result, he limited himself to positions that paid less.

Petitioner claims that he was only able to find a job paying $8.25 per hour. The respondent asserts that there were more suitable employment opportunities, as identified by the labor market surveys dated November 3, 2013 and September 12, 2014. The labor market surveys identified employers willing to hire the petitioner, with a mean wage of $10.58 to $11.12 per hour.

Petitioner worked with two vocational rehabilitation companies, both companies' representatives stating that the petitioner's behavior sabotaged his efforts to obtain employment. Petitioner found a job paying $8.25, which is the minimum wage; he states that he is a deliveryman, but reported that he does not drive or have a driver's license.

Petitioner testified that he did not apply to various jobs provided by MedVoc and Genex because they were too far from his home or in dangerous areas, but the petitioner's commutes to his current job, by public transportation, for forty (40) minutes to one (1) hour.

Petitioner testified that he has personal knowledge of what a cement mixer would make today, but was unable to say for sure what he would make if he was still working for Respondent. Petitioner testified that he was still a member of local union 76, but reported to MedVoc that he was no longer a union member.

Petitioner offered into evidence, a document that references salary information for laborer's local 1092 and laborers local 1001, however, petitioner's job title, according to Respondent, was that of cement mixer. Further, these documents do not support petitioner's testimony that he is a member of local union 76.

The Arbitrator finds that the petitioner has not proven, by a preponderance of the evidence that he is entitled to a wage differential, as identified in the Workers' Compensation Act. The Arbitrator awards 15% loss of use of a person.

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12WC8827
SIGNATURE PAGE

Signature of Arbitrator

January 23, 2015
Date of Decision

JAN 2 3 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lori Smith,
Petitioner,

vs. No. 12 WC 09395

Havana Amusements d/b/a Hair Studio Spa & Fitness,
Respondent.

16IWCC0598

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 Corrected Decision[1] of Arbitrator Dollison finding that Petitioner proved her bilateral carpal tunnel syndrome and left cubital tunnel syndrome were casually related to repetitive trauma on March 15, 2011, and vacates the Arbitrator's award of medical expenses, temporary total disability and permanent partial disability. A copy of the Arbitrator's Corrected Decision is attached hereto and made a part hereof.

Petitioner testified she is a cosmetologist who, prior to purchasing and operating her own business, Head To Toe Salon in December 2011, worked at Respondent's salon, Hair Studio Spa and Fitness, from 2003 until June 9, 2011. Her duties at Respondent included cutting men's and women's hair, shampooing and massaging scalps, using scissors, vibrating electric clippers, drills, blow dryers, combs, brushes and buffers. She also performed manicures and pedicures. Since June 9, 2011, she has performed similar duties at other salons. While at Respondent, Petitioner worked 35-40 hours per week, each day spending an average of: 3-4 hours doing hair, 2-2½ hours using a nail drill, and 2½ hours using a buffer.

[1] In the initial Arbitration decision issued on July 1, 2015, the Arbitrator awarded Petitioner, inter alia, §8(e) benefits of: **93.125 weeks**, including, "12-1/2% loss of the right hand (**30.75 weeks**)." The July 30, 2015 corrected Arbitration decision revised the figures of this award to: **88 weeks**, including, "12-1/2% loss of the right hand (**25.625 weeks**)."

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Petitioner testified she first noticed pain, tingling and numbness in her wrists, hands and fingers while working at Respondent's salon in the fall of 2010. She did not seek medical treatment until March 15, 2011, when she went to the office of Dr. Richard Wagoner, MD, and saw his physician's assistant, Sherie Turner. She also saw Dr. Wagoner on April 26, 2011. Dr. Wagoner prescribed ibuprofen and exercises, and gave her a wrist splint, which she wore to work. Around March 15, 2011, Petitioner provided oral notice of her wrist pain to Respondent's owner, Vanessa Bergman.

Petitioner last worked for Respondent on June 9, 2011. On that date, Vanessa asked her to leave because she had heard that Petitioner was buying a competing business. Petitioner testified she told Vanessa that wasn't true; however, the very next day Petitioner posted the following on her Facebook page: "U hoo everyone... I am now at Totally Fit, I will b[e] the new owner soon! ... Call my cell..." On June 12, 2011, Petitioner also posted on Facebook, "...I set goals 4 myself always. I have met another; by getting my own place..." Petitioner filed her instant workers' compensation claim after her termination by Respondent.

Between June 10, 2011 and December 11, 2011, Petitioner applied for and received unemployment benefits. She testified that during that period, she would often visit her friend Kim Larson at Totally Fit Salon, but Petitioner denied doing any work there or anywhere else, until December 2011 when she began operating Head To Toe Salon. On cross-examination, however, Petitioner admitted that during that period, her clients followed her to Totally Fit Salon; she bartered her cosmetologist services in exchange for donations, materials and services, and she put feathers in the hair of her daughter and her friends. Petitioner further admitted that on July 25, 2011 she posted a Facebook message announcing that she went to work at 7:00 am that day and did a pedicure. Her clients also posted messages on Petitioner's Facebook page, indicating that they had or would be scheduling appointments for her services, including: haircuts, feathers, manicures and pedicures. Kim Larson testified at arbitration that beginning June 2011, Petitioner came to Totally Fit Salon and worked there three days a week, answering the phone and conducting her own personal business.

After seeing Dr. Wagoner on April 26, 2011, Petitioner received no further medical care until March 23, 2012, when she saw Dr. Edward Trudeau, MD, for NCV testing. Thereafter, she saw Dr. Blair Rhode, MD, who administered an injection to her left wrist and then ultimately performed left carpal and cubital tunnel releases on September 18, 2012, and a right carpal tunnel release on February 26, 2013. Dr. Rhode released her from care on April 28, 2013.

Rochelle Hurst, a stylist who worked with Petitioner at Respondent's salon, testified at arbitration that Petitioner complained to her that work made her wrist stiff and sore. She also testified that the Oster clipper which Petitioner may have used produced some vibration.

Dru Bergman, president of Respondent, testified that Petitioner never informed him she was suffering from a work-related condition; he first learned of Petitioner's claim when he received a letter from her attorneys dated March 11, 2012. Vanessa Bergman testified that she is a hair stylist for Respondent and also performs administrative tasks of the business. In early 2011, Petitioner was in Respondent's salon 36 hours a week but she did not always work the entire day; she usually had 1 to 2 hours of downtime each day. Around March 15, 2011,

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Petitioner told Vanessa that her wrists hurt and she had carpal tunnel. Petitioner wore a wrist splint, but she did not say it was related it to her employment. Vanessa first received notice of Petitioner alleged claim when she received a letter from Petitioner's attorney around June 2012.

Dr. Blair Rhode, MD, a board certified orthopedic surgeon, testified via deposition that when he first examined Petitioner on June 13, 2012, she gave him a history of work-related bilateral wrist and left elbow pain and numbness for the past 3 years. Dr. Rhode performed a left cubital release and a left carpal tunnel release on September 18, 2012, and a right carpal tunnel release on February 26, 2013. Dr. Rhode opined that Petitioner's job as a cosmetologist is highly repetitive, specifically her utilization of scissors – Petitioner reported 70,000 repetitions per day. Dr. Rhode relied upon this history from Petitioner, along with other information, to come to his opinion that her carpal tunnel syndrome and cubital tunnel syndrome were related to her job exposure. He acknowledged that carpal tunnel can be idiopathic, and that Petitioner may have had other risk factors for developing this condition, including being female and obese.

On cross-examination, Dr. Rhode also admitted that: between June 2011 and March 13, 2012, Petitioner continued to work as a cosmetologist although he did not know where; the findings on her March 13, 2012 EMG could have arisen after she stopped working at Respondent on June 9, 2011; Petitioner told him her symptoms actually began around June 2009; Petitioner's body mass index (BMI) above 30 is associated with carpal tunnel syndrome; Petitioner's treaters documented no complaints from her or diagnoses regarding any right-sided condition or right carpal tunnel condition on March 15, 2011 and on April 26, 2011; Dr. Rhode had no independent knowledge of the number of hand repetitions Petitioner performed in her job, other than what she described; and, Dr. Wagoner's records show that on April 26, 2011, he did evaluate Petitioners left wrist for a compressive neuropathy by performing Tinel and Phalen's maneuvers, both of which were negative.

On April 24, 2013, Dr. Rhode prepared a nature and extent report utilizing AMA Impairment Guide Ratings; he found Petitioner had 0% impairment ratings to both upper extremities and she could work full duty.

Dr. Michael Vender, MD, a board certified hand surgeon with a certification in hand surgery, saw Petitioner on August 27, 2012 for a Section 12 examination at which he also took x-rays. He also reviewed her medical records and job description. He testified via deposition that Petitioner reported a history of bilateral upper extremity pain, numbness and tingling since March 2009. Dr. Vender diagnosed bilateral carpal tunnel syndrome and left epicondylitis, and perhaps a left ulnar neuropathy. He opined that Petitioner's conditions were not related to her job activities at Respondent, because: the nature of her work activities did not cause any special stresses across her elbows; she performed many different types of activities which involved different use patterns of her hands; she did not have any persistent repetitiveness in her work, and Petitioner had very limited forceful work. Dr. Vender also testified that Petitioner presented with several of the major risk factors for carpal and cubital tunnel: her age, her gender and her increased body mass index. When Petitioner last worked for Respondent in June 2011, there were no indications of right upper extremity problems; those only developed well after she left Respondent. Petitioner's left hand complaints when she worked for Respondent were more suggestive of de Quervain's disease rather than carpal tunnel syndrome. Dr. Vender testified that the fact that she did not have any EMG or NCV studies until 9 months after she last worked for

Respondent broke the chronological relationship and substantiated that she didn't have symptoms while she was working there.

Medical records from Petitioner's primary physician, Dr. Richard Wagoner, MD, were introduced into evidence. Although Dr. Rhode reported that Petitioner had been treating with Dr. Wagoner for bilateral elbow and wrist pain since 2009, Dr. Wagoner's records (PX5) offered into evidence contain no notes of any treatment prior to the March 15, 2011 date of accident alleged by Petitioner. Dr. Wagoner's records show that on March 15, 2011, Petitioner presented to his physician's assistant, Sherie Turner, complaining of left wrist pain which came on gradually over the past 4 months, but which became really bad on March 11, 2011. Petitioner reported her pain was aggravated by her work as a hairdresser and pedicurist, and although she denied having prior similar symptoms, Petitioner was concerned she might have carpal tunnel syndrome. Sherie Turner's impression was that Petitioner had left wrist pain, probably secondary to DeQuervain tenosynovitis. On April 26, 2011, Dr. Wagoner examined Petitioner, who at that time was still complaining of left wrist pain. Dr. Wagoner's assessment was, "likely overuse injury." He recommended consideration of further imaging and/or nerve conduction studies if her problems continued. Petitioner, however, neither sought nor received any treatment for 11 months. By then, she had left Respondent's employ, worked at Totally Fit Salon from June 10, 2011 through December 2011, and then continued working at her own business, Head To Toe Salon. On March 13, 2012, Petitioner saw Dr. Edward Trudeau, MD, who conducted an NCV test which showed bilateral carpal tunnel syndrome and left cubital tunnel syndrome.

The Commission finds Petitioner's credibility lacking. In addition to her varying reports of when her symptoms began, her arbitration testimony was contradicted by other evidence: her testimony that when she went to Dr. Wagoner's office in March 2011 she complained of pain, tingling and numbness in both wrists, fingers and hands is contradicted by Dr. Wagoner's records, which document no complaints of right wrist or left elbow pain, and which specifically note that Petitioner, "denies numbness." Petitioner denied to her employer on June 9, 2011 that she was purchasing a competing business, yet the very next day she announced on Facebook that she was. She testified that during the six months after she left Respondent's employment, she did not have a job, did not work anywhere, and did no repetitive work with her hands other than work around her house. But when Petitioner was confronted with evidence clearly showing she was working during this time, she admitted she had been. Even Dr. Rhode was aware that Petitioner continued working as a cosmetologist after June 2011. The Commission also finds Petitioner's claim of performing 70,000 hand repetitions per day while working at Respondent to be unsupported by evidence or even explanation. Given her one to two hours of downtime each day, as well as her other various duties such as shampooing and massaging client's scalps, using electric clippers, blow-drying and combing hair, none of which entails 10,000 repetitions per hour as Petitioner reported to Dr. Rhode, the Commission finds Petitioner's figure exaggerated.

There is no evidence that Petitioner missed any work due to elbow or wrist problems while she was employed by Respondent. The only records in evidence which document treatment Petitioner received while working for Respondent were the records from Dr. Wagoner's office dated March 15, 2011 and April 26, 2011 showing left wrist complaints only – despite evidence showing Petitioner had been treating with Dr. Wagoner for bilateral elbow pain and wrist pain, "for the last 3 years," before June 13, 2012. (PX7, 6/13/12 note.)

The above evidence suggests that, prior to March 15, 2011, Petitioner may have known she had, or may have even been diagnosed with, carpal tunnel syndrome and cubital tunnel syndrome. She mentioned to Sherie Turner on that date that she was concerned she might have carpal tunnel syndrome, and volunteered that she had previously been diagnosed with right cubital tunnel syndrome. Vanessa Bergman testified that Petitioner told her on or about that date that she had carpal tunnel syndrome, though she denied Petitioner told her it was work-related.

Based on the evidence of record, the Commission finds the Petitioner did not present credible evidence that would establish the manifestation date to be March 15, 2011. While records may exist which would confirm a manifestation date earlier than March 13, 2012, the date of the EMG/NCV test, such have not been offered into evidence. The evidence which is in the record is conflicting and does not adequately corroborate March 15, 2011 to be the manifestation date: Petitioner's March 15, 2011 history of symptoms to Sherie Turner, reporting pain, "for the past four months," and Petitioner's denial of prior symptoms in that same report (PX5); her report to Dr. Vender that she had been experiencing bilateral upper extremity pain, numbness and tingling since March 2009 (RX1, pp 5-7), and her history to Dr. Rhode of work-related bilateral wrist and left elbow pain and numbness for which she had been treating since June 2009 (PX7)).

The Commission further finds Petitioner did not prove she sustained an *accident* occurring or manifesting on March 15, 2011. On that date, Petitioner only complained of left wrist pain, which Sherie Turner, considered to be secondary to DeQuervain's tenosynovitis. Dr. Vender agreed with that assessment. On April 26, 2011, Dr. Wagoner diagnosed her left wrist pain as most likely being an overuse injury. No right sided complaints were documented in any of Petitioner's medical records until almost one year later, long after she had left Respondent's employ.

The Commission also finds Petitioner has not proven her bilateral carpal tunnel syndrome or her left cubital tunnel syndrome was *causally related* to her work at Respondent. In so finding, the Commission finds the opinions of Dr. Vender, a surgeon who specializes in hand surgeries, more persuasive than those of Dr. Rhode. Dr. Vender opined that Petitioner's work at Respondent was not forceful or repetitive enough to have caused her conditions. He found her duties were varied throughout her day. He noted she had other risk factors for developing her conditions. He believed it was more likely than not that the findings on her March 13, 2012 NCV testing arose after she left Respondent's employment.

The Commission finds Dr. Rhode's causation opinion less persuasive than Dr. Vender's for several reasons. He acknowledged that the findings on Petitioner's 3/13/12 EMG test could have arisen after she ended her employment at Respondent. He admitted his causation opinion was based upon Petitioner's unsubstantiated history to him of 70,000 hand repetitions per day. Because Dr. Rhode relied upon Petitioner's misleading and inaccurate history, the Commission finds his opinions to be flawed and not persuasive.

16IWCC0598

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision of the Arbitrator filed July 30, 2015 is hereby reversed, and the arbitration award of all benefits under that Decision, including medical expenses under §8(a) of the Act, temporary total disability under §8(b) of the Act and permanent partial disability under §8(e) of the Act, is hereby vacated.

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

DATED: SEP 16 2016

o-08/15/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

SMITH, LORI
Employee/Petitioner

Case# **12WC009395**

HAVANA AMUSEMENTS D/B/A HAIR STUDIO SPA & FITNESS
Employer/Respondent

16IWCC0598

On 7/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1824 STRONG LAW OFFICES
HANIA SOHAIL
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0507 RUSIN & MACIOROWSKI LTD
THOMAS P CROWLEY
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
CORRECTED

Lori Smith
Employee/Petitioner

v.

Havana Amusements d/b/a Hair Studio Spa & Fitness
Employer/Respondent

Case # 12WC 09395

16IWCC0598

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed out to each party. The matter was heard by the Honorable **Gregory Dollison** Arbitrator of the Commission, in the city of **Peoria, Illinois on March 23, 2015 and May 27, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0598

FINDINGS

On **3/15/11**, 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 her employment.

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

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

In the year preceding the injury, Petitioner earned $16,420.19; the average weekly wage was $315.77.

On the date of accident, Petitioner was **50** years of age, ***single*** with **two** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of $0.

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 $286.00/week for 16-3/7 weeks, commencing September 18, 2012 through November 14, 2012 and February 26, 2013 through April 24, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, in the amount of $81,792.62, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week for 88 weeks, because the injuries sustained caused the 15% loss of the left hand (30.75 weeks); 12-1/2% loss of the right hand (25.625 weeks); and 12-1/2% loss of the left arm (31.625 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.

Signature of Arbitrator

7/29/15
Date

JUL 30 2015

ARBITRATOR FINDINGS OF FACTS

Petitioner filed an Application for Adjustment of Claim on June 11, 2012. The Application for Adjustment of Claim alleges that Petitioner sustained a repetitive trauma injury to both her hands and arms on March 15, 2011.

Petitioner testified that on March 15, 2011 she had been employed by Respondent, Havana Amusements d/b/a Hair Studio Spa & Fitness, as a cosmetologist and a nail technician. Petitioner testified that she started working for Respondent in April 2005. Petitioner testified that she is left hand dominant. She testified that as a cosmetologist and a nail technician she was required to use tools like scissors, curling irons, flat irons, combs and brushes, coloring bowls, brushes, nail filers, electrical drills, blow dryers, electrical clippers and nail buffers. Petitioner testified that part of her job duties also included using her hands for giving a deep tissue massage. Petitioner testified that essentially all aspects of her job duties required the use her hands. Petitioner testified that while using scissors and curling irons she has to flex her elbows in awkward positions. Petitioner also testified that when using hair clippers she has to hold the hair clippers in an awkward position. Petitioner provided that the some of the tools she used, including the electrical nail driller and the hair clippers, would produce vibration. In addition to the above, Petitioner also provided that she would perform general office and computer duties including booking appointments, answering the telephone, and following up with clients.

Petitioner testified that she would work anywhere from 32 to 40 hours a week, 6 to 7 hours a day. Petitioner testified that throughout the day she is using repetitive motion including when she is using hair cutting tools, curling irons, flat irons, and shampooing and coloring client's hair. Petitioner submitted what is titled "Petitioner's Job Description Form" which purports to be a form filled out and signed by Petitioner on November 30, 2012. (PX 4) Petitioner's testimony regarding her job description is consistent with what's documented in said form. Also submitted is a document titled "Job Description." This document dated March 26, 2012 appears to have been prepared and completed by Respondent. The document provides that Petitioner was required to frequently use simple grasping with both her right and left hands. Petitioner was occasionally to engage in fine manipulation with her right and left hand and push and pull with her hands. (PX 3)

Petitioner testified that while in performance of her job duties she started experiencing problems in the Fall of 2010. She complained of numbness in both wrists, fingers, and hands with associated tingling and also problems with her bilateral elbows including pain in her elbow that was aggravated by movements of her hands. On March 15, 2011, Petitioner presented at the offices of Dr. Richard Wagoner of the Havana Medical Group. At that visit she was seen by physician's assistant Sherie Turner with complaints of left wrist pain that has come on gradually over the past four months. Petitioner claimed that the pain was aggravated by her work as a hairdresser and pedicurist. The pain was constant, but was aggravated by certain movements. She indicated that ulnar deviation of the left wrist aggravated the pain across the radial aspect of her left wrist into her thumb. She occasionally experienced mild tingling in the distal aspect of her index, long, and ring fingers. Petitioner denied any numbness. She denied a history of similar symptoms. She was concerned that she may have carpal tunnel syndrome as she previously had right cubital tunnel surgery. Upon examination, the physician's assistant found mild tenderness to palpation over the distal head of the radius and ulna with no deformities palpable. There was tenderness over the base of the metacarpal joint of the thumb. There was mildly positive Finklestein's testing and the radial pulse was intact, bilateral, and symmetric. The physician's assistant's impression was left wrist pain, probably secondary to De Quervain's tenosynovitis and differential diagnoses would include carpal tunnel syndrome. She was given a left wrist splint which Petitioner was to wear while inactive and at night while sleeping. She was to follow up with Dr. Wagoner at the next available opportunity at which time a cortisone injection could be considered if no improvement was noted. (PX 5) Petitioner testified that at that time, her left

hand complaints were worse than the right. She also indicated her elbow complaints were worse on the right than the left.

Petitioner testified that after her visit to the doctor's office, she presented to work wearing the prescribed splint. Petitioner provided that she notified the office manager, Ms.Vanessa Bergman, of her condition and advised that her condition was associated with her job activities.

Petitioner next presented to offices of Dr. Wagoner on April 26, 2011. Records submitted show she reported she was still having left wrist pain on both the medial and lateral aspect. She reported it was usually worse after she completed multiple pedicures. Otherwise, she reported it felt good. Upon examination of the left wrist, Dr. Wagner noted no pain with palpation over the lateral medial aspect. Petitioner had good range of motion with both abduction and adduction and flexion-extension of the wrist. Petitioner had a negative Finkelstein maneuver, Tinel and Phalen test. Dr. Wagner noted that Petitioner's left wrist pain was likely an overuse injury. He wanted to consider an entrapment syndrome. He noted Petitioner seemed to be getting relief with over-the-counter Motrin and Petitioner should continue with this therapy. If this continued to be a problem, Dr. Wagoner would consider further imaging or nerve conduction studies. Petitioner also had a history of elevated blood sugar, depression, and hypertension. (PX 5)

Petitioner testified that although she continued experiencing symptomatology, she continued to work for Respondent until June 9, 2011 when she was terminated. Petitioner testified that she was instructed to "pack your things and leave" when Respondent, Ms.Vanessa Bergman, learned she was exploring buying her own salon.

Petitioner testified that she acquired and started a new business, Head to Toe Salon, on December 9, 2011. Petitioner testified that she acquired the salon from a previous owner. Petitioner testified that before she acquired Head to Toe Salon, the prior Salon named Totally Fit in Havana was ran by her friend Kimberly Larson. Petitioner stated that she was unemployed between her termination in June 2011 and the opening the salon in December 2011. During that timeframe, she would from time-to-time appear at Totally Fit and voluntarily give a haircut or perform pedicures for family or acquaintances. She provided that she never actually worked at Totally Fit and never charged for any of the services she performed at Totally Fit. Petitioner's testimony is consistent with what was submitted as Respondent's Exhibit #2, being Facebook postings associated with Petitioner and her relationship with Totally Fit. Petitioner testified that after opening her salon she continued to perform the duties of a cosmetologist.

Petitioner testified that after the April 26, 2011 visit with Dr. Wagoner, she did not receive any medical care until March 13, 2012, when she saw Dr. Edward Trudeau for EMG/NCV testing. Petitioner stated that due to her economic situation, she could not afford to seek any medical care or treatment any sooner. Dr. Trudeau's EMG/NCV testing revealed bilateral median neuropathy at the wrist, moderately severe on either side, with the left greater than right. The testing also revealed cubital tunnel syndrome at the left elbow that was mild to moderately severe. (PX 6)

Following the EMG/NCV study, Petitioner returned to Dr. Wagoner on March 23, 2012. Dr. Wagoner documented the findings of the study. The doctor noted Petitioner continued having numbness, tingling and weakness in her hands and pain in the left elbow. Also noted was that Petitioner wanted to pursue release by surgery. Dr. Wagoner diagnosed her with worsening bilateral carpal tunnel syndrome and left cubital tunnel syndrome. Dr. Wagoner referred her to an orthopedic physician. (PX 5)

Records submitted show that on June 13, 2012, Petitioner presented to Dr. Rhode's with a referral from Dr. Wagoner. Dr. Rhode at that time noted that Petitioner complained of bilateral wrist pain and numbness and tingling to the thumb, index and long finger. She also complained of left medial-sided elbow pain with numbness and tingling to the ring and little finger. Dr. Rhode noted that Petitioner had been working as a cosmetologist for the last seven (7) years. Petitioner described that she had been experiencing symptomatology for approximately three (3) years. Petitioner described her job duties as cutting hair for approximately 50% of the time and the other 50% of the time consisted of a pedicurist/nail technician. Dr. Rhode noted that while performing pedicures, she administered foot massages. After obtaining a history, performing a physical examination and reviewing the EMG/NCV study performed by Dr. Trudeau, Dr. Rhode diagnosed bilateral carpal tunnel and left cubital tunnel syndrome. Dr. Rhode noted that Petitioner had performed the duties of cosmetologist for seven (7) years that required her to cut hair as well as perform pedicures and perform foot massage. Dr. Rhode noted Petitioner did not have diabetes or thyroid dysfunction. Dr. Rhode also noted Petitioner had previously underwent oral medication and bracing. Dr. Rhode during his visit proceeded with a left carpal tunnel steroid injection. Dr. Rhode indicated that if the injection did not provide relief, a left carpal and cubital tunnel release would be appropriate. (PX 7)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Michael Vender on August 29, 2012. In his report dated same, Dr. Vender provided that he reviewed job information which he noted included activities of shampooing, hair combing, hair brushing, hair drying, hair coloring, and perming and styling hair, pedicures, manicures, curling hair, and cutting hair in addition to performing massages to people's feet. Dr. Vender opined that the above referenced were not the type of activities that would affect structures around the elbow such as the ulnar nerve or lateral epicondylar musculature. He opined that there was not a pattern of forceful, repetitive work to be considered contributory to possible carpal tunnel syndrome. He identified additional risk factors for Petitioner's condition, such as her age and gender, along with increased body mass. Dr. Vender also opined that the treatment through the date of his evaluation was reasonable. (RX 7, dep #2)

On September 18, 2012, Dr. Rhode performed left carpal and cubital tunnel release surgery. (PX 8) (The Arbitrator notes that although the records of Dr. Rhode document right carpal tunnel and cubital tunnel releases, the doctor provided during depositional testimony, that the procedure was in fact a left sided carpal tunnel and left sided cubital tunnel release.)

On November 13, 2012, Dr. Vender authored a subsequent Section 12 report. Dr. Vender reviewed additional medical records including the operative report from the September 18, 2012 surgery. Dr. Vender provided that the additional information did not change his August 29, 2012 opinion. (RX 7, dep #4)

Post-operatively, Petitioner continued to treat with Dr. Rhode. On November 14, 2012, Dr. Rhode noted Petitioner continued to experience subjective complaints of right-sided carpal tunnel symptomatology. He noted she had attempted conservative management and at that point she was unwilling to live with her symptomatology. The doctor wrote that Petitioner wished to proceed with surgical intervention. (PX 7)

On February 26, 2013, Dr. Rhode performed right open carpal tunnel release surgery. (PX 9) Post-operatively, Petitioner returned to Dr. Rhode on April 24, 2013. The doctor recorded that Petitioner wanted to return to full-duty work. At that time Petitioner stated she experienced occasional palmar wrist pain. Dr. Rhode released Petitioner to full-duty work and placed her at maximum medical improvement. (PX 7)

The Arbitrator notes that after proceeding with surgical intervention, Dr. Rhode placed Petitioner off work from September 18, 2012 through November 14, 2012, with regards to her left carpal and cubital tunnel

surgery and then from February 26, 2013 through April 24, 2013, with regards to her right carpal tunnel surgery.

Dr. Rhode also provided a nature and extent report dated April 28, 2013. At that time he conducted an examination to determine the nature and extent of the disability. Dr. Rhode noted Petitioner was status post left carpal and left cubital tunnel release and a right carpal tunnel release. Dr. Rhode provided an impairment rating of 0% of the upper extremities and 0% total person impairment. (PX 7)

On March 31, 2014, Dr. Vender authored a third report. Dr. Vender noted that he reviewed all the previous provided medical records which included treating evaluations along with a job description and electrodiagnostic studies. Dr. Vender noted that prior to Petitioner leaving employ with Respondent, she only had limited evaluation to her left wrist and the records did not indicate any complaints referable to her right upper extremity. The doctor opined that "[i]t is more likely than not the findings of the EMG/NCV testing arose after she left the employment of Havana Amusement." The doctor also felt the treating records indicate causes other than her job duties as the etiology of Petitioner's bilateral upper extremity complaints. (RX 7, dep #3)

Petitioner testified that she feels "a lot better." She provided that she has some loss of strength in her hands. She has difficulty opening tubes of color and bleach. She experiences achiness when busy and with daily activities. Petitioner also provided that she experiences no "real problems" with her right elbow. She takes over-the-counter medication once or twice a week as needed. She continues to perform her regular duties as a cosmetologist on a full time basis.

Kimberly Larson was called to testify on behalf of Petitioner in this matter. Ms. Larson testified that she previously worked at Totally Fit in Havana. Ms. Larson testified that Petitioner did not start working at that location until she acquired her business, Head to Toe Salon. Ms. Larson testified that Petitioner was "in and out" of the facility prior to the acquisition. She provided that Petitioner would answer phones "and stuff."Ms. Larson inferred that Petitioner would occasionally provide service to a family member.

Rachelle Hurst was called to testify on behalf of Petitioner in this matter. Ms. Hurst testified that she worked as stylist for Respondent from March 2001 through November 2012. She and Petitioner were employed by Respondent at the same time. Ms. Hurst testified that she talked to Petitioner about the problems with her wrist. She stated that Petitioner said that her left wrist hurt with messages, and sometimes her right wrist hurt. She observed Petitioner wearing splints at work. Ms. Hurst also testified that Petitioner did not specifically state to her that her wrist pain was related to her job, but Petitioner did indicate that the job made them worse.

Respondent presented Mr. Dru Bergman as a witness in this case. Mr. Bergman testified that he is the President of the corporation known as Havana Amusements Incorporated, D/B/A Hair Studio and Spa. He is a 100% owner, and there are no outstanding shares of ownership. Mr. Bergman testified that he never received notice from Petitioner that she was alleging work-related conditions or repetitive trauma at any point during her employment with Respondent. Mr. Bergman testified that the first notice he received of any workplace injury was when he received a letter from Petitioner's attorney, the Law Office of Todd Strong & Associates, sometime in 2012.

Respondent also presented Vanessa Bergman as a witness. Ms. Bergman testified that she is the Secretary of the corporation Havana Amusements Incorporated, and currently manages and runs the salon known as Hair Studio and Spa. She performs the duties of a cosmetologist as well as the administrative duties including booking appointments and answering the telephone. She also performs payroll and other similar administrative duties. Ms. Bergman testified that she did not receive any notice from Petitioner of a claimed

work-related condition either in the Fall of 2010 or in March 2011. Ms. Bergman stated that in March 2011, Petitioner presented to work wearing a wrist splint. Ms. Bergman indicated Petitioner informed her that the doctor told her she had carpal tunnel. Ms. Bergman stated that however, Petitioner did not state the carpal tunnel was related to work at Respondent. Ms. Bergman testified that the first notice she received that Petitioner was alleging a work-related condition was when she received a letter from Petitioner's attorney in June 2012.

On cross-examination, Ms. Bergman testified that she may have received notice earlier than the June 2012 letter from Todd Strong's law office. Ms. Bergman acknowledged filling out a form outlining Petitioner's job duties sometime in March 2012, likely at the request of her workers' compensation insurance carrier.

Dr. Rhode testified by deposition in this matter on March 13, 2014. Dr. Rhode testified Petitioner first presented to him upon referral from Dr. Wagoner on June 13, 2012. Dr. Rhode testified that after obtaining a history, performing an examination and reviewing an EMG/NCV study he diagnosed Petitioner with left carpal and cubital syndrome and right carpal tunnel syndrome. The doctor provided that as a result of his diagnoses he performed a left carpal and cubital tunnel release. The doctor noted a typographical error exists in the operative report on September 18, 2012. Dr. Rhode testified that Petitioner underwent left carpal and cubital tunnel release as opposed to the right carpal and cubital tunnel release noted on the report. (PX 13, pgs.9-12) Dr. Rhode testified that postoperatively, Petitioner continued to demonstrate symptoms in her right wrist and he ultimately performed a right carpal tunnel release on February 26, 2013. He released her at maximum medical improvement on April 24, 2013. (PX 13, pgs. 13-16)

During the deposition, Dr. Rhode was asked to review job descriptions of a cosmetologist prepared by both Petitioner and Respondent (PX 3 and PX 4), as well as the description prepared in his initial intake form. Dr. Rhode opined that "a cosmetologist's job is highly repetitive. You know, obviously there's a – there's typically a dominance to that, to the job specifically with utilizing scissors." Dr. Rhode provided that Petitioner was left handed and she was more symptomatic on the left which he felt supported the dose-response theory. Dr. Rhode added, "If you look at, you know, her breakout of repetition (referring to Petitioner's Exhibit 4)…she got 70,000 repetitions per day, 8 to 10,000 per hour…she's doing hair cutting, she's doing pedicures, manicures, massaging, working with rollers." With respect to vibratory exposure, with exception to electric scissors, Dr. Rhode did not feel the electric cutters would meet his threshold. (PX 13, pgs. 18-19) Dr. Rhode explained that dose response means the amount of exposure. He stated "you know you do an activity and you have a result and there's a threshold where you become symptomatic. And, obviously, it differs from individual to individual; it differs from job to job…" (PX 13, p. 20)

Dr. Rhode testified that besides occupational causes, there are other risk factors associated with carpal tunnel. He felt that other than the fact Petitioner was a female, she did not have any risk factors associated with carpal tunnel. Dr. Rhode summarized his opinion on causal connection testifying that based on the history provided and the information that was made available to him (referring to Petitioner's Exhibit 3 and 4), Petitioner's job exposure was causative to her carpal and cubital tunnel syndrome. The doctor stated, "…based upon the patient's job exposure, based on the fact that she was even more symptomatic on her dominant side; that she, in this job duty, I think would be heavily hand-dominant-dependent. What I mean by that is: I don't know if you have ever tried to cut scissors with your non dominant hand, It's not easy…You know she's using scissor and all that, she's primarily using that with her left hand which was her more symptomatic side. You would think that in an idiopathic, that it would be random and symmetric bilaterally. Again, that the patient's risk factor, so to speak, would be that she's a female. She didn't have a history of diabetes or thyroid dysfunction."(PX 13, pgs. 22-23)

Dr. Rhode when further asked about occupational causes for cubital tunnel, he testified that they are similar to those with carpal tunnel adding that "...the patient had to assume a lot of posture; a lot of repetitive flexion-extension of the elbow. A lot of hyper flexion can cause the symptoms." Dr. Rhode believed that the Petitioner's job exposure was causative to her left cubital tunnel syndrome. (PX 13, p. 24)

On cross-examination, Dr. Rhode was asked if the findings on the EMG/NCV testing that was done on March 13, 2012, could have arisen after she stopped employment at Respondent in June 2011, Dr. Rhode replied, "that's not the way the patient described her symptoms to me, but yes." (PX 13, p. 29) When asked what is the force required for someone to operate scissors while cutting hair, the doctor stated, "I think that the activities, especially in a dexterous fashion, is the static hold that you have maintain your thenar muscle in a static hold for extended period of time...there's significant literature out there to support haircutting as a causative mechanism for carpal tunnel syndrome." (PX 13, pgs. 39-40)

Respondent's Section 12 examiner testified via deposition in this matter on August 4, 2014. Dr. Vender opined that Petitioner suffered from bilateral carpal tunnel syndrome along with possible ulnar neuropathy and left elbow lateral epicondylitis. Dr. Vender testified that Petitioner provided a history that she was a cosmetologist. He also reviewed a job description that was prepared by Petitioner (Petitioner's Exhibit 4). Dr. Vender provided that he did not believe the diagnoses at the time of his examination were related to Petitioner's job activities with Respondent. Dr. Vender explained that "...while there was some onset of symptoms on the left side while she was working there, there were never any symptoms indicated on the right side while she was working on there...As far as just the general principle, whether it's right, left, or bilateral, the nature would not cause the types of problem indentified." With respect to the elbow, Dr. Vender stated, "there's nothing that she does that represents any special stresses across the elbows...basically all of her activities would be considered utilizing the hand and wrists..." Dr. Vender went on to state, "...she performs many different types of activities that involve different use patterns of the hands. So you don't have the concept of persistent repetitiveness, doing the same type of activities, that may lead to any particular condition. Also, very importantly, the forceful nature of the work would be very limited. There may be elements of intermittent force, but there's no indication of any significant persistent forceful use." (RX 7, pgs. 14-16) Dr. Vender stated that Petitioner had risk factors that could cause or contribute to her condition other than employment factors. In her case, the doctor provided Petitioner had the appropriate age and gender; she had increased body mass index; and she had a history of elevated blood sugar. (RX 7, p. 17) When asked about the significance of the EMG/NCV study being done after she stopped working for Respondent, Dr. Vender stated same "breaks the chronology relationship and substantiates that she didn't have the symptoms while she was working there and this developed afterwards." (RX 7, p. 20)

On cross-examination, Dr. Vender testified that the treatment Petitioner received was reasonable. Dr. Vender testified that that he was not aware whether Petitioner was working part time or full time at Respondent. He was unaware as to how many hours per day Petitioner worked at Respondent. He was also unaware regarding the breakdown as how much time Petitioner spent working as a cosmetologist/hair stylist or a nail technician/pedicurist. (RX 7, pg. 33-34)

With respect to (C.) Did an accident occur that arose out of and in the course of the Petitioner's employment by Respondent and (F.)Is Petitioner's condition of ill-being causally related to the injuries, the Arbitrator finds as follows:

The Arbitrator having had the opportunity to listen to Petitioner's testimony finds and acknowledges that Petitioner testified credibly at the time of the arbitration. Petitioner testified that on March 15, 2011 she had been employed by Respondent, Havana Amusements d/b/a Hair Studio Spa & Fitness, as a cosmetologist and a

nail technician. Petitioner testified that she started working for Respondent in April 2005. She continued to work at Havana Amusements d/b/a Hair Studio Spa & Fitness until June 9, 2011, when she was terminated.

Petitioner is left hand dominant. As a cosmetologist and a nail technician she was required to use numerous tools, i.e., scissors, curling irons, flat irons, combs and brushes, coloring bowls, brushes, nail filers, electrical drills, blow dryers, electrical clippers and nail buffers. Her job duties also included using her hands for giving a deep tissue massage. Essentially all aspects of her job duties required the use her hands. Petitioner's credible testimony demonstrates that while using scissors and curling irons she has to flex her elbows in awkward positions. Also, when using hair clippers she had to hold the hair clippers in an awkward position. Some of the tools she used, including the electrical nail driller and the hair clippers, would produce vibration.

Petitioner worked anywhere from 32 to 40 hours a week, 6 to 7 hours a day. Throughout the day she is using repetitive motion including when she is using hair cutting tools, curling irons, flat irons, and shampooing and coloring client's hair. Petitioner's testimony regarding her job description is consistent with what's documented in Petitioner's Exhibit No. 3 titled "Petitioner's Job Description Form" which purports to be a form filled out and signed by Petitioner on November 30, 2012. Her testimony is further buttressed by Petitioner's Exhibit No. 4, a document titled "Job Description "prepared and completed by Respondent on March 26, 2012. Also of note is the testimony of Respondent's manager, Ms. Venessa Bergman, who indicated that Petitioner's testimony was consistent with the job duties. The Arbitrator also notes that Ms. Bergman concurred that the nail buffers required constant gripping and grasping and that the nail drills and hair clippers produce vibration.

Petitioner credibly testified that in the Fall of 2010, she began experiencing numbness in both wrists, fingers, and hands with associated tingling and also problems with her elbow that was aggravated by movements of her hands. On March 15, 2011, Petitioner presented at the offices of Dr. Richard Wagoner of the Havana Medical Group. At that visit she was seen by physician's assistant Sherie Turner who documented complaints of left wrist pain that has come on gradually over the past four months. Petitioner claimed that the pain was aggravated by her work as a hairdresser and pedicurist. The pain was constant, but was aggravated by certain movements. She denied a history of similar symptoms. She was concerned that she may have carpal tunnel syndrome as she previously had right cubital tunnel surgery. Petitioner was assessed with left wrist pain, probably secondary to De Quervain's tenosynovitis and differential diagnoses would include carpal tunnel syndrome. Petitioner credibly testified that she did not complain about the right hand at that time because her left hand complaints were worse than the right. She also indicated her elbow complaints were worse on the right than the left.

Petitioner next presented to offices of Dr. Wagoner on April 26, 2011. Dr. Wagner noted Petitioner's left wrist pain was likely an overuse injury. The doctor noted that if her symptoms continued further imaging or nerve conduction studies would be appropriate.

Petitioner continued experiencing symptomatology. She continued to work for Respondent until June 9, 2011 when she was terminated. Subsequent thereto, Petitioner acquired and started her own salon, Head to Toe Salon, on December 9, 2011. During that three month period Petitioner would from time-to-time voluntarily perform a haircut and/or pedicures for family or acquaintances. She never charged for any of the services performed.

Petitioner did not receive any further medical care until March 13, 2012, when she saw Dr. Edward Trudeau for EMG/NCV testing. The diagnostic testing revealed bilateral median neuropathy at the wrist, moderately severe on either side, with the left greater than right. The testing also revealed cubital tunnel

STATE OF ILLINOIS)
) SS.
COUNTY OF KANE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Winburn,

Petitioner,

vs. No. 12 WC 22124

State of Illinois,

16IWCC0617

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of evidentiary rulings, causal connection, medical expenses, section 8(j) credit, permanent disability, penalties and attorney 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.

Petitioner's application for adjustment of claim alleges that on May 1, 2012, Petitioner sustained accidental work-related injuries to the back. Petitioner, a juvenile prison guard at St. Charles Youth Center, testified that he worked for Respondent for over 26 years. In 2012, Petitioner worked the third (night) shift, which was easier than the other two shifts because the inmates were usually asleep. On May 1, 2012, Petitioner had to restrain a violent inmate. After the incident, Petitioner noticed soreness in his right low back and near the tailbone. Petitioner reported the incident, completed associated paperwork, and went home. The accident report in evidence is consistent with Petitioner's testimony.

The following day, Petitioner began treating with Dr. Michael Bauer, a chiropractor with whom he had previously treated from January through April of 2011 after a prior work-related injury to the back. Petitioner stated he worked full duty from February of 2011 until the work

accident on May 1, 2012. The medical records from Chiropractor Bauer, spanning the time period from May 2, 2012, through February 14, 2013, note persistent low back pain after an incident with a hostile inmate on May 1, 2012. On May 2, 2012, Petitioner rated the pain a 9/10. Over the course of treatment, Petitioner generally rated the pain a 7-8/10.

The medical records in evidence further show that on May 21, 2012, Petitioner consulted Dr. Ankur Chhadia at Suburban Orthopaedics on a referral from Dr. Bauer. Dr. Chhadia opined the work accident permanently aggravated Petitioner's preexisting low back condition. Dr. Chhadia prescribed medication and instructed Petitioner to continue physical therapy with Dr. Bauer. On June 18, 2012, Petitioner followed up with Dr. Chhadia, reporting severe, persistent symptoms. Dr. Chhadia ordered an MRI. On June 29, 2012, Dr. Chhadia reviewed the MRI results with Petitioner, noting "disc desiccation and bulge and spondylolisthesis." The MRI report in evidence notes "[d]isk desiccation and mild bulge at L4-5" and "[b]ilateral spondylolysis of L5 without listhesis." Dr. Chhadia referred Petitioner to a pain management specialist.

On July 27, 2012, Petitioner saw Dr. Dmitry Novoseletsky, a pain management specialist at Suburban Orthopaedics. Petitioner complained of back pain with some tingling in the right leg. Dr. Novoseletsky took Petitioner off work and ordered an EMG, which Petitioner underwent on August 9, 2012. The EMG/NCV showed "[b]ilateral L5 radiculitis." On September 17, 2012, Petitioner followed up with Dr. Novoseletsky, reporting no change in his condition. Petitioner's main problem was back pain. Dr. Novoseletsky recommended a lumbar epidural steroid injection. On October 10, 2012, Dr. Novoseletsky performed the injection at L5-S1. On October 24, 2012, Petitioner followed up, reporting no significant relief from the injection. Dr. Novoseletsky recommended additional injections. Petitioner testified that Respondent did not approve the injections. Instead, Respondent scheduled a section 12 examination with Dr. Daniel Troy at Midwest Orthopaedic Consultants.

On January 8, 2013, Petitioner was examined by Dr. Troy. During his testimony, Petitioner denied sustaining or reporting to Dr. Troy any work injuries to his back other than the ones he sustained in January of 2011 and on May 1, 2012. Petitioner added that the only other work injury he sustained occurred in October of 1990 and involved his leg.

The report from Dr. Troy notes the following history: "The claimant has suffered a significant number of Work Comp. injuries over the last several years. On September 21, 2007, [the claimant] reported injuring his lower back while he was lifting boxes. On November 19, 2004, he reported another lower back injury when he attempted to sit in a chair and its legs collapsed. On September 30, 2009, the claimant twisted his lower back *** when he attempted to break up a fight between two hostile youths. An additional back injury occurred on June 10, 2010, when [the claimant] was struggling to restrain another hostile youth. On January 19, 2011, the claimant slipped on the ice and again twisted his lower back. ¶ [The claimant's] most recent claim occurred on May 2, 2012, when he attempted to restrain a combative youth and again injured his lower back." Petitioner complained of persistent low back pain. He also reported

developing pain down his right leg after 15 minutes of sitting. The pain would usually resolve upon standing. Dr. Troy noted: "[He] appears to have a long-term relationship with Drs. Bauer and Freeland at West Chicago Chiropractic Clinic." Later in the report, Dr. Troy stated: "Although the full medical records from Drs. Freeland and Bauer were not available, it seems that the patient has received years of treatment with these doctors." Dr. Troy's understanding of Petitioner's course of treatment after the accident on May 1, 2012, was as follows: "The claimant reported only one evaluation with Dr. Novoseletsky and stated that he has not received any treatments for his lower back since October of 2012 at Suburban Orthopaedics for Lyrica and meloxicam refills. *** [The claimant] has only received chiropractic treatments since the time of his injury, and attended therapy three times a week for several months." Later in his report, Dr. Troy stated: "[The claimant] received chiropractic intervention during the month of May and then was evaluated by Suburban Orthopaedics twice. He reportedly continued chiropractic therapy from July to October three times per week. The claimant has been treated with Lyrica, a Medrol-Dosepak, and meloxicam. [The claimant] has not received any further evaluation outside of chiropractic treatment since July of 2012. He returned to Suburban Orthopedics one time in October for a medication refill only. The note from this visit was not available for review."

On physical examination, Dr. Troy noted a reduced range of motion. X-rays obtained in the office showed "mild degenerative disc disease at the L4-5 and L5-S1 level with a questionable lytic defect at the L5-S1 level." Dr. Troy further noted: "The MRI films and report of the lumbosacral spine were reviewed and demonstrated mild degenerative disc disease at the L4-5 level. There was no foraminal or spinal stenosis. Bilateral L5-S1 spondylitic defects were present. No spinal or foraminal stenosis was present at this level either. All findings were chronic in nature."

Dr. Troy opined the work accident on May 1, 2012, caused "a lumbosacral strain and aggravation of pre-existing degenerative changes." Regarding Petitioner's present condition, Dr. Troy opined: "I do not believe that the claimant's lumbosacral pain is secondary to the alleged occurrence on May 1, 2012. [The claimant] may have had a temporary aggravation of pre-existing degenerative changes to his back, but more likely suffered a lumbosacral strain which should have resolved with two to three physical therapy sessions a week over six to twelve weeks. *** From my standpoint, he should have returned to full duty work by August 2012." On the subject of maximum medical improvement, Dr. Troy stated: "I do believe [the claimant] has reached a level of maximum medical improvement and I would have placed him at MMI as of August 1, 2012. Because of the significant pre-existing changes at the L4-5 and L5-S1 levels, [the claimant] is at great risk for reinjuring his back again through activities of daily living as well as incidents at work. He may even need surgical intervention in the future to address this chronic pain condition but any further treatment for his low-back is not Work Comp. related." Among his conclusions, Dr. Troy stated: "The claimant has been treated extensively for the alleged occurrence on May 1, 2012, and he should have been returned back to work full-duty as of August 1, 2012. The claimant's chronic low-back difficulties have been documented for many years. It would be helpful to review the records from Drs. Bauer and Freeland to assess how long

this patient has been receiving chiropractic treatment and to determine if he has sought physical therapy treatment elsewhere for his multiple Work Comp. injuries."

Petitioner testified that after Dr. Troy's examination, Respondent advised him that he had been released to return to work full duty and required no further treatment. Petitioner introduced into evidence a letter from Respondent dated February 5, 2013, declaring him at maximum medical improvement and terminating temporary total disability benefits based on the opinions of Dr. Troy. Petitioner testified that on February 5, 2013, he returned to work full duty, even though he continued to suffer from severe back pain. Because Petitioner worked the third shift, he was able to perform his job duties, albeit with difficulty. Fortunately, there were no incidents requiring him to use physical force.

After returning to work, Petitioner continued to treat for his low back condition through his group medical insurance. The medical records show that on February 7, 2013, Petitioner consulted his primary care physician, Dr. Ashok Kumar at DuPage Medical Group. Petitioner requested a referral to an orthopedic surgeon through his group medical plan. Dr. Kumar referred Petitioner to a spine surgeon. On February 14, 2013, Petitioner saw the physician's assistant of Dr. Ronjon Paul. Petitioner reported that he returned to work on February 5, 2013. The physician's assistant noted: "[H]e states that he has been tolerating it, but he is significantly painful and he feels like if he was on any other shift as opposed to the third shift, that he would be unable to fulfill his job requirements." Petitioner complained of low back pain radiating to the right posterior thigh and calf, with numbness and tingling. On March 1, 2013, Petitioner saw Dr. Paul, who noted that X-rays and the MRI showed "minimal changes but no spondylolysis. Flexion and extension films were taken today and they do not show a significant spondylolisthesis." Dr. Paul referred Petitioner to a physiatrist. On March 5, 2013, Petitioner saw Dr. Lena Shahbandar, who recommended physical therapy, trial facet injections and possible radiofrequency ablation. Petitioner underwent physical therapy from March 8 through May 9, 2013. Petitioner underwent facet injections at L4-L5 and L5-S1 on March 12 and April 1, 2013. Lastly, on May 3, 2013, Petitioner underwent radiofrequency ablation of the medial branch nerves from L3 through L5.

Petitioner testified the radiofrequency ablation helped a great deal, and he stopped treating for his injuries after May 9, 2013. Regarding his current condition, Petitioner testified: "I am a little older. I don't feel that great. * * * I don't have any [back pain]. I don't have any nerve pain, sharp pains. I have some dull pain but I don't know if it's old age. I don't think I have any pain as a result of that injury anymore." Petitioner continued that he has "[m]ild" back pain "from time to time but that could be attributed to working or overexerting myself. I am not going to say I have pain every day because I certainly do not." Petitioner felt fully capable of performing his regular job duties.

On cross-examination, Petitioner was asked about the prior injuries Dr. Troy mentioned in his report. Petitioner recalled injuring his low back while lifting boxes at work on September 21, 2007. Petitioner also recalled injuring his low back when a chair collapsed as he sat down on

November 19, 2004. Petitioner did not recall whether he sustained back injuries in June of 2010 or September of 2009.

The Arbitrator found that Petitioner failed to prove a causal connection between the work-related back injury he sustained on May 1, 2012, and his condition of ill-being after August 1, 2012. We disagree.

The Commission gives little weight to the opinions of Dr. Troy. Dr. Troy's report indicates he was forwarded very few medical records. As a result, Dr. Troy was unaware that on August 9, 2012, Petitioner underwent electrodiagnostic studies, which showed bilateral L5 radiculitis. On October 10, 2012, Dr. Novoseletsky performed an epidural steroid injection at L5-S1. When Petitioner reported no improvement, Dr. Novoseletsky recommended additional injections. Dr. Troy was apparently unaware that the reason Petitioner did not receive treatment since October of 2012 was because Respondent denied further treatment.

The Commission finds it significant that although Petitioner had a preexisting low back condition, he was able to perform his regular job duties before the work accident on May 1, 2012. The accident caused Petitioner's low back condition to become much more painful, necessitating considerable conservative treatment. The Commission finds Petitioner did not reach maximum medical improvement until May of 2013.

The Commission awards related medical bills in evidence pursuant to sections 8(a) and 8.2 of the Act and the appellate court decision in Tower Automotive v. Workers' Compensation Comm'n, 407 Ill. App. 3d 427, 438 (2011) (the purpose of the Act is satisfied when the employee is relieved of the costs of reasonable and necessary medical care. The Act does not contemplate a windfall to the employee).[1] Correspondingly, the Commission awards Respondent a credit for the medical bills paid by Respondent and the medical bills paid/adjusted by the group medical plan, provided that Respondent holds Petitioner harmless from any claims by the group medical plan.

Regarding the nature and extent of Petitioner's disability, the Commission finds the injuries sustained caused permanent disability to the extent of 5 percent of the person as a whole.

Turning to penalties and attorney fees, the Commission finds the Arbitrator erred in rejecting Petitioner's Exhibits 24 through 28. The exhibits consist of the petition for penalties and attorney fees, and emails from Petitioner's counsel to Respondent's counsel demanding payment of benefits. Petitioner seeks penalties and attorney fees for failure to timely pay his medical bills. Having carefully considered the entire record, including Petitioner's being less than forthcoming during his testimony about his prior back injuries, the Commission finds that penalties and attorney fees are not warranted.

[1] The Commission did not consider the "Fee Schedule Exhibit" attached to Petitioner's brief because the exhibit violates section 19(e), which prohibits introduction of new evidence on review.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 15, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence pursuant to §§8(a) and 8.2 of the Act and the appellate court decision in Tower Automotive v. Workers' Compensation Comm'n.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit for all medical benefits that have been paid. Respondent shall hold Petitioner harmless from any claims the group medical plan.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 5 percent disability to 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.

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

SEP 27 2016

DATED:
o-08/25/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WINBURN, JAMES
Employee/Petitioner

Case# **12WC022124**

STATE OF ILLINOIS
Employer/Respondent

16IWCC0617

On 9/15/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4220 LULAY LAW OFFICES
MICHAEL LULAY
2323 NAPERVILLE RD SUITE 220
NAPERVILLE, IL 60563

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
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1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

SEP 15 2015

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

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

James Winburn
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

16IWCC0617

Case # 12 WC 22124

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 **Ketki Steffen**, Arbitrator of the Commission, in the city of **Geneva**, on **March 12, 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 **PX 24-28.**

16IWCC0617

FINDINGS

On **May 1, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$72,192.12**; the average weekly wage was **$1,388.31**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **1** dependent children.

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

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

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

Respondent is entitled to Section 8 (J) for bills paid under the group health care for treatment rendered on or before the MMI date of 8/1/12.

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services for treatment rendered on of before August 1, 2012 as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 3% loss of use of man as a whole pursuant to §8(d)2 of the Act.

Penalties

Petitioner's request for penalties is declined

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

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

Kethi Steffen

Signature of Arbitrator

9/15/15

Date

SEP 15 2015

PROCEDURAL HISTOY

This matter was first commenced for a hearing before Arbitrator Ketki Steffen at the Geneva, Illinois site on June 12, 2014. The matter was continued and Petitioner was allowed leave to file an amended penalty petition. The matter was finally concluded at the Chicago hearing site on July 8, 2015. Petitioner did file an amended penalty petition but failed to serve the same upon the Respondent. Respondent objected to the amended petition based on lack of notice. The Arbitrator will address the penalty issue based on the initial penalty petition and because the stipulation sheet (AX1) list the same as one of the issues to be decided.

FACTUAL HISTORY

Petitioner, James Winburn, works for the Respondent, State of Illinois. This action was filed in regards to an injury he sustained during the course of his employment on May 1, 2015.

Petitioner testified that he worked for Illinois Department of Juvenile Justice. At the time of his accident he was married with one child under age 18. He was employed by the Illinois Department of Juvenile Justice as a Juvenile Justice Specialist for 26 years. Petitioner's duties include direct supervision of juvenile inmates, movements, count, and security. If warranted, petitioner is required to physically restrain or encounter youth inmates.

In 2012, Petitioner was working the third shift and explained, "There is not as much going on obviously at night. Everybody is pretty much asleep, but on occasion there are movements at nighttime and inmates to deal with." T. 15. On May 1, 2012, a violent inmate was brought into the Youth Prison in restraints. T. 15. Petitioner testified,

"Our procedure involves a second set of restraints with a lead chain that is to be led through a chuckhole and the door secured, and then the lead chains are removed from restraints and then the restraints are removed. In the process of putting these new restraints on, he became combative and struggled with that and in the process I hurt my back." T. 15-16. Petitioner testified that this inmate was 6 feet 2 inches and 180 pounds. T. 16. Petitioner was injured when he grabbed the inmate's arms and restrained him down to the bed. T. 17. Petitioner had an onset of back pain a couple minutes after the incident happened. T. 18. Petitioner felt this pain near his tailbone all the way across the back area and predominately on the right side with a sharp and dull pain. T. 19.

Petitioner filled out paperwork about the incident approximately 15 minutes after it happened. T. 20. Petitioner's supervisor was present during the altercation and was made aware that the Petitioner injured his back. T. 20. Petitioner thought his back was getting worse as the time went on into the hour after the incident. T. 21-22. Petitioner did not complete his work day and went home with his supervisor's permission. T. 22.

Petitioner presented for medical care with Dr. Michael Bauer, a chiropractor, the day after the incident. T. 22-23. Petitioner had last seen Dr. Bauer in April of 2011 connected to a prior work injury where he fell on ice at work. T. 23. Petitioner testified he performed his work fully since the 2011 injury. T. 24. Petitioner was off work for his ice injury for approximately 4 weeks. T. 24. Petitioner sought no medical care after his treatment for his ice injury. T. 25.

When Petitioner saw Dr. Bauer after the injury in this case, Petitioner's treatment included adjustments, massage therapy, hot packs, and electric stimulation. T. 25.

Petitioner testified, unlike his ice injury, his pain for his injury in the instant case was a sharp pain. T. 26. Petitioner did not have sharp pain for this ice injury. T. 26. Petitioner rated his pain with Dr. Bauer for the instant case at probably 9 out of 10. T. 26. Petitioner was sent to Dr. Chhadia at Suburban Orthopedics by Dr. Bauer. T. 26-27. Petitioner was given restricted work duties and stopped working after May 2, 2012. Petitioner testified he received extended benefits after the injury due to the incident involving inmate violence. T. 27.

Petitioner saw Dr. Chhadia and an examination was performed on May 21, 2012. T. 28. Dr. Chhadia discussed a treatment plan with Petitioner. T. 28. Petitioner was then told to return to Dr. Chhadia in 4 weeks and medication was prescribed. T. 29. And that time Petitioner was put on limited duty. T. 29. Petitioner testified that he had informed Respondent about his limited work duty and that he had not been accepted back to work. T. 29. Petitioner was told to continue to see Dr. Bauer. T. 29. Petitioner saw Dr. Chhadia on June 18, 2012 expressing that he was not able to sleep due to his pain and that his condition was not improving. T. 29-30. Petitioner testified his sleep was interrupted by his ice fall, but not as bad as in this instant case. T. 30.

Petitioner had an MRI completed on June 26, 2012 and was referred to a pain management doctor for possible injection. T. 31. When petitioner was seeing Dr. Bauer, he was performing many active physical exercises. T. 32-33. Petitioner did see Dr. Novoseletsky, a pain management doctor, on July 27, 2012. T. 34. Dr. Novoseletsky performed an examination on the Petitioner. T. 35. Petitioner testified he saw Dr. Novoseletsky on September 17, 2012 and at that time his condition was staying the same. T. 35.

Petitioner testified he had complaints of pain going down his leg and that it felt like it went to sleep for a short time. T. 36. Petitioner testified that sitting would cause this type of feeling. T. 36-37. Petitioner was prescribed a lumbar epidural steroid injection, which was performed on October 10, 2012. T. 37. Petitioner was continuing with his physical therapy with Dr. Bauer at this time. T. 37. Petitioner testified that the first shot did not have much of an effect. T. 37. Dr. Novoseletsky wanted to do another shot and Petitioner was interested in that. T. 38.

Petitioner saw Respondent's Section 12 doctor, Dr. Daniel Troy, on January 8, 2012. The medical report from Dr. Troy's examination is introduced into evidence. (RX1) Dr. Troy opined that that Petitioner suffered a lumbosacral strain and that after extensive treatment his condition reached MMI as of August 1, 2012. Dr. Troy notes that the Petitioner has a long history of low-back difficulties due to pre-existing degenerative changes at the L4-5 and L5-S1 levels. He also notes that Petitioner has received extensive chiropractic therapy three times a week from May to October, although he should have returned to full duty as early as August, 2102. Dr. Tory noted the extensive documented history of Petitioner's chronic back pain and multiple prior reported injuries.

Petitioner testified regarding is IME visit with Dr. Troy. He states his visit was 10 or 15 minutes. T. 39. Petitioner did not remember filling out any forms and just talked to Dr. Troy. T. 39. Petitioner was asked if there would be any reason for why he would tell Dr. Troy that he only saw Dr. Novoseletsky once when in fact he had seen him 4 times. T. 40. Petitioner answered that there were no reasons and that he would have told Dr. Troy the number of visits and "[w]hatever he asked I would have told him." T. 40.

Petitioner recalled Dr. Troy had a copy of a disk, which was probably an MRI disk, but Petitioner did not know what other records he had. T. 40. Petitioner did not remember if Dr. Troy asked him whether he had any pain shooting down his leg, but Petitioner testified that if he had he would have shared it with him. T. 40-41. Petitioner was asked, "He writes in his report, the claimant has recorded a significant number of work injuries involving his lower back. Did you tell the doctor any words to that effect?" Petitioner answered, "If he asked me if I had a prior injury, I would have told him, yes, and when." T. 41. Petitioner testified he did not tell Dr. Troy he had other prior work injuries to his back other than the ice fall in January 2011. T. 41. Petitioner testified that the work injuries to his back consisted of the injury in January 2011 and the injury in the present case. T. 41.

Petitioner testified he had a workers' compensation case for his foot back in October of 1990. T. 42. Petitioner did not recall Dr. Troy, or any other doctor, making any statements to him that Petitioner has a long-standing degeneration going on in his back. T. 42. Petitioner testified there would have been no reason why he would have told Dr. Troy he stopped physical therapy in October, as it was on going in January. T. 42-43.

Petitioner went on to testify there would have been no reason he would have not wanted Dr. Troy to know about the shot he received and the shot recommended by Dr. Novoseletsky and if Dr. Troy asked him about that, he would have told him. T. 43. Petitioner testified that Dr. Ron Paul explained Petitioner needed more shots. T. 44. After his independent medical evaluation, Petitioner was released to come back to full work duty. T. 44-45. Petitioner testified he went back to work due to financial necessity.

T. 45. Petitioner was asked how he was feeling going back in performing all of his duties and he testified, "On the third shift, unless there is an emergency going on or I am dealing with a hostile inmate which I never had to during that time, it's pretty much a quiet atmosphere, walking cell houses, counting, and I was able to move around a lot, lie on my back on the day room floor if I needed to. T. 46. Petitioner testified that he was called upon to deal physically with a prisoner, that would not have been advisable and he would not have had a choice. T. 46. However, Petitioner testified that during this time back to work, there were no incidents requiring him to become physically involved with a prisoner. T. 47.

Petitioner testified in February of 2013 that his low back pain condition was no different and had pain at 9 out of 10 at that time and that he was still interested in pursuing treatment. T. 48. Petitioner saw Dr. Kumar and then saw a PA, Mr. Paul Ellis, and that PA noted back pain radiating down his right leg upon sitting down a long time. T. 48-49. Petitioner later met with Dr. Ronjon Paul, a spine surgeon. T. 50. Petitioner was recommended for physical therapy. T. 50. Petitioner testified he last saw Dr. Bauer in February of 2013, though he did not recall the date. T. 52.

When he began his physical therapy, Petitioner had radicular symptoms up to his right calf and back which goes away as he walked. T. 54. Petitioner testified on April 1, 2013 he came back to Dr. Sayed and reported he had about 70 to 80 percent improvement with the ability to sleep. T. 54.

Petitioner had about 30 percent overall reductions in pain. T. 54. Petitioner testified that up until this point, his sleep was still interrupted by back pain. T. 55. Petitioner testified that he did not believe the doctors were progressing him in his

treatment up until this point. T. 55. Petitioner had his second injection on April 1, 2013. T. 55. On May 3, 2013 Petitioner reported about 60 to 70 percent overall improvements in his back pain. T. 55. Petitioner was then recommended to do a burning of a nerve for "trying to get that pain to go away." T. 56. Petitioner underwent the radio frequency ablation on May 3, 2013. T. 56.

Petitioner had his final physical therapy visit on May 9, 2013 and has not been back to a doctor since. T. 56. Petitioner testified that the "last procedure helped" and he self-discharged from care at that time. T. 56.

Petitioner testified it could have been a combination of physical therapy and the shots that helped him, but he was betting it was the shot procedures that helped him. T. 58. Petitioner testified the radio frequency burn also gave him his ultimate relief. T. 58. Petitioner testified no doctor ever told him his pain was from general aging of his back and no doctor ever told him his pain was not from the May 1, 2012 injury. T. 58. Petitioner testified no doctor ever told him he only suffered a sprain from his May 1, 2012 injury. T. 58.

Petitioner testified since he saw the independent medical examiner, he is a little older and he does not feel that great. T. 59. Petitioner testified the doctors at DuPage Medical Group agreed he needed treatment similar to what Dr. Novoseletsky was going to do. T. 59.

Petitioner was asked,

> "Presently since your last shot, do you continue to suffer any back pain?" Petitioner answered, "No, I don't have any. I don't have any nerve pain, sharp pain. I have some dull pain but I don't know if its old age. I don't

think I have any pain as a result of that injury anymore. Q. Then again, you are not a doctor, right? A. No. I said I don't think. Q. Do you continue to suffer pain in your back of any type? A. Mild from time to time but that could be attributed to working or overexerting myself. I am not going to say I have pain every day because I certainly do not. Q. Nothing has taken you to a physician? A. No." T. 59-60.

Petitioner was later asked if he felt "fully capable of anything that your job would throw at you?" Petitioner answered, "Yes." T. 60. Petitioner attributed his success to the procedures done at DuPage Medical Center and the radio frequency burn. T. 60-61.

On cross-examination, Petitioner was asked, "Did you ever report an injury about your back to your employer that wasn't filed with the Workers' Compensation Commission?" T. 63. Petitioner answered, "No." T. 63. Petitioner was then they asked, "Did you ever report to your employer in June of 2010 that while restraining a hostile youth, you hurt your back?" Petitioner said he did not recall. T. 63. Petitioner testified on direct examination that he had no prior work incident at all. T. 42; 62. Petitioner was asked, "Did you ever report to your employer in September of 2009, September 30th that you twisted your lower back and injured your hands when you attempted to break up a fight between youths?" T. 63-64. Petitioner was asked, "Your answer is No? A. I don't recall. Q. Your answer is you don't recall? A. No - - yes, that's my answer." T. 64. Petitioner was then asked, "And on September 21, 2007, did you report to your employer that you injured your lower back while lifting boxes?" Petitioner answered, "Yes," and affirmed that he remembered that injury. T. 64. Petitioner was asked, "On

November 19, 2004 did you report another lower back injury, Mr. Winburn, when a chair collapsed on you when you sat down on it?" Petitioner answered, "Yes." T. 65.

Independent Medical Evaluation of Dr. Troy

Petitioner was evaluated by Dr. Troy on January 8, 2013. Dr. Troy noted Petitioner has worked for the Department of Juvenile Justice since May of 1988. Dr. Troy notes:

> "The claimant has suffered a significant number of work comp injuries over the last several years. On September 21, 2007, Mr. Winburn reported injuring his lower back while he was lifting boxes. On November 19, 2004, he reported another lower back injury when he attempted to sit in a chair and its legs collapsed. On September 30, 2009, the claimant twisted his lower back and injured his hand when he attempted to break up a fight between two hostile youth. An additional back injury occurred on June 10, 2010, when Mr. Winburn was struggling to restrain another hostile youth. On January 19, 2011, the claimant slipped on the ice and again twisted his lower back. Rx1, pg 1.

Dr Troy reviewed Petitioner's treatment history with doctors Bauer, Freeland, Chhadia, and Novoseletsky.

Regarding Petitioner's X-rays, Dr. Troy noted, "X rays of the lumbar spine demonstrated normal alignment without evidence of fracture or dislocation. There was a mild degenerative change noted and mild spondylolisthesis present at the L5 – S1 level. Dr. Chhadia believed that the claimant again sustained a lumbar strain and ordered an

MRI for further evaluation of his recurring pain. Physical therapy was recommended in addition to chiropractic sessions at West Chicago Chiropractic Treatment. The patient was continued on light duty restrictions." Rx1, page 2. Dr. Troy then went on to note, "An MRI of the lumbosacral spine was performed at Suburban MRI on June 26, 2012, and demonstrated disc desiccation and a mild bulge at the L4-5 level. There was bilateral spondylolisthesis of L5 without listhesis, disc bulge, or herniation. No foraminal narrowing or central spine canal stenosis was present. Both findings at the L4-5 and L5 - S1 levels are chronic in nature. The levels above L4 were normal in appearance. Dr. Troy notes the complete records were not provided for review. Rx1, page 2.

Dr. Troy noted, "Although he admitted to smoking on the intake history, the claimant denied that he smoked in the office. He did smell of smoke and then claimed that he smoked one cigar for day. He denies excessive alcohol use." Rx1, page 3.

Dr. Troy conducted a physical examination on Petitioner and found: "Subjective complaints of pain across the lower lumbar region bilaterally. The claimant stated that if he sat for more than 15 minutes he would develop pain down his right leg towards the front. This pain would usually resolve upon standing again. The claimant was able to flex and reach within four inches of the floor and he could extend approximately 10 degrees. He had 50 percent lateral bending and rotation." Rx1, page 3.

Dr. Troy did complete a physical examination and noted the following: "The claimant sat on the examining table without difficulty and each leg demonstrated 5 / 5 strength and no sensory deficits or hyperreflexia. The calves and thighs were soft and diffusely nontender and straight leg raise testing was negative bilaterally." Rx1, page 3.

Dr. Troy did take his own images and noted: "Lumbosacral radiographs obtained in the office today demonstrated mild degenerative disc disease at L4-5 and L5-S1 level with a questionable lytic defect at the L5 – S1 level. Plain radiographs of the pelvis were normal with well - maintained joint spaces and noted bilaterally. The MRI films and report of the lumbosacral spine were reviewed and demonstrated mild degenerative disc disease at L4-5 level. There was no foraminal or spinal stenosis. Bilateral L5-S1 spondylitic defects were present. *All findings were chronic in nature.*" Rx1, page 3 (Emphasis added). It is clear from Dr. Troy's evaluation time with Petitioner that Petitioner only told Dr. Troy about one visit with Dr. Novoseletsky and, notably, nothing more.

Dr. Troy found Petitioner's lumbosacral pain is not secondary to the occurrence on May 1, 2012. Dr. Troy finds: "Mr. Winburn may have had a temporary aggravation of pre-existing degenerative changes to his back, but more likely suffered a lumbosacral strain which should have resolved with two to three physical therapy sessions a week over six to twelve weeks. The claimant reported attending chiropractic therapy three times a week from May through October. From my standpoint, he should have returned to full duty work by August 2012." Rx1, page 4.

Dr. Troy went on to find, "because of the significant pre-existing changes at the L4-5 and L5-S1 levels, Mr. Winburn is at great risk for reinjuring his back again through activities of daily living as well as incidents at work. He may even need surgical intervention in the future to address this chronic pain condition but any further treatment for his low - back is not Work Comp. related." Rx1, page 4. Dr. Troy also found, with regard to his work injury in this case, Petitioner could return to work full duty. Rx1, page

5. Dr. Troy further found Petitioner to have no activity restrictions and that "[a]ny restrictions that the claimant currently places upon himself are subjective in nature and not related to the injury of May 2, 2012." Rx1, page 5.

FINDINGS/ANALYSIS

Is petitioner's current condition of ill - being causally connected to a work - related injury?

The Arbitrator finds that the Petitioner did suffer a lumbosacral strain, was treated extensively, and that his condition is not related to his accident of May 1, 2012. He reached MMI by August 1, 2012. Petitioner clearly suffered a work accident that is well documented and testified.to. However, Petitioner condition as a result of his work accident was a temporary aggravation that has healed and Petitioner has returned to full time, unrestricted work duties. He current complaints of occasional slight dull pain is not related to his work accident but may be the result of his long history of degenerative changes as well as age related factors (per his own admission)

The history of Petitioner's accident and injuries support the argument that Petitioner suffered a temporary sprain. The mechanism of the injury and the diagnosis of all physicians indicate a sprain type injury. Petitioner testified that he was injured at work on May 1, 2012. He related that he was involved in an altercation with a hostile inmate and while twisting and turning to restrain the prisoner, he injured his lower back. Petitioner explained that the inmate made a move towards Petitioner who then grabbed his arms and spun him around and took him down onto a nearby bed while he was kicking and resisting. The combination of this sudden twisting and lifting caused him to experience sharp low back pain. And Petitioner being dragged by the inmate caused

Petitioner the sudden onset of low back pain, which he noticed immediately after the altercation.

Within fifteen minutes of the incident, Petitioner reported the incident to his supervisor and filled out the necessary paperwork as required by his employer. PX1. Petitioner asked and was allowed to go home due to his pain and injury. The next day, Petitioner also sought treatment for his injuries at West Chicago Chiropractic. He had treated at his facility for prior back pain relating to a previous work injury. Petitioner also sought treatment with Dr. Bauer who took him off work and referred him to an orthopedic surgeon, Dr. Chhadia of Suburban Orthopedics. On May 21, 2012 Dr. Chhadia placed Petitioner on limited work duties.

Petitioner was diagnosed with a lumbosacral strain and aggravation of pre-existing degenerative changes. Dr. Chaddia ordered on MRI and referred Petitioner to an anesthesia pain management specialist for possible injections

Petitioner went to see Dr. Novoseletsky, a pain manager at Suburban Orthopedics who advised Petitioner to stay off work and get an EMG.

On August 9, 2012 Petitioner underwent an EMG but complained to Dr. Novoseletsky that his back pain had not improved. He also stated that he now had pain in his right leg. Novoseletsky administered a spinal injection on October 10, 2012. Petitioner stated that the injection provided no relief.

Petitioner continued physical therapy and home exercise as prescribed by Dr. Bauer.

On January 8, 2013 Petitioner was examined by IME,. Dr. Daniel Troy. Dr. Troy examined the Petitioner and his medical records and opined that Petitioner was able to return to full duty work. He also opined that Petitioner had reached MMI as of August 1, 2012. He specifically asked Petitioner about his prior work injuries and the epidural shot and Petitioner denied having any injuries or such treatment. (Note that during in-court testimony Petitioner denied making such statement to Dr. Troy)

Following his IME, Petitioner opted to return back to work for financial reasons and continued treatment for his back. Ultimately, on March 1, 2013 Petitioner treated with Dr. Ronjon Paul a spine surgeon at DuPage Medical. He prescribed that Petitioner see a physiatrist for therapy and to go see the pain manager at that clinic too. Petitioner treated with the psychiatrist and started treatment with Dr. Sayeed, on March 11, 2013. Dr. Sayeed provided epidural shots and Petitioner testified that he felt 70-80 % improvement. He was also treated with a second shot and a nerve burn called an RF or radiofrequency and ablation.

The nerve burn was performed on May 9, 2013 and Petitioner claims that his treatment was so helpful that he self-discharged himself for future treatment. He claims it helped so much that this was his last visit as he self-discharged from all care.

He has no more back pain, nerve pain or sharp pains as he did from the injury. He has some dull ongoing pain. He feels fully capable of doing his job again. He attributes his recovery to the shots at DuPage Medical that were denied by his employer.

Based on a review of the medical evidence as well as judging Petitioner's failure to provide a complete and honest history of his prior work injuries and back pain, the

Arbitrator finds that his condition was temporary and that his current condition is unrelated to his work accident. Clearly Petitioner suffered other back injuries dating as far back as 2004. Rx1, Petitioner was not forthcoming at all about these prior lower back injuries and, in fact indicated in court that he believed he had no prior work incidents. *See* T. 41.

The medical history introduced into evidence bears out that the Petitioner has had long-standing back problems prior to his work incident on May 1, 2012. Dr. Troy took his own images and noted: "Lumbosacral radiographs obtained in the office today demonstrated mild degenerative disc disease at L4-5 and L5-S1 level with a questionable lytic defect at the L5 – S1 level. Plain radiographs of the pelvis were normal with well - maintained joint spaces and noted bilaterally. The MRI films and report of the lumbosacral spine were reviewed and demonstrated mild degenerative disc disease at L4-5 level. There was no foraminal or spinal stenosis. Bilateral L5-S1 spondylitic defects were present. *All findings were chronic in nature.*" Rx1, page 3 (Emphasis added).

Therefore, the Arbitrator finds that Petitioner suffered a lumbosacral strain and his current condition is not related to his accident of May 1, 2012.

Were the medical services provided to the Petitioner reasonable and necessary, and has Respondent paid all appropriate charges for all reasonable and necessary medical expenses?

Petitioner seeks payment of medical fees totaling over $ 52,945.86.

A summary breakdown of the bills is as follows:

PX 18 5/2/12-2/6/13	West Chicago Family Chiropractic	$17,242.88
PX 19 5/21-10/24/12	Suburban Orthopedics	$5,205.65

PX 20 8/9/12	Precision Diagnostics	$2,460.57
PX 22	DuPage Medical Group	
8/20-5/9/13	Physician Charges:	$11,324.60
3/11; 4/1; 5/3/13	Facility Charges:	$16,712.16

A detailed breakdown of the bills is as follows:

FEE SCHEDULE EXHIBIT

1. **West Chicago Family Chiropractic**

Date	Billed Amount	CPT Code	Fee Schedule	Units
5/2/2012	$110.00	99214	$100.15	1
	$45.00	97140	$42.65	1
	$100.00	72100	$99.13	1
5/3/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/4/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/5/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/7/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/8/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/9/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/11/2015	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/14/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/16/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/19/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/22/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/24/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/26/2012	$50.00	98941	$40.37	1

	$45.00	97140	$42.65	1
5/29/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
5/31/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
	$80.00	99213	$64.92	1
6/2/2012	$50.00	98941	$40.37	1
	$45.00	97140	$42.65	1
6/4/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/6/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/8/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/11/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/13/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/15/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/18/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1

	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/20/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$50.00	97110	$43.42	1
	$45.00	97140	$42.65	1
	$30.00	97035	$29.71	1
6/22/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/25/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
6/27/2012	$50.00	97110	$43.42	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
6/29/2012	$50.00	98941	$40.37	1
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$50.00	97110	$43.42	1
7/2/2012	$45.00	97140	$42.65	1
	$50.00	97110	$43.42	1
7/5/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$45.00	97140	$42.65	1
7/9/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$20.00	97010	$20.31	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$80.00	99213	$64.92	1
7/11/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/13/2012	$100.00	97110	$86.84	2 ($43.42/unit)

	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/16/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/18/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/20/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/23/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/25/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/27/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
7/30/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/1/2012	$30.00	97014	$26.03	1
	$45.00	97140	$42.65	1
	$30.00	97035	$29.71	1
8/4/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/6/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/8/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/11/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/13/2012	$30.00	97014	$26.03	1

	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/15/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/18/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/20/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/22/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/25/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
8/27/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/29/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
8/31/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/5/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/7/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/8/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/10/2012	$100.00	97110	$86.84	2 ($43.42/unit)

	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/12/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/15/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/18/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/20/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/22/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/25/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/27/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
9/29/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/1/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/3/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1

	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/5/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/8/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/9/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/12/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/15/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/17/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/19/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/22/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/23/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/25/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1

10/29/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
10/30/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
11/5/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/7/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/9/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/12/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/14/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/16/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/19/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/23/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/26/2012	$30.00	97014	$26.03	1

	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
11/30/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/3/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/7/2012	$100.00	97110	$86.84	2 ($43.42/unit)
	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
12/10/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/14/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/17/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/20/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/26/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/29/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1
	$45.00	97140	$42.65	1
	$100.00	97110	$86.84	2 ($43.42/unit)
12/31/2012	$30.00	97014	$26.03	1
	$30.00	97035	$29.71	1

	$45.00	97140	$42.65	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/4/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/7/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/11/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/14/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/18/2013	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/22/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/25/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
1/29/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
2/1/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
2/4/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)

2/6/2013	$30.00	97014	$26.47	1
	$30.00	97035	$30.21	1
	$45.00	97140	$43.37	1
	$100.00	97110	$88.30	2 ($44.15/unit)
Subtotal:	$19,060.00		$17,242.88	

2. **Suburban Orthopaedics**

Date	Billed Amount	CPT Code	Fee Schedule	Units
5/21/2012	$149.00	72100	$99.13	1
	$429.00	99245	$280.00	1
6/18/2012	$223.00	99215	$145.71	1
6/26/2012	$1,940.00	72148	$1,309.65	1
6/29/2012	$223.00	99215	$145.71	1
7/27/2012	$149.00	99214	$100.15	1
8/9/2012	$457.00	95861	$293.08	1
	$2,056.00	95903	$163.11	1
	$572.00	95904	$109.16	1
	$200.00	95934	$127.94	1
	$200.00	95934	$127.94	1
9/17/2012	$149.00	99214	$100.15	1
10/10/2012	$15.00	J1100	$0.95	1
	$90.00	Q9966	$47.88	1 (POC 53.2)
	$329.00	77003	$233.51	1
	$857.00	62311	$636.68	1
10/24/2012	$149.00	99214	$100.15	1
	$174.00	97760	$92.56	1 (POC 53.2)
	$2,053.00	L0637	$1,092.19	1 (POC 53.2)
Subtotal:	$10,414.00		$5,205.65	

TOTAL	
Subtotal	$10,414.00
DOS's partially paid 6/18 - 7/27 by Resp. per RX2	-$1,633.16
	$8,780.84

3. **Precision Diagnostics**

Date	Billed Amount	CPT Code	Fee Schedule	Units
8/9/2012	$365.00	99243	$170.09	1

16IWCC0617

	$710.00	95861	$293.08	1
	$3,512.80	95903	$1,304.88	8
	$1,128.00	95904	$436.64	4
	$317.00	95934	$127.94	1
	$317.00	95934	$127.94	1
Subtotal:	$6,349.80		$2,460.57	

4. **DuPage Medical Group (Physician Services)**

Date	Billed Amount	CPT Code	Fee Schedule	Units
8/20/2012	$20.00	36415	$14.85	1
	$26.00	61001	$13.83	1 (POC 53.2)
	$49.00	80061	$63.94	1
	$128.00	84153	$67.73	1
	$212.00	82308	$165.41	1
	$169.00	80050	$130.62	1
9/21/2012	$152.00	99213	$64.92	1
10/25/2012	$152.00	99213	$64.92	1
1/18/2013	$152.00	99213	$66.02	1
1/22/2013	$72.00	93000	$64.54	1
	$224.00	99214	$101.84	1
2/7/2013	$152.00	99213	$66.02	1
2/13/2013	$0.00	99241	$98.78	1
2/14/2013	$265.00	99245	$284.73	1
3/1/2013	$152.00	99213	$66.02	1
	$123.00	72100	$100.81	
3/5/2013	$350.00	99204	$101.84	1
3/6/2013	$61.00	97110	$44.15	1
3/8/2013	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1
	$71.00	97112	$36.14	1
3/11/2013	$389.00	99244	$220.45	1
	$970.00	64493	$400.39	1
	$482.00	64494	$248.61	1
	$91.00	99144	$48.41	1 (POC 53.2)
3/18/2013	$61.00	97110	$44.15	1
	$114.00	97140	$43.37	1
	$71.00	97112	$36.14	1
3/20/2013	$61.00	97110	$44.15	1
	$57.00	97140	$43.37	1
	$71.00	97112	$36.14	1

	$30.00	97035	$30.21	1
	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1
3/25/2013	$61.00	97110	$44.15	1
	$57.00	97140	$43.37	1
	$71.00	97112	$36.14	1
	$38.00	97014	$26.47	1
3/27/2013	$122.00	97110	$44.15	1
	$71.00	97112	$36.14	1
4/1/2013	$970.00	64493	$400.39	1
	$482.00	64494	$248.61	1
	$91.00	99144	$48.41	1 (POC 53.2)
	$152.00	99213	$66.02	1
4/3/2013	$128.00	97110	$44.15	1
	$71.00	97112	$36.14	1
	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1
4/8/2013	$128.00	97110	$44.15	1
	$71.00	97112	$36.14	1
	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1
4/10/2013	$128.00	97110	$44.15	1
	$71.00	97112	$36.14	1
	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1
4/23/2013	$192.00	97110	$44.15	1
	$71.00	97112	$36.14	1
	$15.00	97010	$20.65	1
	$38.00	97014	$26.47	1
4/25/2013	$320.00	93971	$301.26	1
4/26/2013	$4,579.00	36478	$2,436.02	1 (POC 53.2)
4/29/2013	$320.00	93971	$301.26	1
4/30/2013	$128.00	97110	$44.15	1
	$71.00	97112	$36.14	1
	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1
5/2/2013	$128.00	97110	$44.15	1
	$59.00	97140	$43.37	1
	$71.00	97112	$36.14	1
	$38.00	97014	$26.47	1
	$15.00	97010	$20.65	1

5/3/2013	$157.00	99213	$66.02	1
	$2,854.00	64635	$1,518.32	1 (POC 53.2)
	$1,488.00	64636	$791.61	1 (POC 53.2)
	$1,488.00	64636	$791.61	1 (POC 53.2)
5/9/2013	$128.00	97110	$44.15	1
	$71.00	97112	$36.14	1
5/10/2013	$281.00	99396	$128.04	1
	$72.00	93000	$64.54	1
	$55.00	80053	$57.09	1
	$9.00	80061	$65.02	1
	$20.00	36415	$15.10	1
Subtotal:	**$20,625.00**		**$11,324.60**	

5. DMG Center for Pain Management (Facility Charges)

Date	Billed Amount	CPT Code	Fee Schedule	Units
3/11/2013	$8,320.00	64493	$400.39	1
	$6,364.00	64494	$248.61	1
	$421.00	99144	$223.97	1 (POC 53.2)
4/1/2013	$8,320.00	64493	$400.39	1
	$6,364.00	64494	$248.61	1
	$421.00	99144	$223.97	1 (POC 53.2)
5/3/2013	$11,492.00	64635	$6,113.74	1 (POC 53.2)
	$8,320.00	64636	$4,426.24	1 (POC 53.2)
	$8,320.00	64636	$4,426.24	1 (POC 53.2)
Subtotal:	**$58,342.00**		**$16,712.16**	

Total due under §8(a) **$52,945.86**

Based on her reasoning and finding that Petitioner suffered a temporary aggravation, a sprain/strain back injury and reached MMI by August 1, 2012, the Arbitrator finds that the treatment rendered to the Petitioner on or before August 1, 2012 including the IME was reasonable and related to the work injury of 5/1/2012. The Arbitrator awards the medical bill per section 8(a) and subject to the fee schedule. , Respondent is entitled to and shall receive a credit under Section 8(j) for any and all

medical expenses paid by Petitioner's state-provided insurance for treatment rendered on or before August 1, 2012.

What is the nature and extent of the injury?

This case arises out of a May 1, 2012 accident, a date after September 1, 2011 amendment of Worker's Compensation Act ("Act"). Post amendment, pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

In applying these guidelines and factors to the case at bar the Arbitrator notes that neither side has submitted an AMA rating, the Petitioner was a Juvenile Justice Specialist or correctional officer for the State of Illinois; he was 46 years of age and suffered a sprain to his back during the course of his work. Although he suffered no loss of income, Petitioner states that he has difficulties performing his work functions and sometimes has a dull back pain. The Arbitrator finds that the Petitioner age, income

occupation are neutral factors as he is of middle age and has not suffered any impediment to his job or earnings as a result of his injuries. The Arbitrator finds that although the Petitioner received extensive treatment for his back and the later treatment was not related to his work accident but likely the result of pre-existing degenerative condition which was documented to be chronic in nature. Therefore the Arbitrator finds that the Petitioner has suffered permanent partial disability of 3% of Man as a Whole arising from his May 1, 2012 accident.

Is Petitioner entitled to an award of penalties and fees?

Petitioner claims penalties and fees under Sec.19, Sec. 19(1) and Sec. 16 of the Act. Specifically, Petitioner claims that Respondent was unreasonable and vexatious in its failure to pay for the medical care rendered to the Petitioner based on the opinion of IME Dr. Troy. Petitioner claims that Dr. Troy did not have complete records and his opinion should have been disregarded.

The Arbitrator finds that Respondent's reliance on Dr. Troy's opinion was sound. Dr. Troy diagnosed Petitioner with a sprain, same as his treating physicians. Although Dr. Troy lacked a complete set of medical records, he had access to objective MRI records. Most importantly he examined the Petitioner and noted the extensive history of Petitioner's prior degenerative, chronic condition. Petitioner was less then forthright to the doctor and claims that he did reveal certain facts because the physician did not specifically question him regarding the same. The Arbitrator has examined and reread Dr. Troy's findings and finds his opinion to be sound and the Respondent's reliance upon the same to be appropriate.

The Arbitrator further notes that the Respondent continued to pay TTD benefits to the Petitioner until his IME. The Respondent has also substantial payments towards Petitioner's medical care, as evidenced by Respondent's Exhibit 2.

Therefore, Petitioner's request for Penalties and fees is denied.

Ketki Steffen
Arbitrator Ketki Shroff Steffen

9/15/15
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

TERRANCE SMITH,

Petitioner,

vs.

NO: 12 WC 23629

16IWCC0603

TRI-STATE FIRE PROTECTION DISTRICT,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 24, 2015 is hereby affirmed and adopted.

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

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

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

16IWCC0603

DATED: SEP 2 2 2016

MJB/tdm
O: 9/12/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

SMITH, TERRANCE
Employee/Petitioner

Case# **12WC023629**

TRI-STATE FIRE PROTECTION DISTRICT
Employer/Respondent

16IWCC0603

On 1/27/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0787 MEYERS & FLOWERS LLC
MICHAEL P HELLMAN
30 SECOND ST SUITE 300
ST CHARLES, IL 60174

0075 POWER & CRONIN LTD
RORY M McCANN
900 COMMERCE DR SUITE 300
OAK BROOK, IL 60523

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
CORRECTED ARBITRATION DECISION

Terrance E. Smith
Employee/Petitioner

v.

Tri-State Fire Protection District
Employer/Respondent

Case # **12** WC **23629**

Consolidated cases: ____

16IWCC0603

An *Application for Adjustment 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 **Wheaton**, on **8/24/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **May 28, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**77,286.04**; the average weekly wage was $**1,486.27**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**105,733.87** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**105,733.87**.

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

ORDER

Based on the criteria under Section 8.1b of the Act and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 55% loss of use of his body as a whole pursuant to §8(d)(2) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $695.78.per week for 275 weeks.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

1/6/15
Date

JAN 27 2016

STATE OF ILLINOIS)
)SS
COUNTY OF DUPAGE)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

TERRANCE SMITH,
Petitioner,

v.

TRI-STATE FIRE PROTECTION DISTRICT,
Respondent.

Case No: 12 WC 23629

16IWCC0603

CORRECTED
ADDENDUM TO THE DECISION OF ARBITRATOR

On July 13, 2015, this matter proceeded to hearing before Arbitrator Jessica A. Hegarty in Wheaton, Illinois. The only disputed issues are causal connection and the nature and extent of Petitioner's injury.

STATEMENT OF FACTS

The Petitioner (DOB: 9/30/53) testified that at the time of his work injury he was employed by the Respondent for the past 15 years as a firefighter and engineer.

It is uncontested that on May 28, 2012, Petitioner was injured at work while he was cleaning a large ladder truck. Petitioner had climbed up on the top of the truck carrying cleaning supplies. As he was walking past the ladder, the hood of his shirt caught on a breathing air bottle, causing him to lose his balance. Petitioner was close to the edge of the truck, so he threw everything out of his hands to try and stop from falling and then he jumped. Petitioner had to jump away from the outriggers on the ground on the side of the truck. Petitioner landed on his feet, more on the right foot than the left, and immediately fell to the ground in pain. Petitioner testified that he had immediate pain to his right leg, lower leg and ankle. He was immediately transported by ambulance to Hinsdale Hospital.

Hinsdale Hospital records note that Petitioner was diagnosed with a fracture-dislocation of the right ankle. The talus was dislocated anteriorly relative to the distal tibia. There was an impacted intra-articular comminuted fracture of the distal anterior right tibia with anteriorly displaced fracture fragments. Also noted was a displaced fracture of the distal diaphysis of the fibula and some small osseous densities adjacent to the lateral talus suggesting small avulsion fractures. As to the left foot/ankle, Petitioner was

diagnosed with a comminuted fracture of the distal fibula and lateral malleolus at the level of the ankle joint. (PX. 1)

The Petitioner underwent surgery to his right foot/ankle by Dr. Paik that same day. The surgery consisted of a right lower extremity closed reduction and application of an external fixator with screws and plates. The left ankle was splinted. Petitioner remained an in-patient at Hinsdale Hospital for 3-4 days before being transferred to Mercy Provena McAuley Manor Rehabilitation Center where he remained for approximately six weeks. (PX. 7)

On June 27, 2012, the Petitioner underwent a second surgical procedure by Dr. Paik at Bolingbrook Hospital consisting of a left ankle examination under anesthesia, a right ankle removal of the external fixator, debridement of the bone, open reduction and internal fixation of the right ankle pilon fracture along with an associated lateral malleolar fracture. (PX. 2 & 3) The post-operative diagnoses were right pilon fracture, status post closed reduction and external fixation, right talus fracture and left ankle fracture, lateral malleolus. (PX. 2 & 3)

At his December 11, 2012 follow up with Dr. Paik, Petitioner was administered an arthrocentesis injection to the right ankle and diagnosed with right ankle plantar fasciitis. (PX. 3) On December 31, 2012, Dr. Paik administered another injection and as well as aspiration to the right ankle. (Id.).

The Petitioner followed up with Dr. Paik on April 3, 2013 who noted complaints of persistent right ankle pain, swelling and soreness. The doctor noted Petitioner was limping. It was noted that Petitioner continued to experience significant limitations despite work conditioning including the inability to carry or climb ladders or stairs, kneeling, lifting from floor, pulling objects to complete work related tasks, pushing objects and repetitive standing, squatting or walking. Dr. Paik diagnosed post-traumatic arthritis and recommended Petitioner not return to full duty work. A referral to Dr. Garapati, a foot/ankle trauma specialist for a second opinion was noted. (Id.)

On April 19, 2013, Petitioner presented to Dr. Rajeev Garapati who noted a history of right ankle pain with some numbness and stinging at rest. Dr. Garapati noted that Petitioner can walk approximately one block and then is limited secondary to pain. The doctor noted swelling on the right side when compared to the left. Range of motion of the right ankle was limited from about 0-5 degrees of dorsiflexion to about 40 degrees of plantar flexion. X-rays were also reviewed which revealed significant loss of ankle joint space on right with ankle joint arthritis. Dr. Garapati gave Petitioner his choices of conservative care for the right ankle including, but not limited to injections, bracing and a cane, or ankle fusion surgery or ankle replacement surgery. (PX. 5)

On August 19, 2013, Petitioner underwent his third right ankle surgery. Dr. Michael Pinzur at Loyola University Hospital performed a right STAR ankle replacement surgery. Gastrocnemius muscle lengthening and removal of plate and screws from the right tibia were also noted (PX. 6 & 8)

Dr. Pinzur released Petitioner to light-medium work level as of March 4, 2014. At that visit, Dr. Pinzur examined the Petitioner and noted that he walked with a mild limp and had regained 50% of the motion in the right ankle following the ankle replacement surgery. Dr. Pinzur placed the Petitioner at maximum medical improvement as of that date. (PX. 8)

On June 17, 2014, the pension board awarded the Petitioner a line-of-duty disability pension pursuant to Section 4-110 of the Illinois Pension Code (40 ILCS 5/4-111). Petitioner has never returned back to work since the date of the accident.

Dr. Pinzur, on September 9, 2014, noted the Petitioner to be walking with a slight limp and had at least a 30-40 degree arc of motion. It was further noted that Petitioner's right ankle was large in size compared to the left. (PX. 8)

On May 15, 2015, Dr. Pinzur noted that plantar fasciitis had developed on Petitioner's right ankle. A very small arc of motion of the right ankle and tenderness at the origin of the plantar fascia was also indicated. (PX. 6) Dr. Pinzur opined that the plantar fasciitis was likely related to limited motion and recommended that the Petitioner obtain a prostretch device. (Id.)

Petitioner testified that as of May 2012, he was also employed as a member of the Illinois National Guard as a Lieutenant Colonel and worked in the plans, operations and training division. He had been an active member of the National Guard for around 37 years. Petitioner testified that because of his injury he had to retire from the National Guard. His unit with the Guard required war fighting and walking with loads on uneven ground and because he could no longer perform such activities, he was told by the National Guard that he had to retire. Petitioner testified that it was not his intention to retire at that time. Petitioner testified that he had been selected to lead the next unit into Afghanistan as the commander and would have been promoted to Colonel for which he had already begun training.

Petitioner was examined by Dr. Simon Lee on two separate occasions at the request of the Respondent pursuant to Section 12 of the Act. On May 12, 2014. Dr. Lee noted that Petitioner's right ankle seemed chronically swollen compared to the left. Dr. Lee noted that the left ankle had range of motion of 15 degrees of dorsiflexion, 45 degrees of plantar flexion and the right ankle had 5 degrees of dorsiflexion, 15 degrees of plantar flexion. (R.X. 1) Dr. Lee noted tenderness mainly along the lateral aspect of his joint line as well as over the lateral posterior fibular region of the right ankle. (R.X. 1) Dr. Lee also noted increased tenderness over the peroneal tendons to direct palpation. Dr. Lee also noted some mild discomfort over the anterolateral fibular joint line. (R.X. 1) Dr. Lee diagnosed status post left distal fibula fracture, resolved and right lower extremity pilon fracture status post posttraumatic arthrosis and status post total ankle arthroplasty and Achilles lengthening. (R.X. 1) Dr. Lee also opined that Petitioner's condition of ill-being in both ankles were causally related to the injury of May 28, 2012. (R.X. 1) Dr. Lee determined that Petitioner was at maximum medical improvement.

Dr. Lee also performed an AMA Impairment Rating which determined the Petitioner's impairment in his right ankle to be 37% lower impairment rating or 15% whole person impairment and determined a 0% impairment rating in relation to the left ankle.

Dr. Lee examined the Petitioner again on June 10, 2015. Petitioner reported that he continues to have limitations and difficulty with everyday activities such as negotiating stairs and climbing down stairs that have no railing. He reported that he cannot be on uneven surfaces and that he now uses a riding lawnmower as he is unable to use an upright due to his limitations. He further reported his symptoms have been progressively worsening in terms of pain and functional limitations. (R.X. 2) Petitioner informed Dr. Lee that his walking was limited to one block and could not do more than 30 minutes of any particular standing or walking activity. (R.X. 2) Petitioner also explained to Dr. Lee that in addition to the chronic ankle pain he continues to have pain in the plantar fascial region of his foot along with swelling and stiffness. (R.X. 2)

Dr. Lee's physical examination of Petitioner revealed an antalgic gait with shortened stride, generalized venous stasis changes over the right lower extremity compared to the left and generalized thickening and swelling over his right hindfoot and ankle compared to the left "unaffected" side. (R.X. 2) On the right ankle, tenderness was noted along the anterior tibiotalar joint line and over the mid arch and plantar fascial region. Diagnosis remained the same with the addition of the plantar fasciitis. (R.X. 2) Dr. Lee opined that the current complaints appear to be directly and causally related to his previous injury and that the treatment to date appeared to have been reasonable, necessary and appropriate. (R.X. 2) Dr. Lee opined that the added diagnosis of plantar fasciitis would not change the previous impairment rating and further opined that the Petitioner's objective to subjective complaints appear to be consistent and appropriate. (R.X. 2) Dr. Lee opined that the Petitioner was incapable of returning back to his previous duties as a firefighter. (R.X. 2)

Petitioner testified that he continues to take Codeine with Empirin daily. He described the pain in his right ankle as throbbing unless he hyperextends the foot and then he feels a shooting pain. He also has pain in the plantar fasciitis on the bottom of the right foot. He has more pain in the ankle when it gets colder out.

Petitioner wears special shoes with orthotics . Typically he can walk for only one block before he must sit down. He testified that going down stairs is a controlled fall because his right foot does not bend downward. He goes down stairs sideways and won't go down stairs that do not have a railing. The Petitioner cannot run or jump anymore.

Petitioner testified that he has anxiety about doing anything where he could slip . He has problems with uneven surfaces and had to buy a riding lawn mower for his quarter acre lot.

CONCLUSIONS OF LAW 16IWCC0603

Causal Connection

The Arbitrator adopts the opinions of Dr. Paik, Dr. Pinzur and the Respondent's Section 12 examining Physician, Dr. Lee, that the Petitioner's present condition of ill-being in both feet and ankles, including, but not limited to, the plantar fasciitis in the right, the pilon fracture to the right ankle and the fibula and lateral malleolus fractures to the left foot/ankle, are causally related to his work related fall on May 28, 2012.

Nature and Extent of the Injury

For injuries occurring on or after September 1, 2011, all permanent partial disability awards shall be established using the following criteria. No single factor shall be the sole determinant of disability, the weight given to each factor must be explained in the written arbitration decision.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Dr. Lee performed an AMA Impairment Rating and determined the Petitioner's impairment in his right ankle to be 37% lower impairment rating or 15% whole person impairment and determined a 0% impairment rating in relation to the left ankle. Dr. Simon Lee's impairment rating equates to 75-80 weeks of disability. This correlates closely to 45% loss of the foot. The Arbitrator gives greater weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, Petitioner was employed at the time of his work accident injury as an engineer. Petitioner's duties included driving fire trucks, doing rig checks and cleaning trucks which required him to climb up on the top of the truck carrying cleaning supplies. Petitioner has never returned back to work as a since the date of the accident. Petitioner testified that as of May 2012, he was also employed as a member of the Illinois National Guard as a Lieutenant Colonel and worked in the plans, operations and training division. He testified that he had been an active member of the National Guard for 37 years. Petitioner testified that his unit with the Guard required war fighting and walking with loads on uneven ground and because he could no longer do activities like that, he was told by the National Guard that he had to retire. Petitioner testified that it was not his intention to retire at that time. In fact, Petitioner had been selected to lead the next unit into Afghanistan as the Commander and would have been promoted to Colonel for which he had already begun training. The Arbitrator assigns *greater* weight to this factor in her determination of a PPD award based on the fact that Petitioner's occupation as an engineer and his duties with the National Guard required strenuous physical activity with significant leg/foot activities.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes Petitioner's date of birth is 9/30/53. The Arbitrator finds this factor to be relevant in her PPD analysis and assigns *greater* weight to this factor given Petitioner's injuries and the limitations and

16IWCC0603

residual burdens that comes with someone of his age dealing with his significant injuries.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, Petitioner has not returned to work since his accident. Dr. Lee opined that the Petitioner was incapable of returning back to his previous duties as a firefighter. (R.X. 2) Petitioner was also told by the National Guard that he had to retire. Petitioner testified that it was not his intention to retire at that time. The Arbitrator finds the above facts establish that Petitioner's future earning capacity has significantly diminished as a result of his work accident and accordingly gives *greater* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes:

- The Petitioner underwent the first of three surgeries to his right foot/ankle on the date of his accident which consisted of a right lower extremity closed reduction and application of an external fixator with screws and plates. .Petitioner was hospitalized for 3-4 days before his transfer to a rehabilitation center for approximately six weeks. (PX. 7).
- On June 27, 2012, the Petitioner underwent a second surgical procedure consisting of a left ankle examination under anesthesia, a right ankle removal of the external fixator, debridement of the bone, open reduction and internal fixation of the right ankle pilon fracture along with a lateral malleolar fracture that was associated with it. (PX. 2 & 3)
- On December 11, 2012 office Dr. Paik administered an arthrocentesis injection to the right ankle and diagnosed Petitioner with right ankle plantar fasciitis. (PX. 3) On December 31, 2012, Petitioner underwent another injection and as well as aspiration to the right ankle. (Id.).
- On April 3, 2013, Dr. Paik noted Petitioner's complaints of persistent right ankle pain as well as swelling and soreness. The doctor noted Petitioner was limping. Dr. Paik also noted that Petitioner continued to experience significant limitations despite work conditioning which including the inability to carry or climb ladders or stairs, kneeling, lifting from floor, pulling objects to complete work related tasks, pushing objects and repetitive standing, squatting or walking. Dr. Paik diagnosed post-traumatic arthritis and recommended Petitioner not return to full duty. A referral to Dr. Garapati, a foot/ankle trauma specialist for a second opinion was noted. (Id.).
- On April 19, 2013, Petitioner presented to Dr. Rajeev Garapati who noted a history of right ankle pain with some numbness and stinging at rest. Dr. Garapati noted that Petitioner can walk approximately one block and then is limited secondary to pain. Dr. Garapati noted swelling on the right side when compared to the left. Range of motion of the right ankle was limited from about 0-5 degrees of dorsiflexion to about 40 degrees of plantar flexion. X-rays were also reviewed which revealed significant loss of ankle joint space on right with ankle joint arthritis.
- On August 19, 2013, Petitioner underwent his third right ankle surgery. Dr. Michael Pinzur at Loyola University Hospital performed a right STAR ankle

replacement surgery . Gastrocnemius muscle lengthening and removal of plate and screws from the right tibia were also noted (PX. 6 & 8).

- Dr. Pinzur released Petitioner to the light-medium work level as of March 4, 2014. At that visit, Dr. Pinzur examined the Petitioner and noted that he walked with a mild limp and had regained 50% of the motion in the right ankle following the ankle replacement surgery. Dr. Pinzur placed the Petitioner at maximum medical improvement as of that date. (PX. 8)
- On May 15, 2015, Petitioner followed up with Dr. Pinzur who noted that plantar fasciitis had developed on Petitioner's right ankle. The doctor also noted a very small arc of motion of the right ankle and tenderness at the origin of the plantar fascia. (PX. 6) Dr. Pinzur opined that the plantar fasciitis was likely related due to the limited motion and recommended that the Petitioner obtain a prostretch device. (Id.)
- Petitioner testified that he continues to take Codeine with Empirin which he takes two pills in the morning to get started, but same days the pain gets so bad that he has to take more. Petitioner also testified that he wears special shoes that have a wide enough back to fit his foot and he wears orthotics in them. Petitioner's activity level has decreased since the accident so he has gained weight. He further testified that his ability to walk is reduced and that he can typically walk for only one block before he must sit down doe to pain. He has significant problems going down stairs because his right foot does not bend downward. He goes down stairs sideways and won't go down stairs that do not have a railing.
- Petitioner testified that he has pain in the right ankle which is throbbing unless he hyperextends the foot or something and then he feels a shooting pain. He also has pain in the plantar fasciitis on the bottom of the right foot. Petitioner has more pain in the ankle when it gets colder out. The Petitioner cannot or jump anymore.

Given that the treating records contained in the record support and corroborate Petitioner's testimony with respect to chronic pain and disability, the Arbitrator assigns *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 **55% loss of use of his body as a whole** pursuant to §8(d)(2) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of **$695.78.per week for 275 weeks.**

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

Maria Perez,

Petitioner,

16IWCC0594

vs.

NO: 12 WC 28744

A.J. Antunes & Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 24, 2015 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.

16IWCC0594

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: SEP 16 2016
KWL/vf
O-9/12/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0594

PEREZ, MARIA
Employee/Petitioner

Case# **12WC028744**

A J ANTUNES & COMPANY
Employer/Respondent

On 11/24/2015, 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 0.35% 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:

1072 LAW OFFICES OF JACK R EPSTEIN
4346 W 26TH ST SUITE 2000
CHICAGO, IL 60623

0560 WIEDNER & McAULIFFE LTD
JESSICA R MILLER
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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)

16IWCC0594

Case # 12 WC 28744

Consolidated cases:

Maria Perez
Employee/Petitioner

v.

A.J. Antunes & Company
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Wheaton** and **Elgin** on **March 26, 2015** and **November 20, 2015**, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0594

FINDINGS

On the date of accident, **July 3, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,266.24**; the average weekly wage was **$505.12**.

On the date of accident, Petitioner was 45 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 of **$8,441.12** for TTD, **$0.00** for TPD and **$0.00** for maintenance, and, for a total credit of **$8,441.12.**

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

Respondent shall be given a credit in the amount of **$64,416.70** for medical benefits.

ORDER

Medical Benefits

Respondent shall the following unpaid medical bills for the reasonable and necessary medical services rendered, pursuant to Section 8(a) and subject to Section 8.2 of the Act: **$30,125.00** for Gray Medical and **$2,255.00** for NovaCare Rehabilitation. PX 4 indicates that the respondent has made no payments to Gray Medical; PX 5 indicates that the respondent has previously paid **$11,088.00** to NovaCare Rehabilitation.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$336.75**/week for **28-1/7** weeks, commencing **12/08/2012** through **6/22/2013**, 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.

Brian T. Cronin

Signature of Arbitrator

11-24-15

Date

ICArbDec19(b)

NOV 24 2015

Maria Perez v. A.J. Antunes & Company

12 WC 28744

16IWCC0594

FINDINGS OF FACT

The petitioner, Ms. Maria Perez, is a 48-year-old female formerly employed with A.J. Antunes & Company as a direct employee since 2000. The petitioner testified that she worked for A.J. Antunes & Company as an assembler, assembling industrial-sized toasters and steamers, testing machines, and training people.

The petitioner reports a work accident on July 3, 2012 while working on the toaster assembly line. The petitioner testified that on July 3, 2012, she and her co-workers were using carts that were not suitable for the toasters. Specifically, she stated that the toasters were too large for the size of the carts. The petitioner testified that the toasters she was working with weighed between 200 and 250 pounds. She said she was going to pass a toaster on one of the carts down to her co-worker, Graciela. To do so, she grabbed a bracket on the toaster with her right hand and pushed it towards Graciela. The toaster began to fall off the cart, pulling the petitioner's right hand. The petitioner said Graciela helped her pull the toaster back onto the cart. The toaster did not fall all the way to the ground. The petitioner testified that she felt pain in her right arm, a lot in the right shoulder, and in her neck.

The petitioner testified that after the toaster was put back onto the cart, "Carlos" from Human Resources was passing by along with her supervisor, "Bear," and her line leader. The petitioner testified that she told Carlos that the toaster came off the cart and pulled her hand. She also believed her co-worker, Juan Salazar, was coming from the bathroom.

Juan Salazar testified for the respondent that he was working as the petitioner's line leader on July 3, 2012. He said he witnessed the toaster falling from the cart and immediately came to help the petitioner re-position the toaster. Mr. Salazar testified that when he asked the petitioner if she was okay, she stated to him that she had pain in her right arm and shoulder.

The petitioner testified that the incident occurred close to the end of her shift. She worked for ten more minutes and felt pain as she finished out the day. After the Fourth of July holiday, the petitioner testified, she came back to work and felt pain in her whole right arm, shoulder, and a little bit of her neck. She continued to work until July 13, 2012, when she was sent to the doctor.

On July 13, 2012, Nina L. Taylor, D.O., at Concentra Medical Center ("Concentra") saw the petitioner. The petitioner reported an injury to the arm on July 3, 2012 while at work. The petitioner told Dr. Taylor: "I was pushing a cart with a machine on top, when I was pushing it the machine moved and was about to drop, the cart pulled my arm with the force and [I] felt pain on my right arm." She said she kept working ever since, but had pain in her right shoulder and hand. She denied any pain at rest but stated that at the end of her shift, her pain could become a "7" in her shoulder. The petitioner denied numbness and tingling of her right upper extremity or any other associated injuries. She was noted to have a prior surgical history of bilateral carpal tunnel release with full recovery per patient. Dr. Taylor conducted an examination of the petitioner's right shoulder and right hand and found the following: "Right Shoulder: Patient is in NAD. FROM of shoulder without crepitus or pain. Negative impingement. Negative pain to palpate. Good neuro, circ, motor function. Good strength noted. Right Hand: No deformity. No navicular tenderness. No swelling or tenderness. Full range of motion." Preliminary readings of x-rays of right shoulder and right hand were negative. Dr. Taylor assessed the

petitioner with shoulder strain and hand pain, prescribed Naproxen 550 mg. po bid, released her to regular activity but did not release her from care. (PX 1)

The petitioner returned to Concentra on July 17, 2012, at which time Gregory S. O'Neill, M.D., examined her. The petitioner did not take the medication because of intolerance. She denied any paresthesias, sensory loss, numbness, difficulty breathing, shortness of breath, chest pain, neck pain, snapping, clicking, popping, swelling and radicular symptoms. Associated limited movement and weakness of right shoulder. (PX 1)

Upon examination of the cervical spine, Dr. O'Neill found: "Spurlings test is negative. No pain on motion. No swelling. No tenderness. Full active range of motion with normal extension, flexion, axial rotation and lateral flexion." (PX 1)

Upon examination of the right shoulder, Dr. O'Neill found: "Decreased active Range of Motion. Extension 75 degrees with pain. Abduction: Slightly decreased with pain. External rotation: With pain. No ecchymosis. Shoulder shows no deformity. No tenderness present. Normal biceps function. Normal radial pulse." (PX 1)

Upon examination of the right wrist, Dr. O'Neill found: "The patient reports Mild tenderness to palpation over the dorsal aspect of wrist. No snuff box tenderness. No swelling. Full range of motion with normal flexion, extension, ulnar and radial deviation. Normal radial pulse. Decreased grip strength. The patient can make a complete fist. Wrist shows no deformity. (PX 1)

Dr. O'Neill assessed the petitioner with a shoulder strain and wrist pain. He prescribed Ibuprofen 600 mg. every 8 hrs as needed, discontinued Naproxen, ordered a course of physical therapy and released her to regular activity. (PX 1)

The petitioner began physical therapy at Concentra on July 23, 2012. Katie J. Peterson, P.T., conducted the Initial Evaluation. Ms. Peterson wrote, *inter alia*, the following:

"Chief Complaint: she c/o pinching pain of her R shoulder & elbow. She c/o R upper trap pain also. Her pain gets to 7-9/10 at work. She is taking pills 3x/day ***

Exacerbating Factors: working, reaching behind her back, (into external rotation), reaching forward motions hurt (into flexion) ***

Pre-Injury Status: Patient working at regular duty status prior to injury with no history of injuries or impairments to her right shoulder. Prior h/o CTS R hand. Her 3rd & 4th fingers cannot feel hot & cold on her right hand ***

Posture: Rounded shoulders noted B/L

Sensation: R hand 3rd & 4th finger numbness noted

Joint Mobility: R GH joint WNL – pain noted due to pressure on her pec muscle

Palpation: + exaggerated tenderness noted to her R upper trap/posterior RC/pectorals." (PX 1)

On July 24, 2012, the petitioner saw Gregory S. O'Neill, M.D., at Concentra. She told him that her shoulder is still bothering her, she has been on regular activity, and she did not feel better with physical therapy. She denied sensory loss, numbness, stiffness, limited movement, neck pain, snapping, clicking, popping, swelling and bruising. Upon examination, Dr. O'Neill found that the cervical exam was negative, the right wrist exam revealed mild tenderness to palpation over the dorsal aspect, and the right shoulder exam revealed tenderness of the anterior

aspect of the shoulder diffusely and the petitioner experienced pain and had weakness with resisted external rotation with elbows fixed at the sides. (PX 1)

Dr. O'Neill again assessed the petitioner with shoulder strain and wrist pain, continued the medication and physical therapy and kept her on the regular activity status. (PX 1)

At therapy on July 24, 2012, the petitioner reported 8-9/10 right shoulder pain after work with continued pinching pain with all shoulder movements. On July 26, 2012, she described worsening pain with therapy. Ms. Peterson expressed concern that symptom magnification may be an issue. (PX 1)

On August 3, 2012, Maqsood H. Jafri, M.D., of Concentra saw the petitioner. The petitioner reported pain on the top of the shoulder, in the shoulder, the outer forearm, and the wrist. She could no longer tolerate physical therapy and was working full duty with 8-9/10 pain. Dr. Jafri found that her neurological exam was normal, and when he examined her neck, he found the following: "Full range of motion. No palpable bony or muscular tenderness. Negative spurling and axial load." His musculoskeletal exam revealed the following: "SHOULDER: tender on the top of shoulder and Front, back and outer aspect of the shoulder. Thender (sic) on the outer aspect of the forearm and around teh (sic) wrist. The ROM are associated with discomfort." Dr. Jafri gave the petitioner modified activity restrictions, prescribed Tramadol and a muscle rub, and told her to continue therapy for one week. (PX 1)

At the August 8, 2012 physical therapy session, Katie J. Peterson, P.T., noted that palpation to the petitioner's right shoulder revealed warmth. She also noted redness of the shoulder. The petitioner complained that a severe burning sensation of the right anterior and medial shoulder region started on August 7, 2012. Ms. Peterson suspected early stages of complex regional pain syndrome. (PX 1)

On August 10, 2012, Ms. Peterson wrote: "I feel the patient may be magnifying her symptoms as she does not show pain mannerisms while doing therapy exercises but she rates her pain at 8/10." (PX 1)

The petitioner also returned to Dr. O'Neill on August 10, 2012. When the doctor examined the petitioner's cervical spine, he made the following findings: "Spurlings test is negative. No pain on motion. No swelling. No tenderness. Full active range of motion with normal extension, flexion, axial rotation and lateral flexion." Upon examining the petitioner's right shoulder, he made the following findings: "No bruising. No ecchymosis. Shoulder shows no deformity. The patient reports Mild tenderness to palpation over the top of the shoulder diffusely. Normal biceps function. The patient experienced pain and there was weakness with resisted external rotation with elbows fixed at the sides." Dr. O'Neill assessed the petitioner with a shoulder strain, continued the medication, physical therapy, and modified activity status. (PX 1)

At the August 14, 2012 physical therapy session, Katie J. Peterson, P.T., recorded, *inter alia*, the following: "She c/o neck pain, R posterior and anterior shoulder pain, with pain radiating to her albow and wrist/hand. She also c/o numbness & tingling of her hand and shoulder, and then later she said her entire R UE. She c/o pain with laying on her R shldr & with using power tools." (PX 1)

When the petitioner returned on August 16, 2012 to Dr. O'Neill at Concentra, she reported no improvement. She told him she has been working within the duty restrictions. Once again, she denied paresthesias, sensory loss, numbness, chest pain, neck pain, snapping, clicking, popping and radicular symptoms. Associated weakness and limited movement. Examination of the right shoulder revealed mild tenderness to palpation over the top of the shoulder and the

petitioner experienced pain and there was weakness with resisted external rotation with elbows fixed at the sides. Cervical spine examination was negative. Dr. O'Neill assessed the petitioner with shoulder strain, shoulder pain, continued the medication and physical therapy, kept her on modified-duty restrictions and referred her to an orthopedic surgeon. (PX 1)

On August 18, 2012, the petitioner was evaluated by Ellis K. Nam, M.D., an orthopedic surgeon. She complained of mainly right shoulder pain with some right elbow and wrist pain. She denied any prior problems in these areas. The petitioner described the July 3, 2012 work accident, and told him that she reported immediate pain in the right shoulder, elbow, and wrist. Examination of the cervical spine demonstrated good range of motion, negative Spurling's sign, neurovascularly intact. Examination of the right shoulder demonstrated painful range of motion, forward flexion of 150 degrees with pain, abduction of 90 degrees, external rotation of 40 degrees, internal rotation to T10, positive impingement, and rotator cuff weak at 4/5. Examination of the right elbow and wrist demonstrates full range of motion, but some tenderness along the medial and lateral epicondyle of her right elbow. Dr. Nam ordered a MRI to rule out rotator cuff tear or possible labral injury. The petitioner was kept on activity restrictions. (PX 2)

On August 25, 2012, a right shoulder MRI without contrast showed supraspinatus tendinopathy with associated bursitis. On September 1, 2012, Dr. Nam administered a Cortisone injection. The petitioner was kept on restrictions. (PX 2)

On September 29, 2012, Dr. Nam noted that the Cortisone injection did not significantly relieve her pain and that she is still having persistent pain in her right shoulder since the work injury on July 3, 2012. Dr. Nam ordered an MRI arthrogram to evaluate the labrum. (PX 2)

An October 10, 2012 right shoulder MRI arthrogram was interpreted by the radiologist as showing supraspinatus tendinopathy with associated bursitis; no additional findings or changes.

On October 13, 2012, Dr. Nam wrote that he does agree with the radiologist that there is no obvious rotator cuff tear. However, he noted that she does have some increased signal on the attachment site. Although no obvious labral tear is showing, Dr. Nam felt that labral structures are difficult to evaluate. After discussing the options with the petitioner, Dr. Nam planned on proceeding with a diagnostic arthroscopy of the right shoulder. He imposed a work restriction of no use of the right arm. (PX 2)

On November 15, 2012, at the respondent's request, and pursuant to Section 12 of the Act, the petitioner presented to orthopedic surgeon Guido Marra, M.D., for an examination. The petitioner reported right shoulder pain as a result of pushing a 200-pound object at work with a pulling strain in her right shoulder. Dr. Marra diagnosed traumatic impingement syndrome with a partial thickness rotator cuff tear, causally related to the accident. Dr. Marra recommended surgery and advised the petitioner to stay off work in the interim. (RX 1)

The petitioner underwent, on December 8, 2012, a diagnostic arthroscopy with subacromial decompression, extensive debridement of a partial superior labral tear and partial bursal-sided rotator cuff tear, and a right shoulder partial synovectomy. Dr. Nam performed the surgery and offered the following post-operative diagnosis: (1) Right shoulder impingement syndrome (2) Right shoulder partial bursal-sided rotator cuff tear and posterosuperior labral tear (3) Right shoulder synovitis. (PX 2)

The petitioner reported that her pain is relatively well-controlled when she followed up with Dr. Nam on December 15, 2012. His staff showed her some general exercises. Dr. Nam indicated that she will start passive range of motion therapy only. (PX 2)

On January 19, 2013, the petitioner reported continued pain and discomfort to Dr. Nam. He kept the petitioner off work so that she could focus on therapy. By February 16, 2013, her

pain was relatively well-controlled, but she was getting stiff. Dr. Nam continued her p.t. for 1 month.(PX 2) In p.t, Ms. Perez complained of radiating pain from neck to elbow to shoulder blade.(PX 5)

The petitioner followed up with Dr. Nam on March 16, 2013. It was noted that she was starting to develop left shoulder pain. Dr. Nam kept the petitioner off work due to this new symptom, recommended additional therapy and prescribed Naprosyn (changed to Ultram on March 20, 2013). (PX 2)

On April 5, 2013, the petitioner attended a repeat Section 12 examination with Dr. Marra, who recommended an intraarticular corticosteroid injection with aggressive therapy. (RX 2)

Dr. Nam administered the injection on April 13, 2013 and returned the petitioner to therapy and restricted duty. At the May 11, 2013 follow-up appointment to Dr. Nam, the petitioner reported that she is much better. Dr. Nam recommended work conditioning, and imposed work restrictions. (PX 2)

The petitioner returned to Dr. Nam on June 8, 2013 after finishing work conditioning. She complained of pain in the right shoulder. She could now lift 40 pounds to near objective examination. Such capabilities were thought to meet her job requirements. Dr. Nam returned the petitioner to full-duty work on a trial basis. (PX 2)

On June 22, 2013, the petitioner reported that she was laid off from work. She was still having complaints of pain in the right arm and now into her right neck region. She stated that her neck pain started after her surgery. Dr. Nam opined that the petitioner was at MMI for her right shoulder. (PX 2)

The petitioner attended a final Section 12 examination with Dr. Marra on July 9, 2013. She told Dr. Marra since the last time he examined her, she developed pain in the neck with associated lateral arm and hand numbness. Dr. Marra found the petitioner to be at MMI for the

right shoulder and recommended a return to work full duty based upon the work conditioning summary. (RX 3)

The petitioner returned to Dr. Nam on July 27, 2013 with complaints of neck pain and numbness down her right arm. She stated that this started after her surgery. Dr. Nam recommended a MRI of the cervical spine. (PX 2)

On July 30, 2013, a cervical spine MRI showed a central disc herniation at C3-C4 with mild spinal stenosis and impingement on the cord, bulging of the C4-C5, C5-C6 through C7-T1 discs, and fusion of congenital "block" vertebra at C2-C3. On August 3, 2013, Dr. Nam recommended that she see a pain management specialist for her neck. (PX 2)

The petitioner attended an initial evaluation by Robert K. Erickson, M.D., on November 22, 2013. She told Dr. Erickson she felt immediate pain on July 3, 2012 in the entire right arm as well as the neck. She also told the doctor that she received physical therapy, but during physical therapy she felt increasing neck pain. She said that the pain became much more severe in the neck approximately 3-4 days into the physical therapy sessions following shoulder surgery. Dr. Erickson diagnosed a disc herniation at C3-C4 and recommended SSEP testing with consideration of an injection, physical therapy that safely may include traction, and close monitoring for a potential anterior cervical discectomy and fusion. Dr. Erickson wrote: "Treatment for cervical spine is a direct consequence to (sic) the injury of 07/03/2012." (PX 7)

On January 10, 2014, the petitioner returned to Dr. Erickson. She reported pain at 7-8/10 in her neck that radiates down her right arm. The petitioner was told to begin therapy as soon as possible. The possibility of fusion surgery was again mentioned. She was put on Mobic and Protonix and kept off work. (PX 7)

The petitioner was evaluated by Dr. Dzielawski at MidCity Spine and Ortho Rehabilitation on January 14, 2014. The history in Dr. Erickson's notes was recited. Therapy with Dr. Dzielawski began on January 16, 2014 for neck pain. (PX 10)

On February 25, 2014, Dr. Erickson found that the Spurling's test is positive, the cranial nerve examination is normal and no long tract signs are appreciated. Dr. Erickson suggested that she seriously consider surgery. He diagnosed the petitioner with "cervical disc disease relative to the injury of July 3, 2012." (PX 7)

Dr. Erickson again discussed surgery at a follow-up appointment on April 30, 2014. (PX 7)

On May 29, 2014, the respondent sent the petitioner for a Section 12 examination by physiatrist Martin P. Lanoff, M.D. The petitioner reported to Dr. Lanoff that her neck pain began on the day of the injury. She said she told Dr. Nam and the Concentra doctors whom she saw immediately thereafter that she had neck pain, as well as about her radiating symptoms (numbness and tingling) into the hand. Dr. Lanoff noted that there was no history of any neck pain in the initial notes from Concentra, and that the petitioner denied any numbness or tingling into the extremity. The petitioner said she told her supervisor about the neck pain, but Dr. Lanoff noted that the injury report only noted pain in the shoulder and wrist. Dr. Lanoff noted that the records showed no pain in the neck for quite some time after the accident and that the onset of cervical symptoms was not consistent with the history taken in his office that day. (RX 4)

Dr. Lanoff saw a fair-sized disc herniation at C3-C4, which was below the level of the congenital fusion at C2-C3. He expected this was degenerative in addition to biomechanically-induced because of the adjacent segment fusion. He said this could be causing some of the right

upper extremity symptoms. Dr. Lanoff first recommended injections. If this failed, surgery would be indicated. Dr. Lanoff prescribed restrictions in the interim. (RX 4)

The petitioner reported to Dr. Lanoff that she has neck and full back pain into the back of the legs and down into the feet. Dr. Lanoff found that this is obviously in a non-dermatomal distribution. Dr. Lanoff found 2 out of 5 Waddell's signs, and also noted a somewhat non-organic finding when the bilateral straight leg raise test reproduced neck pain at 30 degrees. (RX 4)

Dr. Lanoff opined that there was no relationship between the July 3, 2012 incident and the disc herniation symptoms or need for surgery or restrictions. He noted that the history given by the petitioner that her neck symptoms started immediately and that she told all of her doctors about it was not corroborated in the notes. Dr. Lanoff also noted that the neurologic findings and physical examination findings as they would relate to a disc herniation were all negative for quite some time after the injury. (RX 4)

On June 27, 2014, Geoffrey R. Dixon, M.D., saw the petitioner for a surgical consultation. This was a referral from Dr. Nam. The petitioner told him that this pain began when she was lifting a 200 to 300 pound object on July 3, 2012. She stated that the pain is primarily located in the neck with radiation into the right shoulder, head and intrascapular area. Dr. Dixon recommended a C3-C4 transforaminal epidural steroid injection and selective nerve blocks. The petitioner was kept off work. (PX 8)

The petitioner presented to Krishna Chunduri, M.D., on June 30, 2014 with complaints of neck pain that radiates to her shoulders. All of her symptoms were worse on the right side of her neck where she described a throbbing, cramping, burning and numbness. She also stated that she has numbness and tingling in her hands, worse on the right side, and extending up the arm to the

elbow area. She reported that these symptoms are constant and worse with any type of activity or overhead activity. Dr. Chunduri opined that at this time it appears that her cervical pain is likely from the disc herniation at C3-C4. In addition, he noted bilateral paresthesias in the upper extremities, which was noted to be difficult to differentiate from radicular or recurrence of carpal tunnel syndrome without an EMG. The plan was to proceed with the injection. (PX 8)

On July 3, 2014, the petitioner underwent a C3-C4 transforaminal epidural steroid injection and selective nerve root block. On July 10, 2014, Dr. Chunduri administered a bilateral occipital nerve block and recommended follow up with Dr. Dixon. (PX 7)

On December 12, 2014, Dr. Dixon again evaluated the petitioner. Dr. Dixon noted that the petitioner had undergone an injection at C3-4 with temporary relief and a selective block with no relief. Dr. Dixon discussed with the petitioner the option of an anterior cervical discectomy and fusion at C3-C4 as well as the risks and benefits of such surgery. The petitioner wished to proceed with this surgery. (PX 8)

Dr. Dixon opined that the herniated disc at C3-C4 was due to or exacerbated by the work accident of July 3, 2012. Dr. Dixon commented on Dr. Lanoff's opinions. Dr. Dixon stated that any mechanism of injury that resulted in a surgically repairable shoulder could also cause a herniated disc. Dr. Dixon also noted that Dr. Lanoff pointed out the petitioner did not complain of cervical issues at the time of injury. Dr. Dixon wrote that the petitioner complained of neck and shoulder pain simultaneously, but the treating physician initially attributed all of the symptoms to the shoulder. Dr. Dixon noted that there was no testable motor component to the C4 nerve root, so the petitioner's symptoms from this region would likely be limited to pain. He also noted that the petitioner has a congenital fusion of the C2-C3 level, which he said would place additional stress in the adjacent level of C3-C4. (PX 8)

The petitioner testified on direct examination that before the accident, she did not have any pain in her right arm, right shoulder, or neck and she did not have the numbness she is currently experiencing. At the time of trial, the petitioner testified that her pain was an 8/10, that her hands were swollen and that her right cheek/neck area was swollen due to the pain in the neck. She stated that she had numbness in the right fingers and the beginning of numbness in the left fingers. She testified that she was not working pursuant to the recommendations of Doctors Dixon, Erickson, and Chunduri. The petitioner testified that no treatment has been recommended for the right upper extremity since June 2013, and she has not seen any doctors for the neck since December 2014.

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material fact in support of the following conclusions of law:

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

The petitioner and the respondent agree that on July 3, 2012, the petitioner and the respondent were operating under the Act, and that their relationship was one of employee and employer. Furthermore, the petitioner and the respondent also agree that on that same date the petitioner sustained accidental injuries that arose out of and in the course of employment. The question for the Arbitrator is whether the petitioner's neck problems are related to the accident.

The petitioner's treating doctors have opined that the petitioner's cervical condition of ill-being is causally related to the accident. Dr. Erickson took a history from the petitioner. He wrote: " *** She was working in the assembly of large toasters. A toaster fell from the assembly line and she tried to catch the toaster while the line was moving. Her right arm was pulled away from her with force, and she needed the assistance of a co-worker to free her arm. She immediately felt pain throughout the entire right arm as well as the neck." (PX 8) Additionally, Dr. Erickson noted: "She has received physical therapy, but during physical therapy she felt increasing neck pain. The pain became much more severe in the neck approximately 3-4 days into physical therapy sessions following shoulder surgery." (PX 8) Dr. Erickson examined the petitioner. He reviewed the MRI scan, which showed a disc herniation at C3, C4 central and left, and a congenital fusion at C2-C3. Dr. Erickson concluded that the petitioner's cervical injury was caused by the accident and recommended surgery. (PX8)

Dr. Chuduri opined that petitioner's neck injury is work-related. (PX 8)

Dr. Dixon also opined that the petitioner's cervical condition is related to the accident and has recommended surgery. Dr. Dixon strongly disagreed with Dr. Lanoff, the respondent's Section 12 physician, and explained:

> Dr. Lanoff opined that the mechanism of injury is not consistent however any mechanism that resulted in a surgically repairable shoulder injury could also cause a herniated disk. Also he states that she did not complain of any cervical issues at the time of the injury. This is false. She complained of neck and shoulder pain simultaneously however, the treating physician attributed initially all of her symptoms to her shoulder pathology. Also, it should be noted that strictly speaking there is no testable motor component to the C4 nerve root so her symptoms from this lesion would likely be limited to pain. Finally, she has a Klippel-Feil type congenital fusion of C2-3, which would place additional stress on the adjacent level at C3-4. Obviously there is a significant difference between a pre-disposition and a pre-existing condition; the former is accurate in this case." (PX8)

In formulating their opinions that the petitioner's neck condition is causally related to the July 3, 2012 accident, Doctors Erickson and Dixon understood that the petitioner voiced immediate or simultaneous complaints of neck pain following the July 3, 2012 accident. However, Juan Salazar testified that he arrived at the scene of the accident and that the petitioner told him that she was having pain in her arm and shoulder. Moreover, there is no documentary evidence that the petitioner complained of neck pain on July 13, 2012, which was the first day that she treated, post-accident. Her neck and shoulder pain were not simultaneous and immediate. Therefore, the Arbitrator finds the opinions of these three treating physicians to be defective.

There is no evidence that Dr. Erickson, Dr. Dixon and Dr. Chunduri reviewed the petitioner's medical records for the treatment rendered as a result of the accident.

On July 23, 2012, 10 days after she first received treatment for the accident and 20 days after the accident date, the petitioner saw Katie J. Peterson, P.T., her physical therapist at

Concentra Medical Center, for an initial evaluation. At that time, the petitioner complained of right shoulder pain, right hand pain and "R upper trap. pain". (PX 1) On August 14, 2012, Ms. Peterson saw the petitioner in physical therapy and wrote: "She c/o neck pain, R posterior & anterior shoulder pain, with pain radiating to her elbow and wrist/hand. She also c/o numbness & tingling of her hand and shoulder, and then later she said her entire R UE." Ms. Peterson also wrote at that time: " … her symptoms of numbness and tingling are not consistent with a shoulder strain." (PX1)

The Arbitrator notes that the petitioner is claiming acute trauma to her neck and right shoulder, not repetitive trauma.

From July 3, 2012 through December 25, 2012, there were multiple instances in the treating records of specific denials of neck pain, numbness/tingling into the extremities, and radicular symptoms. All of Dr. O'Neill's cervical examinations were negative. On cross-examination, the petitioner consistently denied the accuracy of each certified treating medical records presented, and stated that she told these doctors that she had neck pain. She testified that all of the treating medical records from 17 office visits were "inaccurate" or "incorrect."

The petitioner has presented inconsistencies to her doctors and at trial regarding the onset of her neck pain. When the petitioner reported neck pain to Dr. Nam on June 22, 2013, she stated that the pain began after her shoulder surgery. She reiterated that history to Dr. Nam on July 27, 2013. Similarly, the petitioner told Dr. Marra on July 9, 2013 that the development of neck pain was something new since her examinations of her on November 15, 2012 and April 5, 2013. When she was seen by Doctors Erickson and Dixon, however, the petitioner stated that

her neck pain started immediately after the July 3, 2012 accident. The petitioner testified at trial that she has had neck pain all along.

Dr. Lanoff denied that a causal relationship exists between the petitioner's cervical condition and the July 3, 2012 accident. He noted that the history given by the petitioner that her neck symptoms started immediately and that she told all of her doctors about it was not corroborated in their notes. Dr. Lanoff also noted that the neurologic findings and physical examination findings as they would relate to a disc herniation were all negative for quite some time after the injury. (RX 4)

For the first 5-1/2 months of the petitioner's post-surgical physical therapy at NovaCare Rehabilitation, from December 26, 2012 through May 10, 2013, the therapist recorded the petitioner's Chief Complaint as "Pain: Location: Radiating, UE: Neck To: Elbow: and radiating down to shoulder blade: RIGHT." The Discharge Summary of September 5, 2013 also includes this description of the petitioner's Chief Complaint. Several of these physical therapy records include complaints of clavicular pain. (PX 5)

Yet, there is no medical opinion that causally relates the development of the C3-C4 disc herniation with, specifically, the December 8, 2012 arthroscopic shoulder surgery or the post-surgical physical therapy.

The Arbitrator notes that on June 22, 2013 - - only after she completed work conditioning and only after Dr. Nam released her for a trial return to work full duty - - she first reported to Dr. Nam that she has neck pain that started after the December 8, 2012 surgery.

The Arbitrator finds the opinions of Dr. Lanoff to be more persuasive than those of Doctors Erickson, Dixon and Chunduri. Notwithstanding, even Dr. Dixon opined that the

petitioner has a congenital fusion of C2-C3 discs, which would place additional stress on the adjacent level at C3-C4. Dr. Lanoff opined that there is a fair-sized herniation at C3-C4, which is below the level of the congenital fusion at C2-C3. Dr. Lanoff expected the C3-C4 herniation to be degenerative in nature in addition to being biomechanically-induced because of the adjacent segment fusion.

Therefore, based on the foregoing, the Arbitrator finds the petitioner's condition of ill-being of her right shoulder *only* is causally related to the accident of July 3, 2012.

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

The petitioner entered into evidence the following medical expenses relating to her right shoulder and neck treatment. The Arbitrator has found that only the right shoulder is causally related to the accident. The only unpaid medical bills for the shoulder are from Gray Medical in the amount of $30,125.00 and NovaCare in the amount of $2,255.00. After reviewing the medical records and testimony introduced into evidence, the Arbitrator finds that the medical treatment rendered to the petitioner's right shoulder was reasonable, necessary and related. Dr. Nam ordered these services. Therefore, the Arbitrator finds the respondent liable for these bills and orders them to pay such bills, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

K. **Is Petitioner entitled to any prospective medical care?**

Given the Arbitrator's findings on the causation issue, the Arbitrator denies prospective medical care for the neck. With respect to the petitioner's right shoulder, Dr. Nam found the petitioner to be at MMI on June 22, 2013.

L. **What temporary benefits are in dispute?**

Given the Arbitrator's findings on the causation issue, the Arbitrator finds that the petitioner is entitled to TTD benefits through June 22, 2013.

On Arbitrator's Exhibit #1, the respondent disputes the TTD period claimed by the petitioner (12/8/2012 to 3/26/2015, 119-6/7 weeks) and writes: "NO FURTHER LIABILITY." AX #1 also indicates that the respondent has paid TTD benefits from 12/8/2012 through 6/9/2013.

On June 22, 2013, Dr. Nam declared the petitioner to be at MMI for her right shoulder and released her for a trial of her full-duty work. However, the petitioner never attempted such work as she had been laid off by the respondent. So, the Arbitrator finds that the petitioner is entitled to TTD through June 22, 2013.

The parties agree that the respondent claims it paid $8,441.12 in TTD benefits and $64,416.70 in nonoccupational disability benefits, for which a credit may be allowed under Section 8(j) of the Act. (AX 1)

The Arbitrator finds that the respondent is entitled to a credit in the above amounts.

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

James Dilday,

Petitioner,

vs. NO: 12 WC 31344

State of Illinois/Menard Correctional Center,

Respondent.

16IWCC0605

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employer-employee relationship, accident, notice, causal connection, and medical expenses, modifies and corrects 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.

First, the Commission notes that the Arbitrator erroneously lists the Respondent as Pickneyville Correctional Center when it is actually Menard Correctional Center. Therefore, the Commission hereby corrects the Arbitrator's Decision to reflect that the Respondent in this case is Menard Correctional Center.

Next, the Commission disagrees with the Arbitrator's finding that there was not an employer-employee relationship between Petitioner and Respondent in this case. The Commission notes that in *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 879-880 (1999), the court explained that:

> "[t]he modern rule allows compensation even when an injury occurs at a time and place remote from the employment if its cause is something that occurs entirely within the time and place limits of employment....In repetitive-trauma cases, the manifestation date is significant in fixing the legal relationships between the parties. See *Oscar Mayer & Co. v. Industrial Comm'n*, 176 Ill. App. 3d 607, 611, 531 N.E.2d 174, 176, 126 Ill. Dec. 41 (1988); 3 L. Larson, Workers' Compensation Law § 39.10, at 7-383 (1998). However, in making this change, the supreme court did not intend to give employers an additional shield by requiring the injury to be traced to employment during employment. *Cf. Belwood*, 115 Ill. 2d at 529, 505 N.E.2d at 1028 (liberally construing the Act to further its goal of providing financial protection for injured workers while precluding the employee from seeking common law tort

remedies)."

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Based on the case law, the fact that Petitioner's carpal tunnel syndrome and cubital tunnel syndrome manifested after his retirement from Respondent's employ does not in and of itself negate an employer-employee relationship. As such, the Commission finds that the Arbitrator erred in finding so.

Despite this modification by the Commission regarding the issue of employer-employee relationship, ultimately the Commission finds that the record supports the Arbitrator's finding that Petitioner failed to prove that he suffered a compensable accident under the Act.

The Commission finds Petitioner's testimony that lieutenants do the "same thing" as correctional officers and sergeants unpersuasive. We note that, as explained in the job descriptions, the higher the rank, the more supervisory the position becomes. While there is no doubt that Petitioner performed some of the duties of a correctional officer as a sergeant and lieutenant, the Commission finds it unbelievable that all three jobs are exactly the same and that his duties remained the same for 33 years even though he was promoted twice and then transferred from the maximum security unit to the medium security unit.

The Commission finds the testimony of Joseph Durham, a former correctional officer, sergeant, lieutenant and major, is much more persuasive. Mr. Durham testified that lieutenants followed "along the back of the gallery while we're running chow lines, could be commissary lines or whatever and those officers, lieutenants, they pull on the door using their right and their left arm to make sure that the door's secure as they pass by the cells. They use keys to lock and unlock doors, chuckholes, which are feed slots. Just a variety of different things just as an example." (T.6-7) And while Mr. Durham acknowledged similarities between the jobs of correctional officer, sergeant and lieutenant, the Commission notes that he described the sergeant and lieutenant positions as more supervisory positions. (T.8-9,13-15) He also testified that sergeants bar rapped infrequently and that lieutenants did not use Folger-Adams keys very often. (T.13-15) Mr. Durham also explained that the doors were controlled through a control pod. (T.15-16) Mr. Durham also testified that the amount of paper work done by lieutenants varied and depended on the shift that a lieutenant worked. (T.17-18)

The Commission further notes that the March 9, 2011 lieutenant job analysis states that the job requires the officer to supervise and unlock/lock doors during shift changes, supervise and unlock/lock doors during relief (change) for meal breaks, perform supervisory counts of inmates cells on each level, supervises officers in the performance of their tasks, files paper work, may do yearly evaluations, and completes shift forms, sanitation logs, and gallery tour sheets. (PX11,RX9) As for the physical demands of the job, it requires infrequent lifting/force of 26-50 lbs, occasional lifting/force of 11-25 lbs, frequent lifting/force of 0-10 lbs, infrequent total body pushing/pulling, occasional horizontal reaching, infrequent twisting, infrequent firm grasping with both hands, occasional simple grasping with both hands, infrequent flexion/extension/deviation with both arms, infrequent sitting, occasional standing, occasional stair climbing, and frequent walking.

The Commission also notes that the lieutenant job description/classification indicates that the job consists of instructing and supervising correctional officers "of lower rank in enforcing and maintaining disciplinary, safety, sanitary, security and custodial measures for the control of inmates…carries out directions of superior officers; may have charge of a small prison or farm unit during short periods of time." (RX8) According to the job description, lieutenants also

inspect officers, cells, shops, yards, buildings, and waste usage, as well as arbitrate prisoner disputes, investigate complaints, conduct special investigations, relieve superior officers or other lieutenants during their absence and perform "other duties as required or assigned which are reasonably within the scope of the duties enumerated above." (RX8)

The Commission also reviewed the January 13, 2011 job video, which shows officers explaining their tasks as they perform them. (PX7) The officers are seen answering the phone, buzzing in people, providing keys/equipment to other officers through a chuckhole, opening and locking doors, bar rapping, operating the crank, turning locks, opening/closing chuckholes, using Folgers-Adam keys, and sliding metal doors. The lieutenant position video (RX10) shows the officer opening/closing gates, opening/closing/sliding doors, walking through the prison, filling in a log sheet, supervising prisoners moving through and going through some files.

Based on all the information provided regarding all three positions, the Commission finds that the jobs are varied and do not require any forceful use of hands in a constant and repetitive manner. Considering Petitioner spent 16 years as a lieutenant, the Commission finds that Petitioner did minimal handcuffing, opening/locking doors and, based on his testimony, only bar rapped once a week for no more than five minutes. (T.60-61) The Commission finds that Petitioner failed to show forceful use of his hand and/or performance of vibratory actions in a repetitive manner while carrying out his duties. The Commission further notes that since Petitioner worked the 3 pm to 11 pm shift, he also oversaw mail delivery, an additional and varied task that Petitioner failed to mention but is listed in the job description. (PX10) As such, the Commission finds that Petitioner's job was considerably varied and not repetitive in nature

Therefore, based on the totality of the evidence, the Commission finds that Petitioner failed to prove that he sustained accidental injuries arising out of and in the course of his employment with Respondent.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 4, 2015 is corrected and modified as stated above, and otherwise affirmed and adopted.

16IWCC0605

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

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

DATED: SEP 2 2 2016
MJB/ell
o-06/21/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

DILDAY, JAMES
Employee/Petitioner

Case# **12WC031344**

PICKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

16IWCC0605

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:

0969 THOMAS C RICH PC
MICHELLE RICH
6 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
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CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
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100 W RANDOLPH ST 13TH FL
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1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

DEC 4 - 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Dilday
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # 12 WC 031344

Consolidated cases: N/A

16IWCC0605

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville, IL**, on **09/23/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0605

FINDINGS

On the date of accident, **August 10, 2012**, Respondent ***was not*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, the Petitioner's average weekly wage was **$1,328.46**.

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

ORDER

No benefits are awarded since Petitioner did not sustain accidental injuries on August 10, 2012, that arose out of and in the course of his employment with Respondent. Claim

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

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

Edward Lee

Signature of Arbitrator

12/2/15

Date

ICArbDec19(b)

DEC 4 - 2015

James Dilday v. Menard Correctional Center

IWCC No. 12-WC-9252

16IWCC0605

The Arbitrator finds the following facts:

Petitioner filed an Application for Adjustment of Claim with the Illinois Workers' Compensation Commission on September 5, 2012. Petitioner alleges that he sustained injuries to his right and left hands and right and left arms as a result of repetitive duties while working for Menard Correctional Center. Petitioner alleged a date of accident of August 10, 2012. This is a repetitive trauma claim where Respondent disputed employment, accident, notice, causation, medical bills, and prospective medical. This case proceeded to a 19(b) hearing before Arbitrator Edward Lee on September 23, 2015, at the Collinsville docket.

Petitioner testified that he began employment at Menard Correctional Center as a correctional officer in June 1979. He retired on May 31, 2012. He testified that from June 1979-1993, he was a correctional officer at Menard Correctional Center. From 1993-1996, Petitioner was a correctional sergeant at Menard Correctional Center. From 1996-2012, Petitioner was a correctional lieutenant at Menard Correctional Center. Petitioner testified that the job duties of a correctional officer, sergeant and lieutenant were the same or similar. Petitioner testified that as a correctional lieutenant, he had additional paperwork that took time away from performing the manual duties. Petitioner testified that as a correctional lieutenant, he performed a couple hours per day of paperwork.

Petitioner testified that from 1979-2008, he was at Menard Correctional Center which is the maximum security prison. Petitioner testified that from 2008 until he retired on May 31, 2012, he was assigned to the medium security unit ("MSU"). Petitioner confirmed that Menard MSU was much newer facility than the maximum security prison. The keys and locks used at MSU were different. In addition, cell doors were made of steel doors on hinges that opened more smoothly than those in maximum security prison which were made of cell bars and had to be slid open. Petitioner testified that while there was bar rapping at MSU, it was only in one area of MSU, unlike Menard Correctional Center where all the cell doors are made of cell bars and have to be bar rapped. Petitioner testified that he opened 50 cells doors per day as a correctional lieutenant at MSU on the 3pm-11pm shift. Petitioner testified that he possibly raps bars once per week as a correctional lieutenant at MSU on the 3pm-11pm shift, which would take less than five minutes to rap.

Petitioner testified on direct examination that his symptoms began more than eight years ago. However, on cross-examination, Petitioner testified that he was unsure of when his symtpoms began. Petitioner testified at trial that there hadn't been any changes in his symptoms from August 2012 until September 2015. Petitioner testified that it doesn't take too much activity to bring on his symptoms. He experiences symptoms when driving, sleeping, and when using the television remote.

Petitioner testified that he owns a farm which is a couple hundred acres. He testified that he mows his farm. Also, Petitioner testified that he also plants and combines a friend's fields.

Retired Major Joseph Durham was called as a witness on behalf of Petitioner. Major Durham was employed at Menard Correctional Center for 25 years until his retirement on May 31, 2012. Major Durham was familiar with the job duties of a correctional officer, correctional sergeant, and correctional lieutenant. Major Durham testified that he had been a correctional officer, correctional lieutenant, and Major in his career. Major Durham testified that while the job duties of a correctional officer, correctional sergeant, and correctional lieutenant were the same or similar, Major Durham confirmed on cross-examination that the job duties of a correctional officer, correctional sergeant, and correctional lieutenant were not the same. Major Durham confirmed on cross-examination that the frequency with which Folger-Adams keys are used or bar rapping is performed is different in these positions. Major Durham testified that he was a correctional lieutenant in his career and rarely bar rapped. Major Durham testified that as a correctional lieutenant at Menard Correctional Center, he would "not very often" use Folger-Adams keys to open cell doors. Major Durham explained that correctional lieutenants were there to supervise the correctional officers and correctional sergeants.

The CMS class specification of a correctional lieutenant lists the following job duties:

1. Instructs and supervises correctional officers of lower rank in their duties; explains rules and regulations of the institution and assists correctional officer in non-routine problems.
2. Supervises intra-unit and inter-institutional transfer of inmates and employees; supervises transfer of inmates to courts on writs; escorts large civic and religious groups on tours of the institution.
3. Inspects officers coming on duty; conducts officers' roll call; checks correctional officers for vigilance and attentiveness to duty.
4. Inspects cells, shops, yards and buildings for cleanliness and sanitation; inspects machinery, equipment and safety and security devices for operating efficiency.
5. Checks waste and usage in prison industry jobs, in the dining rooms, stores and other locations; oversees the serving of food, samples food.
6. Arbitrates prisoners' disputes; investigates complaints; conducts special investigations as directed; makes recommendations to supervises for improvement of operations.
7. May relieve superior officers or other lieutenants during their absence; may assign correctional officers to shifts and specific duties in small institutions.
8. Performs other duties as required or assigned which are reasonably within the scope of the duties enumerated above.

On August 10, 2012, Petitioner presented to SI Neurology & Sleep Medicine for an EMG/Nerve Conduction Study. Petitioner was referred by Dr. Sonuga. Petitioner's history was listed as a 51-year-old male with complaint of having tingling involving both hands. Dr. Alam's impressions were as follows: 1) moderately severe bilateral carpal tunnel syndrome, left worse

than right; 2) mild bilateral ulnar neuropathy at elbow; and 3) there is no evidence of cervical radiculopathy on either side.

On August 15, 2012, Petitioner completed a "Workers' Compensation Employee's Notice of Injury". He reported injury to both elbows and wrists due to repetitive bar rapping, repetitive turning of keys, repetitive pushing/pulling of cell doors to secure them, repetitive writing, repetitive typing, repetitive keyboarding, and other repetitive tasks as expected or assigned to a security employee.

On August 21, 2012, Petitioner's supervisor completed a "Demands of the Job". It was noted that Petitioner's use of hands for gross manipulation (grasping, twisting, handling) was 2-4 hours per day and use of hands for fine manipulation (typing, good finger dexterity) was 0-2 hours per day.

On August 22, 2012, a "Supervisor's Report of Injury or Illness" was completed by Paul Olson, Shift Supervisor. He reported that Petitioner was a retired correctional lieutenant at Menard Correctional Center. Petitioner's job duties were listed as all the tasks of a security employee—rap bars, turn keys, push/pull cell doors to secure them, writing, typing, keyboarding & etc. It was noted that Petitioner was tested by Dr. Alam where he was diagnosed with cubital tunnel syndrome of both elbows and carpal tunnel syndrome of both wrists.

On August 22, 2012, an "Incident Report" was completed by Petitioner. Petitioner reported the following:

> On August 10, 2012 at approximately 8:15 am, James Dilday was tested by medical doctor Fakhre Alam at SI Neurology & Sleep Medicine, LLC in Carbondale, IL where James Dilday was diagnosed with cubital syndrome of the left & right elbows and corpal tunnel syndrome of the left & right wrists. Supervisor Acting Superintendent Olson and Workman's Compensation Coordinator Cindy Cowell were notified.

On August 22, 2012, Petitioner spoke with J. Danner at the Orthopaedic Institute of Southern Illinois. He reported that he had filed a workers' compensation claim through the State of Illinois. He stated that he was recently retired from Menard Correctional Center. He stated that he had an attorney and his name was Tom Rich.

On August 23, 2012, Petitioner presented to the Orthopaedic Institute of Southern Illinois and was seen by Phil Erthall, PAC for consultation for right hand numbness and pain which radiated up into the shoulders. Petitioner completed a "Workers Compensation Information" sheet. He listed that the accident happened due to "turning keys, rapping bars, pushing/pulling cell doors, writing, typing, key boarding, and other tasks as expected and/or assigned security employ". Petitioner reported the date and time of the injury as August 10, 2012, at approximately 8:15 am. Petitioner reported both of his hands and his right shoulder were affected. He noted that he was

retired from Menard Correctional Center. Petitioner listed his job title as retired correctional lieutenant. Petitioner also completed a "Work History Questionnaire" in which he noted that he was unsure how long he had the symptoms. Petitioner reported pain and numbness and tinlging in both hands, with the right being worse. Petitioner experienced numbness and tingling in the long, ring, and small fingers of the right hand and the thumb and index finger of the left hand. Petitioner reported that he tried non-prescription anti-inflammatory medication. Petitioner listed his description of job responsibilities as follows:

> Repetitive turning of keys to open locks, repetitive rapping of bars to ensure none have been cut, repetitive pushing/pulling of cell doors to close them and ensure they are secure, repetitive writing of daily paperwork, repetitive typing of paperwork, repetitive key boarding on computer, other repetitive tasks expected and/or assigned a security employee.

Petitioner noted that his symptoms were worsened by any activity that involved his hands. Petitioner reported being a correctional officer for 13 years, correctional sergeant for 4 years, and correctional lieutenant for 16 years. He reported retiring on May 31, 2012. Petitioner noted that he was retired but his symptoms were greatly increased by any activity involving the hands. Petitioner listed a hobby of hunting.

The history taken was listed as follows:

> The patient is a 51-year-old right-hand dominant male patient who states that for quite some time, he has had numbness in his hands bilaterally with pain that does radiate up into the forearms and upper arms. He states that it does wake him up at night. He states his pain level is about an 8 on a scale of 1 to 10. He states that it does affect his activities of daily living. He recently retired as a correctional officer for the state. He states that he worked for 33 years turning keys and keyboarding and writing quite often. He states that he was a correctional lieutenant for 16 of these years. Today, he states that he has filed a workman's comp claim, but he does not have a claim number as of yet. He was seen by his family care physician and nerve study was then ordered, and he was referred to our clinic for further evaluation.

Petitioner was retired from the Department of Corrections. He was 6'2" and weighed 210 pounds. Physical examination revealed full range of motion in both wrists to include flexion, extension, pronation, supination, and radial and ulnar deviation. Petitioner was able to make a complete fist with both hands and was able to extend all the fingers past neutral. He did have a positive Tinel's and a positive median nerve compression test bilaterally. He did have full range of motion in both elbows. Petitioner exhibited a positive Tinel's and a positive ulnar compression test bilaterally. Petitioner had full range of motion in both shoulders. He had a negative empty can's test. Negative Hawkins impingement testing. It was noted that Petitioner

had a nerve conduction study accompanying him which showed moderately severe bilateral carpal tunnel syndrome and mild cubital tunnel syndrome. Petitioner was assessed with bilateral carpal tunnel syndrome and cubital tunnel syndrome. It was felt that a splint would not be of any benefit, so they were going to request approval for carpal tunnel release and ulnar nerve transposition bilaterally for the cubital tunnel syndrome. It was noted that they would wait to hear from workers' compensation to place Petitioner on the surgical schedule.

On August 23, 2012, Dr. Steven Young authored an addendum. Petitioner complained of numbness and tingling involving bilateral upper extremities but stated that the left really did not bother him that much despite the somewhat worse or more impressive findings on his nerve conduction study. Petitioner's ring and small fingers bother him, but he stated occasionally he would have numbness into the long finger in the right hand. Petitioner reported some pain up into the shoulder area. Petitioner stated that his shoulder pain does not occur until he is having problems with his hand. Petitioner recently retired. Petitioner reported his symptoms had worsened, but he stated that he has had these symptoms for over a year. Petitioner noted having worked in a prison and listed multiple activities which would exacerbate his symptoms but stated that it was the typing and writing which were the biggest problems. Dr. Young inquired as to whether this is what he did the majority of the day, and he stated that it was simply the most problematic activity for him. Dr. Young noted that certainly those activities could contribute to a peripheral compression neuropathy. Dr. Young felt Petitioner would benefit from carpal tunnel release and an ulnar nerve transposition on the right side. Dr. Young noted that Petitioner had the inability to fully extend the elbow and thus would not be able to fully extend the elbow postoperatively.

On October 22, 2012, Petitioner was seen by Dr. Anthony Sudekum at Missouri Hand Center for an independent medical examination for evaluation of his bilateral upper extremities. Petitioner was 51-year-old, right-handed man who complained of numbness and tingling of both upper extremities and right shoulder pain. Petitioner was employed as a correctional officer, correctional sergeant, and correctional lieutenant for 33 years and was a correctional lieutanent for the last 16 years of his time at Menard. Petitioner retired from his job as a correctional lieutenant in May 2012. Petitioner reported intermittent numbness and tingling of both upper extremities, right greater than left, for the past several months and that these symptoms had worsened since he retired from his job. He stated that his upper extremity symptoms occurred at night, while driving, and intermittently during the day. He also complained of intermittent right shoulder pain.

Dr. Sudekum noted that Petitioner was not evaluated or seen by Dr. Smaga for upper extremity complaints, but Petitioner had telephoned their office on July 26, 2012, requesting a referral for nerve conduction studies.

Dr. Sudekum performed a physical examination which revealed no notable swelling or deformity of either extremity. Petitioner had mild subjective tenderness with palpation of the bilateral

volar wrists and medial elbows, right greater than left. Grip and pinch strength were normal. Wrist Tinel's was negative bilaterally. Wrist Phalen's and elbow Tinel's and Phalen's were positive bilaterally. Bilateral shoulder range of motion was normal. Elbow extension was reducted bilaterally, right greater than left. Fluoroscopic x-rays of the bilateral hands and wrists revealed no evidence of fracture, significant arthritis or bony abnormality. X-rays of the bilateral elbows revealed mild to osteoarthritic changes involving osteophytes and bone spurs on the olecranon tip, right greater than left.

Dr. Sudekum obtained bilateral nerve conduction studies that day which revealed normal distal motor and sensory latencies for the bilateral median and ulnar nerves. There was no electrodiagnostic evidence of significant median neuropathy, ulnar neuropathy, carpal tunnel syndrome, cubital tunnel syndrome or any peripheral neuropathy.

Dr. Sudekum not only reviewed Petitioner's medical records, workers' compensation documents, written position description from Petitioner's employer, and a verbal job description from Petitioner; but he also visited and toured Menard Correctional Center and Menard Medium Security Unit or "MSU". Dr. Sudekum noted that Dr. Alam's finding of relatively severe carpal tunnel syndrome did not correlate with Petitioner's primary subjective clinical symptoms. Clinically, Petitioner had minimal, if any, carpal tunnel syndrome on the left, so the diagnosis of serve left carpal tunnel syndrome was inconsistent and improvable. Dr. Sudekum noted that Petitioner's primary clinical symptom was ulnar nerve/cubital tunnel on the right side. Dr. Sudekum noted that Dr. Young's diagnosis of severe carpal tunnel syndrome and/or significant cubital tunnel syndrome was not verified by Petitioner's subjective symptoms, findings on physical examination, and/or nerve conduction studies. Dr. Sudekum noted that Petitioner had no objective evidence of carpal or cubital tunnel syndrome on either side but his subjective upper extremity symptoms were most consistent with possible mild, intermittent electrodiagnostically negative right cubital tunnel symptoms. Dr. Sudekum noted that Petitioner's nerve conduction studies did not reveal any evidence of ulnar neuropathy or cubital tunnel syndrome or any evidence of any upper extremity neuropathy (including carpal tunnel syndrome on either side or left cubital tunnel syndrome). Dr. Sudekum believed it was possible that Petitioner could have been experiencing some intermittent paresthesias in the right ulnar nerve distribution since numbness involving the right and little fingers was extremely common and not necessarily indicative of significant pathology. Dr. Sudekum did not feel that surgical intervention was required or indicated, especially since Petitioner had no objective evidence of significant neuropathy. Dr. Sudekum believed that the recommended surgical treatment including bilateral carpal and cubital tunnel releases was unnecessary and not justified and could potentially result in increased disability as a result of the proposed surgical intervention. Dr. Sudekum recommended conservative management for Petitioner's subjective upper extremity complaints and symptoms that included nighttime wrist splints, nonsteroidal anti-inflammatory medications, B vitamins, and occupational therapy.

Dr. Sudekum noted that Petitioner had nonwork-related risk factors which could predispose him to develop peripheral neuropathies such as carpal and/or cubital tunnel syndrome including his age over 51 years and arthritis affecting the bilateral elbows. Dr. Sudekum noted that there was no indication in Peititoner's medical records or any of the workers' compensation documents that Petitioner made any complaints to his employer/physicians, experienced any symptoms, filed an injury report, sought any medical care, or was diagnosed carpal and/or cubital tunnel syndrome during the time while he was employed at Menard Correctional Center.

Based upon his knowledge, Dr. Sudekum opined to a reasonable degree of medical certainty that the work activities Petitioner performed at Menard Correctional Center as a correctional officer or correctional sergeant did not cause or aggravate Petitioner's subjective bilateral upper extremity complaints. Dr. Sudekum noted that for the last 16 years of his time at Menard Correctional Center, Petitioner served as a correctional lieutenant and it was after he quit his job as a correctional lieutenant that he was first evaluated for subjective upper extremity complaints. Dr. Sudekum noted that he previously evaluated the correctional lieutenant position at Menard, and concluded that the job duties performed by correctional lieutenants at Menard would not normally cause or aggravate upper extremity "repetitive motion" injuries or conditions. Dr. Sduekum did not feel that Petitioner's employment activities as a correctional officer, correctional sergeant, and/or correctional lieutenant caused or aggravated his current upper extremity subjective symptoms and/or carpal tunnel syndrome and/or cubital tunnel syndrome, if they existed.

On March 14, 2013, the deposition of Dr. Anthony Sudekum was taken on behalf of Respondent. Dr. Sudekum is surgeon who is board certified in plastic and reconstructive surgery and has a second board certification in surgery of the upper extremity. He holds a certificate of added qualification for surgery of the hand. His practice involves the evaluation and treatment of any and all conditions that affect the upper extremity. Annually, Dr. Sudekum performs an estimated 100 surgeries for carpal tunnel syndrome and 30-50 surgeries for cubital tunnel syndrome. Dr. Sudekum testified that he had toured both Menard Correctional Center and Menard MSU where observed correctional officers, correctional sergeants, and correctional lieutenants. Dr. Sudekum also physically opened and closed different doors, bar rapped, handled food trays, and pushed buttons while on tour of Menard Correctional Center and Menard MSU. Dr. Sudekum testified consistent with his report. He also confirmed that Petitioner indicated that his symptoms had worsened since his retirement.

On June 24, 2014, the deposition of Dr. Steven Young was taken by Petitioner. Dr. Young gave a causation opinion in favor of Petitioner. Dr. Young does not hold a certificate of added qualification for surgery of the hand. Dr. Young was not aware that Petitioner had performed his last four years at Menard MSU (Medium Security Unit). Dr. Young was not aware of the differences between Menard Correctional Center and Menard MSU. Dr. Young did not know the number of times Petitioner would have turned a key as a correctional lieutenant. Dr. Young did not know how many minutes per day Petitioner would bar rap. Dr. Young did not know

which shift Petitioner worked. Dr. Young did not know how many times per day Petitioner would have used handcuffs as a correctional lieutenant. Dr. Young did not know the frequency with which lockdown occurred at Menard Correctional Center. Dr. Young confirmed that on examination, Petitioner exhibited arthritis in his bilateral elbows. Dr. Young confirmed that arthritis can contribute to the development of carpal and cubital tunnel syndromes. Dr. Young confirmed that Petitioner was in his sixth decade of life, which would be a risk factor for the development of carpal and cubital tunnel syndromes. Dr. Young confirmed that given Petitioner's description of his responsibilities, that his tasks were varied. Dr. Young testified that farming would contribute to carpal and/or cubital tunnel syndromes. Dr. Young specifically testified that driving the machinery could be contributory to carpal and/or cubital tunnel syndromes. Dr. Young testified that increased body mass index would also be a risk factor for carpal and/or cubital tunnel syndromes. Dr. Young agreed that Dr. Sudekum had more information about Petitioner's work than he did. Dr. Young testified that he even relied on Dr. Sudekum's report in giving his deposition. Dr. Young testified that riding a motorcycle would also be a risk factor for the development of carpal and/or cubital tunnel syndrome.

On August 25, 2015, Petitioner returned to Dr. Young. He completed a new questionnaire where he was asked whether this was a workman's compensation claim. Petitioner circled no. Petitioner reported numbness and tingling in the left and right hands and fingers. Petitioner stated that he was unable to have surgery when he last saw Dr. Young. Now, he returned wanting to do something. Petitioner reported quite a bit of numbness and tingling and weakness in the hands. Dr. Young ordered a new nerve study since the last nerve study was almost three years old. Petitioner was to follow-up after the study was done. Petitioner stated that he may want to wait until winter time after harvest was over to have the surgery done.

On August 27, 2015, Petitioner underwent a nerve conduction study was performed at SI Neurology & Sleep Medicine, LLC. The history was that Petitioner was a 54-year-old male with complaint of having numbness, tingling, and discomfort involving his upper extremities. The electrodiagnostic study was consistent with moderately severe bilateral carpal tunnel syndrome and mild bilateral ulnar neuropathy at the elbow. There was no evidence of cervical radiculopathy on either side.

Therefore, the Arbitrator concludes:

1. Petitioner was not an employee of Respondent on August 10, 2012. Petitioner retired on May 31, 2012.
2. Petitioner has failed to prove that he sustained an accident arising out of and in the course of his employment with Respondent or that his current conditions of ill-being to his bilateral arms/elbows in the form of cubital tunnel syndrome and to his bilateral hands in the form of carpal tunnel syndrome were a result of his work-related duties as a correctional officer, correctional sergeant, or correctional lieutenant at Menard Correctional Center or Menard MSU. Dr. Sudekum's knowledge of the job duties of

a correctional officer, correctional sergeant, and correctional lieutenant at Menard Correctional Center and Menard MSU is more extensive than Dr. Young's and is thereby given more weight. Dr. Sudekum reviewed Petitioner's medical records, job assignment history, job description, workers' compensation documents and toured Menard Correctional Center Maximum and Medium Security Units. Dr. Sudekum has opened locks and doors at both facilities and his opinion is based upon first-hand knowledge. The Commission has determined that a claimant fails to prove causation from repetitive trauma when the treating physician testified repetitive motions caused the injuries but failed to detail what repetitive motions the petitioner engaged in and the frequency of the motions. *Gambrel v. Mulay Plastics*, 97 IIC 238. An examination of the file and deposition of Dr. Young shows that the causation opinion of Dr. Young was based on incomplete information. Dr. Young did not know the frequency with which Petitioner turned keys at Menard.

3. Claim is denied.

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

Karen Gilbert,
Petitioner,
vs.
Rockford Career College,
Respondent,

NO: 12WC 32788

16IWCC0590

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 12, 2015 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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:
MJB/bm SEP 16 2016
o-9/12/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GILBERT, KAREN
Employee/Petitioner

Case# **12WC032788**

ROCKFORD CAREER COLLEGE
Employer/Respondent

16IWCC0590

On 6/12/2015, 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:

2489 BLACK & JONES
JASON EDMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

0560 WIEDNER & McAULIFFE LTD
PATRICK J MORRIS
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

Karen Gilbert
Employee/Petitioner

v.

Rockford Career College
Employer/Respondent

Case # 12 WC 32788

Consolidated cases: N/A

16IWCC0590

An *Application for Adjustment 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 **Rockford**, on **April 24, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0590

FINDINGS

On **April 19, 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 **$53,000.00**; the average weekly wage was **$1,019.23**.

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.0** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$0.00**.

Respondent has paid benefits of **$5,918.68** under Section 8(j) of the Act.

ORDER

BECAUSE PETITIONER FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT SHE SUSTAINED ACCIDENTAL INJURIES ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT AND FAILED TO PROVE BY A PREPONDERANCE OF THE EVIDENCE THAT HER ALLEGED CONDITION OF ILL BEING IS CAUSALLY CONNECTED TO HER EMPLOYMENT, PETITIONER'S CLAIM FOR COMPENSATION IS DENIED.

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

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

Signature of Arbitrator

June 9, 2015
Date

JUN 1 2 2015

16IWCC0590

Statement of Facts

Petitioner Karen Gilbert testified that on April 19, 2012 she was employed by Respondent Rockford Career College as the Dean of Students. She had been hired on August 9, 2010. Petitioner's resume states that she has a B.S. degree in business administration and an M.A. in public administration. She lists multiple computer and graphic skills. She was employed my multiple municipalities and worked for Virginia Tech University as the College of Engineering public relations coordinator and thereafter as assistant director of the center for student engagement and community partnerships (Rx 4).

Petitioner testified that when she was hired by Respondent that she was responsible for providing support to students in regard to non-academic areas such as student organizations and communications, including a school website. Petitioner testified that she signed a written Job Description dated November 8, 2010. The job description includes responsibility for overseeing all non-educational student programs, as well as serving as a member of the school's Executive Committee; the Administrative Committee, the Academic Team; the Retention Committee; the Security Committee; the Institutional Effectiveness Committee; and various student organizations. The Dean of Students was also the school's contact person for the Department of Education and the ADA. The job description outlined the performance criteria for the Dean of Students.

Petitioner testified that she did not believe that the May 16, 2012, written Job Description entered into evidence by Respondent at trial (Rx 3) was accurate, as the document actually listed more job duties than Petitioner had actually engaged in while working for Respondent as the Dean of Students. The document states that the Dean of Students is responsible for the ADA rights of students, FERPA rights, consumer protections, drug and alcohol policy; safety, sexual harassment, and overseeing the Career Services Department. According to Petitioner, she did not actually have some of the responsibilities listed on this job description.

Petitioner testified that she was also responsible for student retention and student counseling, as well as being in charge of student discipline, which included attendance issues, cheating and plagiarism, and issues involving allegations of disrespectful behavior to faculty members and other students. Petitioner testified that in late November or early December the role of Director of Security was also added to her position as well as coordinating placement.

She testified that she was responsible for coordinating with and directing the private security firm that had been contracted to patrol the campus. She testified that she had no experience or background with security. Petitioner testified that she would be responsible for confronting students. She would have the security guard present and another staff member. She would have to confront a student to a potential issue at least twice a week, sometimes more, other weeks, less.

As part of the head of security position, Petitioner was also responsible for dismissing students. One student, whom Petitioner had to dismiss for selling drugs on campus, became very hostile and had to be restrained by the security guard. The student assaulted the security guard several times while they waited for the police to arrive. Petitioner testified that the student wanted to hit Petitioner but was successfully restrained by the security guard. The student left Petitioner several messages threatening her. As a result of these events occurring from October 15, 2010 through November 17, 2010, a protective order entered December 1, 2010 was taken out against the student (Rx 2). Petitioner's affidavit submitted to the court noted that the student

had shoved Petitioner when she was confronted. Petitioner testified that she did not have any further contact with this student.

Another student, Michael, became very hostile when informed he was going to be dismissed. He leaned over Petitioner's desk, slamming his hands on it. Petitioner also testified that she had to fire her work study student who also threatened her thereafter. He left her a phone message indicating that she would pay for letting him go. Another student who had been previously dismissed was allowed to return to school. When Petitioner had to dismiss him, he threatened suicide. Additional students were caught selling drugs and became hostile when dismissed. Petitioner testified the building had security coverage only from 7:30 in the morning until 1:00 p.m. and then from 5 p.m. until 10 p.m. It also did not have security on Fridays or over the weekends or over breaks when classes were not in session, despite employees still being present. Petitioner also testified that there had been instances of knifings and sexual assaults in the parking lot. Petitioner testified that no student ever put hands on her. She has no records to document the incidents to which she testified.

Petitioner testified that she was also put in charge of conducting investigations of various coworkers. In December 2011, she began reporting to the president of the company instead of the Dean of Academics. In February 2012, Petitioner was put in charge of investigating the new Medical Director, who was accused of being a fraud. Petitioner was in charge of investigating her background. Petitioner had no special training in performing such investigations. The subject of the investigation became aware that Petitioner was investigating her and confronted Petitioner. Petitioner was also asked to investigate the Director of Admissions, who was accused of misrepresenting information, including her job qualifications. Petitioner also testified to an investigation of the Vice President. He had been accused of sexual harassment of a student and requested that Petitioner complete a report and give it to him. She testified that she was asked to perform that investigation without informing the President.

Petitioner sent an email to her supervisor Steve Gibson on May 3 and 4, 2012 (Px 7). She stated she could not physically handle the stress and requested that security be reassigned. She complained it was affecting her heart and rib cage muscles.

Petitioner testified that she was in charge of placements. A change in government regulations increased federal tracking of job placement to continue government loans for students. If numbers were not met, the government would cease funding and programs could be closed. Around May 18, 2012, Petitioner was called into the vice president's office. Petitioner testified that the CEO began to yell at her in an angry manner with a lot of posturing. He was threatening Petitioner and her coworker that they needed to meet their placement numbers. Petitioner testified to feeling intimidated by the CEO. Petitioner testified to a further meeting where the vice president of the board came. The meeting was in a dusty, dirty room. He told them that changes were going to be made. People will be fired. Petitioner stopped working for Respondent on August 17, 2012.

Petitioner testified that she sought medical treatment with her primary care physician, Dr. John Holtan. Dr. Holtan's records were admitted as Petitioner's Exhibit 1. Petitioner testified that she saw him one time in January and then returned on April 19, 2012 because she was getting strong pain in her chest. There is no record of a visit before April 19, 2012. The April 19, 2012 note records complaints of pain in her sternum, which had started the day before. On April 27, 2012, Petitioner underwent chest X-rays which revealed a left lateral mid-lung nodular, probably a calcified granuloma. A chest CT scan without contrast, taken on April 30, 2012, revealed an old granulomatous disease, with no significant intra-thoracic abnormality. Petitioner saw Dr.

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Holtan on April 30, 2012 with complaints of chest pain. The note includes a statement of stress at work (Px 1 p.14).

On May 18, 2012, petitioner underwent stress testing at St. Anthony Hospital. The records of St. Anthony Hospital were admitted as Petitioner's Exhibit 2. The history recorded is that Petitioner has a highly stressful job and has chest pain going on for hours which appears to be atypical for cardiac origin (Px 2 p.39) The stress test results were deemed to be within normal limits(Px 2 p.38-39). The record also includes a July 8, 2011 mammogram study which documents Dr. Holtan as Petitioner's physician (Px 2 p.30).

Petitioner testified that on Sunday, May 20, 2012 she was at the Pecatonica flea market when she had chest pain and was taken by ambulance to Rockford Memorial Hospital. The Rockford Memorial Hospital records were admitted as Petitioner's Exhibit 3. The history recorded is intermittent chest pain for about 2 weeks. The pain is sharp, and comes on in stressful situations and sometimes with exertion. Today she felt that she would pass out and was lightheaded. She reported that she was at a function and began talking to someone and began to feel stressed (Px 3 p.67). By the time she was seen, her chest pain was almost gone and she was feeling much better (Px 3 p.76). The discharge summary notes that Petitioner complained of work related stress and the doctor discussed antianxiety medications (Px 3 p.62).

Petitioner testified that the testing performed in May, 2012 did not reveal any physical problems. She testified she was also having trouble sleeping with nightmares and was hypervigilant. She had trouble breathing. She developed fatigue.

Petitioner was prescribed anti-anxiety medication by Dr. Holtan. She testified that she had been on anti-depressant medication, following her divorce, approximately 10 years prior and only for about a year. As of August 17, 2012, Petitioner filed for short term disability

Petitioner continued treatment with Dr. Holtan for anxiety, chest pain and insomnia (Px 1 p.10) On September 5, 2012, Dr. Holtan provided a note stating that Petitioner was restricted from working at Respondent due to anxiety and chest pain (Px 1 p.8). On October 16, 2012, Dr. Holtan provided a note stating that Petitioner continued to have chest pain and anxiety issues and had been unable to return to her work due to the stress. Petitioner should be able to work elsewhere (Px 1 p.3).

Petitioner was seen for a Section 12 examination by Dr. Marianne Geiger on June 7, 2013 at her attorney's request. The transcript of her October 28, 2014 deposition was admitted as Petitioner's Exhibit 4. Dr. Geiger testified that she is psychiatrist. She was provided a written summary regarding issues she had with Respondent. This summary is in evidence as Respondent's Exhibit 1. This lists a timeline of multiple incidents and events that Petitioner felt relevant to her condition and a narration of the Petitioner's complaints and critique of Respondent's business practices. Dr. Geiger testified that the summary outlined the circumstances of her employment, her realization that the student population was different that she had dealt with in the past being much more likely to have felons and criminals, drug users and have violent tendencies. She described her escalating responsibilities. The history included being required to do jobs for which she was not trained, being berated by corporate representatives, and having her life threatened by students. After her psychiatric examination, Dr. Geiger opined that Petitioner was suffering from post traumatic stress disorder (PTSD) causally related to her employment with Respondent. She testified that the symptoms were brought on by the pressures of work and the perception of being berated and endangered from the students. She notes in her report that much more was expected of Petitioner than is usual for the normal population (Px 4, Ex 2). Dr.

Geiger's report notes that Petitioner's condition is partially resolved. She only occasionally needs medication. Her prognosis is good. She does not need continuing psychiatric care. She can perform a job at a similar school that consists of mainly administrative tasks with a clear chain of command and little contact with students.

Dr. Geiger testified that the examination took about 50 minutes. She has no information as to the incident reported by Petitioner other that the history provided. She did not perform any testing. She testified that the time between the threating event and the symptoms is not a factor in her diagnosis or opinion. She does admit she doubts that you would get PTSD from a single incident two years before symptoms. She was not aware of any prior issues in Petitioner's past. She testified that her perception is that the students at Respondent are losers who can't hack it. Dr. Geiger believes that PTSD is underdiagnosed. She testified that the word "perceived" is not included in the DSM diagnosis for PTSD. She testified that the book is wrong.

Petitioner was seen for a Section 12 examination at Respondent's request by Dr. Hartman, a board certified psychologist neuropsychologist on April 28, 2014, His report was admitted as Respondent's Exhibit 6. The transcript of his January 9, 2015 deposition was admitted as Respondent's Exhibit 7. Dr. Hartman testified that his examination including the testing he performed lasted approximately six to seven hours. Dr. Hartman diagnosed Petitioner with personality disorder with narcissistic and histrionic features (Rx 7 p.50). He also stated that she could have an anxiety disorder, but noted that she had hypothyroidism, which also could be a causative factor in the development of this condition (Rx 7 p. 50). He based these diagnoses on the very consistent impression I had from Ms. Gilbert is that she was disparaging and condescending of every single coworker that she worked with. She found them intellectually, morally or criminally culpable and she painted herself as the only individual who really had it together in that entire place (Rx 7 p. 49). Dr. Hartman also opined that Petitioner's problem was that of work avoidance, i.e., that she does not really want to work in the real world (Rx 7 p.52). Dr. Hartman opined that Petitioner does not have any stress-related or trauma-related difficulties in returning to work (Rx 7 p.53). He testified that he believes that Petitioner simply chose not to return to work. He opined that petitioner is clearly at MMI, and does not require any further treatment or counseling (Rx 7 p.54-55).

Dr. Hartman testified that Petitioner spent the great majority of the clinical interview discussing her allegations as to the work environment at Rockford Career College. Petitioner had informed him that she was quite dissatisfied and quite stressed because she felt that she was not given the "proper authority for her job; that she was being asked to do more work than she felt was not part of her job description; and she was either lectured to or treated in a manner that she did not approve of by the other administrators" (Rx 7 p.22-23). Dr. Hartman testified that Petitioner was quite dissatisfied with her fellow employees whom she "variously alleged had criminal or psychiatric backgrounds" and with whom she felt she had a difficult time working. Petitioner also told Dr. Hartman about an instance where she was asked to conduct an investigation of a sexual harassment claim against the vice president of the school and that this request had been made by the vice president behind the president of the school's back (Rx 7 p.23). When asked about the student body at Rockford Career College, Petitioner advised Dr. Hartman that the students were essentially only there for the financial aid and were individuals with criminal records and drug-related issues (Rx 7 p.24).

Dr. Hartman testified that Petitioner complained that she had little authority to either discipline or control her work environment as the head of security (Rx 7 p.27-28). Dr. Hartman testified that he had asked Petitioner if she would feel less stressed if she had more authority to control the security department, and Petitioner responded, "Yes."

Dr. Hartman testified that Petitioner had advised him that she had been physically abused by her ex-husband in front of their children prior to their divorce (Rx 7 p.28-29). According to Dr. Hartman, the most remarkable part of his clinical interview was that Petitioner did not appear to be unduly anxious or observably depressed (Rx 7 p.29). He stated that she had a kind of occasional histrionic emotional presentation where she would become loud in discussing things. He also noted that Petitioner described everyone at the school – students, facility members, and fellow staff members alike – in very, very negative terms, which was based on Petitioner's feeling that these individuals were all incompetent or had some form of mental disability or criminal underpinning that would work against her ability to work with them (Rx 7 p.30).

Dr. Hartman testified that PTSD is an extreme diagnosis that is caused by extreme circumstances. With respect to Dr. Geiger's testimony that one's perception of a threat or a traumatic event is sufficient to support a diagnosis of PTSD, Dr. Hartman testified that goes completely against the whole development of the DSM, which was to objectify the criteria for a diagnosis (Rx 7 p.45). Dr. Hartman testified that the DSM is quite clear in describing the objective nature of the events in question. Dr. Hartman testified that he would strongly disagree with Dr. Geiger as to the diagnosis of PTSD (Rx 7 p.47). He testified that he did not believe that anyone could develop PTSD from the incidents that petitioner described. Dr. Hartman stated that events and work environment described by Petitioner simply do not rise to the level of trauma that the DSM requires as a gatekeeping criteria to develop PTSD (Rx 7 p.48). Dr. Hartman testified that the threats on her well-being would be a plausible cause for anxiety (Rx 7 p.68).

Petitioner testified that she is worked part time for a political advocacy group doing writing from home. She is working on her PhD in higher education. She is looking towards doing consulting in college campus partnerships. She has applied for online positions at other colleges. She is not currently taking any medication.

Conclusions of Law

In support of the Arbitrator's decision with respect to (C) Accident, the Arbitrator finds as follows:

Petitioner bears the burden of proving by a preponderance of the credible evidence all the elements of her claim including that she sustained accidental injuries arising out of and in the course of her employment. Petitioner is seeking compensation for diagnosed conditions of anxiety and Post Traumatic Stress Disorder as diagnosed by Dr. Holtan and Dr. Geiger. While Petitioner testified to physical symptoms of chest pain and shortness of breath, she has been diagnosed with mental conditions, not a physical injury. Petitioner's testimony in clear that, despite her testimony of threats and confrontations, there was no physical contact or injury inflicted upon her. As such, her claim must be examined under the standard for a mental-mental claim. See *Bertha Marshall v. Fuji Film Hunt Chemicals U.S.A.*, 11IWCC0403, 2011 Ill. Wrk. Comp. LEXIS 374 (headaches); *Shontell Smith v. Ludeman Mental Health Center*, 04WC 59682, 2010 Ill. Wrk. Comp. LEXIS 732 (headaches and neck pain).

She has presented, through her testimony and written summary as well as the medical records and reports, her litany of alleged episodes and a timeline of multiple factors of her employment which she alleges resulted in the stresses that caused her condition. Petitioner's long list of grievances can be categories into basically three groups of behaviors: 1) threats by students, 2) increased duties for which she was not properly trained,

3) stressful demands by supervisors including the internal investigations of co workers and the aggressive meetings on placement numbers and job peformance.

The Arbitrator notes that there is no evidence corroborating Petitioner's testimony as to the events which transpired or the nature of the encounters, other than the December, 2010 protective order. The Arbitrator observed the Petitioner and has reviewed her summary as presented to Dr. Geiger and admitted as Respondent's Exhibit 1. The Arbitrator found Petitioner's demeanor evasive, condescending and defensive and noted the extensive criticism of Respondent's business practices and the handling of her disability claim in her written summary. The Arbitrator agrees with Dr. Hartman's assessment that Petitioner was disparaging and condescending of every single coworker that she worked with. She found them intellectually, morally or criminally culpable and she painted herself as the only individual who really had it together in that entire place. The Arbitrator also agrees with Dr. Hartman's assessment that she had a kind of occasional histrionic emotional presentation. Based upon the Arbitrator's observation of Petitioner's demeanor, the Arbitrator finds much of her description of the events that occurred and her testimony of her reaction of fear, distress and anxiety resulting therefrom not credible.

Because employment conditions in themselves may produce stress, the "mental-mental" theory of recovery is generally recognized as a more difficult basis for claimant to prove that her psychological injury is compensable. Recovery for non-traumatically-induced mental disease is limited to those who can establish that: (1) the mental disorder arose in a situation of greater dimensions than the day-to-day emotional strain and tension which all employees must experience; (2) the conditions exist in reality, from an objective standpoint; and (3) the employment conditions, when compared with the non employment conditions, were the major contributory cause of the mental disorder. The Act does not permit recovery for every non traumatic psychic injury from which an employee suffers merely because the employee can identify some stressful work-related episode which contributes in part to the employee's depression or anxiety. Whether a worker has suffered the type of emotional shock sufficient to warrant recovery should be determined by an objective, reasonable-person standard.

The Arbitrator has considered Petitioner's claim of fear as a result of the threats received from student that Petitioner dismissed or disciplined. As noted in the Arbitrator's assessment of the Petitioner's credibility, the Arbitrator finds the description of the incidents and Petitioner's claimed reaction histrionic and embellished and therefore discounts these incidents. The Arbitrator also notes that these threats are given a minimal focus in Petitioner's summary and barely mentioned as the foundation of Dr. Geiger's opinions. The only documented incident occurred within Petitioner's first few months of employment and over a year before the onset of symptoms. Although not dispositive as a matter of law, evidence that a claimant delayed seeking treatment for alleged psychological injuries for an extended period of time following a work-related accident may still be relevant in a given case. Depending on the facts of the case, such evidence might undermine the inference that the claimant suffered a severe emotional shock that caused a psychological injury. After considering the evidence presented the Arbitrator does not find Petitioner's testimony that she was in fear as a result of these threats persuasive and does not establish an emotional shock sufficient to warrant recovery by an objective, reasonable person standard.

Petitioner's additional allegations of being overworked, undertrained, and placed in uncomfortable, and confrontational situations with superiors and co-workers similarly fail to rise to the necessary level of emotional shock sufficient to warrant recovery by an objective, reasonable person standard. The Commission has been extraordinarily cautious in awarding benefits under the Illinois Workers' Compensation Act in the case of a

"mental-mental" injury without any physical incident or injury. Decisions have been diligent in narrowly defining when an employee might recover benefits for a mental-mental injury. Claims for mental disabilities resulting from arguments with co-workers or supervisors have been denied. *City of Springfield v Industrial Comm.*, 214 Ill. App. 3d 301 (4th Dist. 1991). Claims were unsuccessful if based on a fear for the workers' safety. *Board of Education v Industrial Comm.*, 182 Ill. App. 3d 983 (1st Dist. 1998). Claims have failed where based on disciplinary action taken by the employer. *Esco Corp. v Industrial Comm.*, 169 Ill.App.3d 376, 523 N.E.2d 589 (4th Dist. 1988). In most instances where the trauma related to anxiety connected to the normal employment duties and relationships, benefits have been denied no matter how stressful the particular circumstances may have been. Citing *Shontell Smith v. Ludeman Mental Health Center*, 04WC 59682, 2010 Ill. Wrk. Comp. LEXIS 732.

The Arbitrator has reviewed the testimony of Dr. Geiger and Dr. Hartman with respect to whether Petitioner has sustained a work related psychological trauma. Expert opinions must be supported by facts and are only as valid as the facts underlying them. 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 assessing the opinions rendered by Dr. Geiger and Dr. Hartman, the Arbitrator finds the opinions of Dr. Hartman more persuasive. The Arbitrator notes that Dr. Hartman has greater qualifications, being board certified. He also spent far longer with the Petitioner that Dr. Geiger's 50 minute psychiatric evaluation. He performed objective testing which Dr. Geiger did not. An expert opinion is only as valid as the basis for the opinion. Dr. Geiger admits that her opinions are based upon the summary and history provided by the Petitioner, evidence the Arbitrator has found unpersuasive. Dr. Geiger also admits to her personal bias and personal disdain for the students attending Respondent. Dr. Geiger also premises her opinions on Petitioner's perception of the situation rather than on an objective, reasonable-person standard. And in fact disagrees with the DSM on this issue. Dr. Hartman's assessment of the Petitioner's presentation and demeanor was in agreement with the Arbitrator's assessment of her presentation at trial. His opinions are based upon the more thorough analysis and documented by the testing and interview conducted with Petitioner. After review of all of the testimony and the underlying analysis, the Arbitrator finds the opinions of Dr. Hartman that Petitioner is not suffering from PTSD, does not have a work related mental condition and does not have any stress-related or trauma-related difficulties in returning to work persuasive.

Based upon the record as a whole, including the testimony, medical records and exhibits and the expert deposition testimony, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evident that she sustained accidental injuries arising out of or in the course of her employment.

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

As more fully discussed in the Arbitrator's findings with respect to accident, the Arbitrator finds the opinions of Dr. Hartman more persuasive that those of Dr. Geiger. The Arbitrator has reviewed the exhibits including the Petitioner's summary of her grievances with Respondent that she prepared for Dr. Geiger and has observed the Petitioner's testimony and demeanor.

Based upon the record as a whole including the Petitioner's testimony, the medical records, reports and depositions, and other exhibits admitted, and as supported by the Arbitrator's decision with respect to Accident, the Arbitrator finds that Petitioner has failed to prove by a preponderance of the credible evidence that her condition of ill being is causally connected to her employment with Respondent.

In support of the Arbitrator's decision with respect to (E) Notice, (J) Medical, and (L) Nature and Extent, the Arbitrator finds as follows:

Based upon the Arbitrator's findings with respect to Accident and Causal Connection, the remaining issues of Notice, Medical and Nature and Extent are moot.

Petitioner's claim for benefits is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wieslaw Marciniec,

Petitioner,

16IWCC0592

vs.

NO: 12 WC 44184

Castle Metals,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2016 is hereby affirmed and adopted.

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

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

16IWCC0592

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

DATED: SEP 16 2016
KWL/vf
O-9/12/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0592

MARCINIEC, WIESLAW
Employee/Petitioner

Case# **12WC044184**

12WC044185

CASTLE METALS
Employer/Respondent

On 1/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

0766 HENNESSY & ROACH PC
WILLIAM O'BRIEN
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

16IWCC0592

WIESLAW MARCINIEC
Employee/Petitioner

v.

CASTLE METALS
Employer/Respondent

Case # 12 WC 44184

Consolidated cases: 12 WC 44185

Separate decisions issued

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **CHICAGO**, on **November 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0592

On **October 25, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$66,267.76**; the average weekly wage was **$1,274.38**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$13,229.33** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$15,035.73** for other benefits, for a total credit of **$28,265.06**.

Respondent is entitled to a credit of **$21,665.52** under Section 8(j) of the Act.

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/week** for 75 weeks, because the injuries sustained caused the **15%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits from December 7, 2012 through July 26, 2013, a total of **33-1/7** weeks, in the amount of **$849.55** per week. Respondent is entitled to a **credit** for TTD paid of **$13,229.33** and short term disability paid in the amount of $15,035.73 for a net total credit of **$28,265.06.**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$78,180.04**, as provided in Sections 8(a) and 8.2 of the Act, pursuant to the medical fee schedule or by prior agreement, whichever is less. Respondent is entitled to a credit of **$21,665.52** 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.

Deborah L. Simpson

Signature of Arbitrator

January 14, 2016
Date

JAN 15 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wieslaw Marciniec,	)	
	)	
Petitioner,	)	**16IWCC0592**
	)	
vs.	)	**No. 12 WC 44184**
	)	**consolidated 12 WC 44185**
A. M. Castle,	)	**separate decisions issued**
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 25, 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 on that date the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $66,265.16, and that his average weekly wage was $1,274.33.

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 the 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; (5) What is the nature and extent of the injury; and (6) Is the Respondent due any credit.

There are two cases filed, with two different accident dates and different issues. There is one transcript, and one set of exhibits for both cases. There are separate decisions written for each case since the issues are not the same and there are two different dates of accident.

STATEMENT OF FACTS

Petitioner began working for Respondent in 1993 as a pick and fill order filler and a side loader operator. The Petitioner testified that his job required a lot of heavy lifting, involving packaging and/or banding material, weighing it, and operating a small crane by remote. Whatever the customers ordered is what they had to fill.

On April 20, 2010 Petitioner was helping a co-worker lift a very heavy wooden box weighing approximately 200 pounds when he felt a sharp pain in his low back shooting into his right leg. He reported this pain to his co-worker but attempted to continue to do his job of lifting

and driving the side loader over uneven ground. The pain continued and the Petitioner asked his co-worker to go with him to report the accident to their supervisor.

Petitioner continued to work his regular job and on May 4, 2010, he went to the company clinic, Concentra. Petitioner had to wait for permission to go to the clinic. Petitioner was diagnosed with a lumbar strain. (PX 1) The clinic recommended Advil and physical therapy. Petitioner was allowed to continue to work full duty at that time. Petitioner started physical therapy on May 4th and continued with it until about June 8th, 2010.

Petitioner continued treating with the company clinic while attending physical therapy and on May 7th it was recommended he add some ice and heat to his physical therapy treatment. He returned to Concentra for follow up on May 14th and 21st. On May 21st it was reported that Petitioner was no longer having right leg pain. Petitioner had two final visits on June 1st and June 8th and was released to work full duty. Petitioner testified that although he was returned to work full duty and no longer had pain in his right leg, his back was not the same.

Petitioner's medical records indicate that on May 21, 2010 the lumbar "pain does not radiate any more". On June 1, 2010 he had no pain at all and "felt completely better". On June 2, 2010 he was "pain free". And on June 8, 2010, he had a normal exam. (PX 1)

According to the Petitioner, in the spring of 2012 he began feeling an increase in his back pain while working and lifting. Petitioner testified that the pain continued to increase to the point where he could no longer perform his job. It took approximately 8 months to get to this point.

On October 25, 2012, while performing his job duties of lifting and driving the side loader on bumpy ground, his pain became more severe and started shooting into his left leg. Petitioner reported this to Mike Nelson, his union representative, and was told to go to management. Petitioner testified further that he then spoke with Phil Slighbom and reported that he was having back pain similar to 2010 but shooting into his left leg. Petitioner requested to go to the company clinic. Petitioner stated he was told that the manager needed to check with his bosses if this would be treated as a pre-existing accident or a new accident. Petitioner returned to his work station and performed his job the best he could without lifting. Petitioner testified that Mr. Slighbom came to him later in the day and gave him paperwork authorizing him to go to the company clinic. This document, which was completed by Mr. Slighbom, characterized the injury as recurrent.

Petitioner presented to Concentra on October 25, 2012. He recounted his April 2010 accident and stated that the pain had returned about 8 months ago and that it had been getting progressively worse with his activities at work. Petitioner was given acetaminophen, a Medrol Dose Pak, and another round of physical therapy.

Petitioner was returned to work and continued to work his regular job. Petitioner testified that he was careful with how he lifted materials. He continued treating with Concentra and attended approximately 14 sessions of physical therapy.

On November 6, 2012 Petitioner reported to Concentra that his pain had increased due to working overtime. He was told to avoid overtime and that if his problems continued they would order an MRI. Petitioner returned to Concentra on November 13th and an MRI was ordered.

Petitioner was put on restrictions of no lifting over 20 pounds, no prolonged standing, no walking longer than tolerated, no bending more than ten times an hour, and no pushing or pulling over 25 pounds.

Respondent gave Petitioner a lighter job with longer breaks but he was still required to drive the side loader over bumpy ground which he testified aggravated his pain.

Petitioner returned to Concentra on November 21, 2012 and reported he was feeling a little better. He was referred to an orthopedic, Dr. Charles Mercier. Petitioner first saw Dr. Mercier on December 3, 2012 and requested that his care be transferred to his primary care physician, Dr. Judith Sherman with DuPage Medical Group.

Petitioner saw Dr. Sherman on December 7, 2012 and she took him off work completely. Dr. Sherman referred Petitioner to the LOM Spine Center and recommended he follow up with Dr. Mataragas, a spine surgeon.

Petitioner saw Dr. Mataragas on January 2, 2013 for a surgical consult. At Petitioner's January 15th visit with Dr. Mataragas he agreed to schedule surgery. Petitioner was receiving temporary total disability benefits at this time.

Respondent requested that the Petitioner undergo a Section 12 examination, which was scheduled on March 25, 2013 with Dr. Avi Bernstein. After the examination, Petitioner's temporary total disability benefits were stopped and Respondent stopped paying for medical bills. Petitioner initiated sick pay and began submitting his medical bills to his group insurer.

On May 14th Petitioner saw Dr. Sherman for a pre-op exam and had surgery with Dr. Mataragas on May 30, 2013 at Good Samaritan Hospital. Petitioner had a L5-S1 laminectomy discectomy with foraminotomies of the L5 and S1 nerve roots bilaterally. (PX 2, 3)Petitioner reported feeling better and no more sharp pain shooting into his left leg after the surgery.

Petitioner began a course of physical therapy on June 19th and attended approximately 21 visits up to July 28, 2013. Petitioner was discharged at a medium physical demand level and returned to work on July 29th full duty. Petitioner has been working full duty with no restrictions since.

Petitioner had his last surgical follow-up on November 26, 2013 with no further treatment sought or scheduled since that day.

Petitioner testified that his life has changed since his surgery. He stated his left leg has a lot of irritation doing everyday work. He has a loss of balance and a weakness in his back and legs that make him shaky. His pain level is much better but he cannot walk for a long time due to needing rest and he trips when he runs. At work Petitioner uses different techniques to protect himself and asks co-workers for help with lifting. Petitioner testified that he was a good worker with perfect attendance, had never hurt his back before April 2010, and has not had any subsequent accidents since October 25, 2012.

Petitioner entered into evidence as Exhibit 6 the deposition transcript of Dr. Nicholas Mataragas, the treating orthopedic surgeon. The relevant portions of his testimony were that the initial pathology was caused by the lifting episode of April 20, 2010, and that one lift of 50#

could aggravate disc pathology. He also testified that Petitioner's work activities after his first injury and up to and including October 25, 2012 could have aggravated his pre-existing condition, causing the need for the surgery

Dr. Bernstein, Respondent's section 12 examiner, testified that he was unable to relate the disc herniation to the first accident, and he was unable to identify a second work accident that would be responsible for his condition. When asked on cross if it were shown that the Petitioner had done heavy work over the years, whether that could have been a factor in the development of the pathology, he responded that that could alter his opinion. He further testified that the Petitioner's reported increase in left leg pain while working on October 25, 2012 indicated that he was starting to experience nerve-root compression. He testified that he did not believe that repetitively lifting and twisting with 50# of weight could cause a disc herniation, though he did feel one could have a distinct disc injury from one such lift. He went on to say that he would consider constant lifting and twisting with 50# to be an activity of daily living.

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). This includes the nature and extent of the petitioner's injury.

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974)

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

Employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition. *Rotberg v. Industrial Comm'n,* 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005).

Peoria Motors, Inc. v. Industrial Commission, 92 Ill.2d 260, 442 N.E.2d 144 (1982). In *Peoria Motors, Inc.*, the claimant sustained an injury to his back while working for one employer. *Id.* Following significant medical treatment for his back, including surgery, the claimant was released to return to work. *Id.* The claimant returned to work for another employer. *Id.* The strain of lifting heavy objects in the new job aggravated his back condition and he underwent further surgery for his back. *Id.* The Arbitrator awarded benefits in connection with both cases. *Id.* The Commission found that Petitioner did not sustain a second accident with his subsequent employer and that his current condition of ill-being in his back was causally connected to the original accident. *Id.* The Supreme Court affirmed the decision and found that the work the claimant was performing was aggravating his condition. *Id.*

"Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent, and whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner had sustained a work related injury on April 20, 2010 to his low back and right leg. After a course of physical therapy the back pain and the right leg pain subsided according to what the Petitioner reported to his doctor and physical therapist. He was able to continue doing his regular job, during the course of the physical therapy and after, which consisted of repetitively lifting and twisting product, some of which weighed up to 50#. He was also driving a side loader over bumpy ground.

In the spring of 2012 the Petitioner began to feel an increase in his back pain while performing his job duties. While he continued to work through the summer and into the fall he testified that the pain in his back was increasing. On October 25, 2012 after several hours of work which involved lifting and twisting as well as driving the side loader over bumpy ground, his back pain became more severe and it started shooting into his left leg. The Petitioner went

first to his union representative, Mike Nelson, then to his manager Phil, Slighbom regarding the pain issue. Petitioner told Mr. Slighbom that he was having back pain similar to 2010 but this time it was shooting into his left leg. Mr. Slighbom reportedly checked with his bosses later that day gave Petitioner paperwork authorizing him to go to the company clinic. This document was admitted into evidence as PX8. Petitioner went to the clinic on the same day and gave a history of his 2010 accident and then told them that the pain had returned about 8 months ago and had been getting progressively worse with his activities at work.

He was treated again treated conservatively with physical therapy and a Medrol Dosepak and continued his regular job, being careful with lifting. In November, he reported increased pain which he equated with working overtime. An MRI was ordered and he was put on restrictions. He was given a lighter job with fewer hours but he was still required to drive the side loader over bumpy ground which increased his pain.

He saw his PCP, Dr. Sherman, on December 7, 2012 and she took him off work completely and Respondent initiated TTD payments. She referred Petitioner to Dr. Mataragas who recommended surgery. The Respondent scheduled a Section 12 examination with Dr. Bernstein, on March 25, 2013, who opined no causal connection due to there being no specific incident. Respondent stopped paying TTD and declined to authorize further treatment after the Section 12 examination. Petitioner went on sick pay and put his surgery through group.

The Arbitrator finds that Petitioner has proven both accident and causal connection by a preponderance of the evidence. Specifically the Arbitrator finds the Petitioner to be credible and the fact pattern supportive of an accident in the sense of repetitive trauma aggravating Petitioner's known previous condition. Although the Petitioner did not have an MRI the first time he had symptoms, and the condition of his spine could have existed prior to the first injury, clearly it was not symptomatic until the lifting incident on April 20, 2010. Dr. Bernstein conceded that the disk could have ruptured with the one-time lifting event Petitioner described. That injury was treated conservatively and Petitioner was able to return to work and perform his job duties without restrictions for about 2 years, until the fall of 2012.

In the spring of 2012, the Petitioner began to notice back pain again, but not severe enough to interfere with work. He continued to work, lifting and twisting plus driving the side loader over the bumpy terrain, and the pain continued to get worse, until October of 2012, when the pain in his back became so intense, and then radiated to his left leg, that the Petitioner once again sought medical treatment. This clearly was not a recurrence of the previous injury because the radicular symptoms were primarily left-sided this time as opposed to the right leg. Conservative treatment failed to work and as a result of that Petitioner underwent surgery for the herniated disk in his back. The Petitioner underwent a L5-S1 laminectomy discectomy with foraminotomies of the L5 and S1 nerve roots bilaterally, which alleviated his pain and leg weakness.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner at first received conservative treatment, including pain medications and physical therapy. These modalities had worked in the past. This time however, the therapy was not effective. The doctors ordered an MRI, determined that Petitioner had a herniated disk and that the disk was compressing the nerve root, causing the pain in the back and the left leg, in addition to the other symptoms Petitioner was experiencing. Dr. Mataragas determined that the course of treatment should be surgery. The Petitioner underwent the surgical intervention on May 30, 2013. Within two weeks of surgery the Petitioner was reporting minimal low back pain and that the pain in his left leg was completely gone.

Based upon the foregoing discussion, The Arbitrator finds that the treatment received by Petitioner was reasonable and necessary, and related to his work injury as it pertains to his back, low back and left leg. The Respondent's objection to the claimed medical bills totaling $78,180.04 was based on liability. The Arbitrator having found that the Petitioner has proven that the injury arose out of and in the course of the employment between the Petitioner and Respondent and that his current condition is causally connected to that accident, therefore the medical bills are awarded pursuant to §§8(a) and 8.2 of the Act, subject to the fee schedule or prior agreement, whichever is less. Respondent is entitled to a Section 8(j) credit of $21,665.52.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner was taken off of work by his treating doctors beginning on December 7, 2012. He was released to return to work after the surgery and post operative course of physical therapy on July 26, 2013. Respondent paid TTD benefits from December 7, 2012 until shortly after the Section 12 examination on March 25, 2013, when TTD was stopped based upon Dr. Bernstein's report. The Arbitrator having found that Petitioner did sustain an accidental injury and his condition was causally connected to the injury resulting in the need for surgery finds that the Respondent is liable for TTD from December 7, 2012 through July 26, 2013, a total of 33-1/7 weeks, in the amount of $849.55 per week. Respondent is entitled to a credit for TTD paid of $13,229.33 and short term disability paid in the amount of $15,035.73 for a net total credit of $28,265.06.

In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured

employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b) It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: Neither Petitioner nor Respondent presented an AMA Impairment Rating. Based on the failure to submit an AMA Impairment Rating the Arbitrator cannot consider this factor.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a pick and fill order filler and a side loader operator. The job appears to be in the medium duty category. Petitioner testified that his job required heavy lifting, involving packaging and/or banding material, weighing it, and operating a small crane by remote. The material can weigh up to 50 pounds. After his surgery the Petitioner returned to his regular employment, full duty with no restrictions. He has modified how he does some of the work, and asks for help when he needs it. He is still driving the side loader over bumpy terrain as part of his job duties. The Arbitrator gives significant weight to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 58 at the time of his accident. As Petitioner is in his late 50s he would not be expected to be working as long as younger employees with the effects of his injury and treatment. There is no evidence that Petitioner's age impacted his injury or created any permanent disability. The Arbitrator gives little weight to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that he continues to work at his regular job, full time, with no restrictions for the same pay. He did not testify to any effect that his injury had on his rate of pay, the number of hours that he works or his ability to continue working.

Petitioner did not testify to any diminution of his earnings since this accident. There is no evidence of disability due to this factor no weight is given to this factor.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained an injury to his lower back. As a result of his injuries, the Petitioner underwent low back surgery. Although the surgery was successful, within two weeks of surgery the Petitioner was reporting that he had minimal pain in his low back and no pain in his left leg, describing himself as thrilled with the results, to his doctor. Six weeks after surgery the Petitioner reported that his back pain was gone, he was experiencing some cramping in his left calf. He moved from physical therapy to work conditioning and was returned to work July 29, 2013, without restrictions. At the hearing the Petitioner testified that his life has changed since his surgery. He stated his left leg has a lot of irritation doing everyday work. He has a loss of balance and a weakness in his back and legs that make him shaky. His pain level is much better but he cannot walk for a long time due to needing rest and he trips when he runs. This is not reflected in the medical records.

The Arbitrator gives little weight to this factor.

Based upon the foregoing discussion, the Arbitrator finds that Petitioner suffered 15% loss of use of a man as a whole as a result of the injury. Given the nature of the injury the Petitioner suffered to his back following the October 25, 2012, incident, he is entitled to have and receive from the Respondent compensation for 15% loss of use of the man as a whole, or 75 weeks at a weekly PPD rate of $712.55 / per week.

In support of the Arbitrator's decision with regard to whether the Respondent is entitled to any credit, 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.

Respondent is entitled to a credit for TTD paid of $13,229.33 and short term disability paid in the amount of $15,035.73 for a net total credit of $28,265.06.

Respondent is entitled to a Section 8(j) credit of $21,665.52.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/week** for **75** weeks, because the injuries sustained caused the **15%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits from December 7, 2012 through July 26, 2013, a total of **33-1/7** weeks, in the amount of **$849.55** per week. Respondent is entitled to a **credit** for TTD paid of **$13,229.33** and short term disability paid in the amount of $15,035.73 for a net total credit of **$28,265.06.**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of **$78,180.04**, as provided in Sections 8(a) and 8.2 of the Act, pursuant to the medical fee schedule or by prior agreement, whichever is less. Respondent is entitled to a credit of **$21,665.52** under Section 8(j) of the Act.

Deborah L. Simpson
Signature of Arbitrator

January 14, 2016
Date

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

Wieslaw Marciniec,

Petitioner,

16IWCC0591

vs.

NO: 12 WC 44185

Castle Metals,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 15, 2016 is hereby affirmed and adopted.

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

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

16IWCC0591

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 16 2016
KWL/vf
O-9/12/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0591

MARCINIEC, WIESLAW
Employee/Petitioner

Case# **12WC044185**

12WC044184

CASTLE METALS
Employer/Respondent

On 1/15/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

0766 HENNESSY & ROACH PC
WILLIAM O'BRIEN
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 16IWCC0591

WIESLAW MARCINIEC
Employee/Petitioner

v.

CASTLE METALS
Employer/Respondent

Case # 12 WC 44185

Consolidated cases: **12 WC 44184**
separate decisions filed

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **DEBORAH L. SIMPSON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **November 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/20/10**, 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 **$57,200.00**; the average weekly wage was **$1,100.00**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$660.00/week** for **10** weeks, because the injuries sustained caused the **2%** loss of use of man 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.

Deborah L. Simpson

Signature of Arbitrator

January 14, 2016
Date

JAN 15 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wieslaw Marciniec,	)	
	)	**16IWCC0591**
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 44185**
	)	**consolidated with 12 WC 44184**
A. M. Castle,	)	**separate decision for each case**
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on April 20, 2010, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that on that date the Petitioner sustained accidental injuries that arose out of and in the course of the Petitioner's employment with the Respondent and that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $57,200.00, and that his average weekly wage was $1,100.00.

At issue in this hearing is as follows: (1) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; and (2) What is the nature and extent of the injury.

There are two cases filed, with two different accident dates and different issues. There is one transcript, and one set of exhibits for both cases. There are separate decisions written for each case since the issues are not the same and there are two different dates of accident.

STATEMENT OF FACTS

Petitioner began working for Respondent in 1993 as a pick and fill order filler and a side loader operator. The Petitioner testified that his job required a lot of heavy lifting, involving packaging and/or banding material, weighing it, and operating a small crane by remote. Whatever the customers ordered is what they had to fill.

On April 20, 2010 Petitioner was helping a co-worker lift a very heavy wooden box weighing approximately 200 pounds when he felt a sharp pain in his low back shooting into his right leg. He reported this pain to his co-worker but attempted to continue to do his job of lifting and driving the side loader over uneven ground. The pain continued and the Petitioner asked his co-worker to go with him to report the accident to their supervisor.

Petitioner continued to work his regular job and on May 4, 2010, he went to the company clinic, Concentra. Petitioner had to wait for permission to go to the clinic. Petitioner was diagnosed with a lumbar strain. (PX 1) The clinic recommended Advil and physical therapy. Petitioner was allowed to continue to work full duty at that time. Petitioner started physical therapy on May 4th and continued with it until about June 8th, 2010.

Petitioner continued treating with the company clinic while attending physical therapy and on May 7th it was recommended he add some ice and heat to his physical therapy treatment. He returned to Concentra for follow up on May 14th and 21st. On May 21st it was reported that Petitioner was no longer having right leg pain. Petitioner had two final visits on June 1st and June 8th and was released to work full duty. Petitioner testified that although he was returned to work full duty and no longer had pain in his right leg, his back was not the same.

Petitioner's medical records indicate that on May 21, 2010 the lumbar "pain does not radiate any more". On June 1, 2010 he had no pain at all and "felt completely better". On June 2, 2010 he was "pain free". And on June 8, 2010, he had a normal exam. (PX 1)

According to the Petitioner, in the spring of 2012 he began feeling an increase in his back pain while working and lifting. Petitioner testified that the pain continued to increase to the point where he could no longer perform his job. It took approximately 8 months to get to this point.

On October 25, 2012, while performing his job duties of lifting and driving the side loader on bumpy ground, his pain became more severe and started shooting into his left leg. Petitioner reported this to Mike Nelson, his union representative, and was told to go to management. Petitioner testified further that he then spoke with Phil Slighbom and reported that he was having back pain similar to 2010 but shooting into his left leg. Petitioner requested to go to the company clinic. Petitioner stated he was told that the manager needed to check with his bosses if this would be treated as a pre-existing accident or a new accident. Petitioner returned to his work station and performed his job the best he could without lifting. Petitioner testified that Mr. Slighbom came to him later in the day and gave him paperwork authorizing him to go to the company clinic. This document, which was completed by Mr. Slighbom, characterized the injury as recurrent.

Petitioner presented to Concentra on October 25, 2012. He recounted his April 2010 accident and stated that the pain had returned about 8 months ago and that it had been getting progressively worse with his activities at work. Petitioner was given acetaminophen, a Medrol Dose Pak, and another round of physical therapy.

Petitioner was returned to work and continued to work his regular job. Petitioner testified that he was careful with how he lifted materials. He continued treating with Concentra and attended approximately 14 sessions of physical therapy.

On November 6, 2012 Petitioner reported to Concentra that his pain had increased due to working overtime. He was told to avoid overtime and that if his problems continued they would order an MRI. Petitioner returned to Concentra on November 13th and an MRI was ordered. Petitioner was put on restrictions of no lifting over 20 pounds, no prolonged standing, no

walking longer than tolerated, no bending more than ten times an hour, and no pushing or pulling over 25 pounds.

Respondent gave Petitioner a lighter job with longer breaks but he was still required to drive the side loader over bumpy ground which he testified aggravated his pain.

Petitioner returned to Concentra on November 21, 2012 and reported he was feeling a little better. He was referred to an orthopedic, Dr. Charles Mercier. Petitioner first saw Dr. Mercier on December 3, 2012 and requested that his care be transferred to his primary care physician, Dr. Judith Sherman with DuPage Medical Group.

Petitioner saw Dr. Sherman on December 7, 2012 and she took him off work completely. Dr. Sherman referred Petitioner to the LOM Spine Center and recommended he follow up with Dr. Mataragas, a spine surgeon.

Petitioner saw Dr. Mataragas on January 2, 2013 for a surgical consult. At Petitioner's January 15th visit with Dr. Mataragas he agreed to schedule surgery. Petitioner was receiving temporary total disability benefits at this time.

Respondent requested that the Petitioner undergo a Section 12 examination, which was scheduled on March 25, 2013 with Dr. Avi Bernstein. After the examination, Petitioner's temporary total disability benefits were stopped and Respondent stopped paying for medical bills. Petitioner initiated sick pay and began submitting his medical bills to his group insurer.

On May 14th Petitioner saw Dr. Sherman for a pre-op exam and had surgery with Dr. Mataragas on May 30, 2013 at Good Samaritan Hospital. Petitioner had a L5-S1 laminectomy discectomy with foraminotomies of the L5 and S1 nerve roots bilaterally. (PX 2, 3)Petitioner reported feeling better and no more sharp pain shooting into his left leg after the surgery.

Petitioner began a course of physical therapy on June 19th and attended approximately 21 visits up to July 28, 2013. Petitioner was discharged at a medium physical demand level and returned to work on July 29th full duty. Petitioner has been working full duty with no restrictions since.

Petitioner had his last surgical follow-up on November 26, 2013 with no further treatment sought or scheduled since that day.

Petitioner testified that his life has changed since his surgery. He stated his left leg has a lot of irritation doing everyday work. He has a loss of balance and a weakness in his back and legs that make him shaky. His pain level is much better but he cannot walk for a long time due to needing rest and he trips when he runs. At work Petitioner uses different techniques to protect himself and asks co-workers for help with lifting. Petitioner testified that he was a good worker with perfect attendance, had never hurt his back before April 2010, and has not had any subsequent accidents since October 25, 2012.

Petitioner entered into evidence as Exhibit 6 the deposition transcript of Dr. Nicholas Mataragas, the treating orthopedic surgeon. The relevant portions of his testimony were that the initial pathology was caused by the lifting episode of April 20, 2010, and that one lift of 50# could aggravate disc pathology. He also testified that Petitioner's work activities after his first

injury and up to and including October 25, 2012 could have aggravated his pre-existing condition, causing the need for the surgery

Dr. Bernstein, Respondent's section 12 examiner, testified that he was unable to relate the disc herniation to the first accident, and he was unable to identify a second work accident that would be responsible for his condition. When asked on cross if it were shown that the Petitioner had done heavy work over the years, whether that could have been a factor in the development of the pathology, he responded that that could alter his opinion. He further testified that the Petitioner's reported increase in left leg pain while working on October 25, 2012 indicated that he was starting to experience nerve-root compression. He testified that he did not believe that repetitively lifting and twisting with 50# of weight could cause a disc herniation, though he did feel one could have a distinct disc injury from one such lift. He went on to say that he would consider constant lifting and twisting with 50# to be an activity of daily living.

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). This includes the nature and extent of the petitioner's injury.

"Preponderance of the evidence is evidence which is of greater weight or more convincing than the evidence offered in opposition to it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Central Rug & Carpet v. Industrial Commission*, 838 N.E.2d 39 (1st Dist. 2005).

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs Industrial Commission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974)

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission*, 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner had no history of prior back problems when he sustained a back injury of sudden onset on April 20, 2010. On that date, the Petitioner described lifting an extremely heavy box of parts with a co-worker, and feeling sudden terrible pain in his low back that went into his legs, particularly his right leg. Petitioner stated that he attempted to continue to work but was unable to do so and he asked his co-worker to go with him so that he could report the incident. This accident was reported to the Respondent the same day. Clearly, the injury is traceable to a definite time, place and cause that occurred in the course of the Petitioner's employment.

Petitioner was sent to Concentra, the company clinic where he was diagnosed with a back strain. He was sent for physical therapy, he continued working during this time. He underwent a month long course of physical therapy. He was released from therapy reporting that the right leg pain abated, but he continued to have some low back issues which he described as "not the same" and "about 90%." No diagnostic testing was reported or described at this time.

The Arbitrator finds that based upon the uncontroverted evidence and the credible testimony of the Petitioner, that there was a causal relationship between the accident of April 20, 2010 and the Petitioner's lumbar pathology as it existed upon completion of treatment in June, 2010.

In support of the Arbitrator's decision with regard to the nature and extent of Petitioner's injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

The Petitioner was examined by a doctor, prescribed physical therapy. He attended physical therapy for one month and at the end of that month reported that his pain was gone. He testified that he had residual pain in his back, but it did not prevent him from working for more than one year. Based upon the foregoing discussion, the Arbitrator finds that Petitioner suffered 2% loss of use of a man as a whole as a result of the injury. Given the nature of the injury the Petitioner suffered to his back following the April 20, 2010, incident, he is entitled to have and receive from the Respondent compensation for 2% loss of use of the man as a whole, or 10 weeks at a weekly PPD rate of $660.00 / per week.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability

benefits of **$660.00/week** for **10** weeks, because the injuries sustained caused the 2% loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Deborah L. Simpson

Signature of Arbitrator

January 14, 2016

Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alice Jackson,
Petitioner,
vs.

NO: 12 WC 44472

16IWCC0608

City of Bloomington/Parks and Rec,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, 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 January 21, 2016, is hereby affirmed and adopted.

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

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

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

DATED: SEP 2 2 2016
o090816
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JACKSON, ALICE
Employee/Petitioner

Case# **12WC044472**

CITY OF BLOOMINGTON/PARKS AND REC
Employer/Respondent

16IWCC0608

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

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
STEVEN R WILLIAMS
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0000 RUSIN & MACIOROWSKI LTD
JENNIFER C MEJIA
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

STATE OF ILLINOIS)
)SS.
COUNTY OF McLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Alice Jackson
Employee/Petitioner

v.
City of Bloomington/Parks and Rec
Employer/Respondent

Case # 12 WC 44472

Consolidated cases: N/A

16IWCC0608

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Arbitrator Douglas McCarthy, Arbitrator of the Commission, in the city of Bloomington, on December 18, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On September 28, 2012, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this alleged accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $17,911.92; the average weekly wage was $344.46.

On the date of accident, Petitioner was 47 years of age, single, with 1 child under 18.

The medical services provided to Petitioner were N/A reasonable or necessary.

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

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

ORDER

- Petitioner did not sustain accidental injuries which arose out of and in the course of her employment for Respondent.
  Claim denied. 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 of at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Dylan McEntee

Signature of arbitrator

1/13/2016

Date

ICArbDec p. 2
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JAN 21 2016

FINDINGS OF FACT

Petitioner was employed as a seasonal laborer at City of Bloomington/Parks and Rec ("COB"). (Rx. 1; T. 10). Petitioner claimed she sustained a right shoulder rotator cuff tear in the course of her job duties on September 28, 2012.

Petitioner testified she was setting up tables for a wedding at Miller Park Pavilion on Friday, September 28, 2012. (Tr. 11). She stated she needed to brace large round tables against a pillar in order to roll the tables onto a cart. (Tr. 11-12). Petitioner testified that while she was "rolling the table up," she reached with her arm above her head and felt her shoulder pop. (T. 12).

Bryant Turner testified Petitioner gave him a ride to work on September 28, 2012. (T. 45). He testified he worked as a garbage truck assistant for COB. (T. 45). He stated he spends time with Petitioner outside of work hours and is friends with Petitioner (T. 47).

Mr. Turner testified he went to the pavilion to see Petitioner in the middle of his shift. At that time, Petitioner complained of shoulder pain. (T. 46). In contrast to Petitioner's testimony, he testified he saw Petitioner "putting tables away" rather than setting up tables. (T. 46, 50). He confirmed that it is necessary to brace tables against a pillar in order to roll tables onto a cart. (T. 48). He testified Petitioner told him she injured her right shoulder while she was "trying to flip tables onto a rack." (T. 48).

Robert Moews, Petitioner's supervisor at COB, testified that setting up for a wedding involves setting up tables and chairs. (T. 52). In addition, Petitioner's COB job description lists that event set ups involve rolling round tables "off [of] a cart." (Rx. 1).

Mr. Moews testified there was a Zumba class at the Miller Park Pavilion the morning of September 28, 2012. According to the COB event calendar, Zumba took place in the pavilion from 10:30 a.m. to 11:30 a.m. (Rx. 4). Mr. Moews testified that it takes about 30 minutes after the end of Zumba before anyone can get into the pavilion to set up for a wedding. (T. 60). Therefore, the earliest Petitioner could have started setting up for a wedding was at 12:00 p.m.

Mr. Moews testified that it generally takes at least one and a half hours for two people to set up for a wedding, but it depends on the size of the wedding. (T. 60). Petitioner testified she set up for the wedding by herself on September 28, 2012. (T. 13). She testified the set up took her two hours. (T. 36-37). Petitioner's timecard confirms she left work on September 28, 2012 at 1:04 p.m. (Rx. 2).

Petitioner testified she contacted David Lamb about her shoulder on the same day as the work accident. (T. 13-14). Petitioner stated that Mr. Lamb is a supervisor who fills in when Mr. Moews is not available. Petitioner testified Mr. Lamb told her to call Medcor. (T. 13-14). She testified she called Medcor within a day or two of speaking to Mr. Lamb. (T. 38).

Petitioner also testified she contacted Mr. Moews on September 28, 2012 and told him she injured her shoulder at COB that day. (T. 13).

Later in her testimony, Petitioner stated she waited several days after her work accident before reporting it to Mr. Lamb. (T. 33).

At the time of the alleged accident, Petitioner had concurrent employment at Bloomington Housing Authority ("BHA"). She worked from 3:00 p.m. to 6:00 p.m. at BHA on September 28, 2012. She also worked an 8-hour shift at BHA on September 29, 2012 and a 7.5-hour shift on September 30, 2012. (Rx. 13).

Petitioner met with Dr. Jack Spaniol, her family doctor, on October 2, 2012. Petitioner did not make any complaints pertaining to a shoulder injury, though the reason she was seen was for ear pain and postnasal drainage. Dr. Spaniol did a physical examination and documented that Petitioner had full range of motion in all of her extremities. (Rx. 5). Petitioner testified she was experiencing pain in her right shoulder at the time of this appointment. (T. 37).

Petitioner worked at City of Bloomington on October 3, 2012, October 4, 2012, and October 5, 2012. Petitioner worked a full 6-hour shift each of these days. Specifically, Petitioner worked 7:00 a.m. to 1:00 p.m. on October 5, 2012. (Rx. 2). After this shift was over, she worked at BHA from 3:00 p.m. to 7:00 p.m. Petitioner also worked shifts at BHA on October 6. 2012 and October 7, 2012. (Rx. 13).

Petitioner testified she waited about ten days to seek medical treatment because it was near the end of the work season, and she was trying to work through the pain. (T. 15-16, 33).

On October 8, 2012, Petitioner met with Dr. Cipolla at OSF St. Joseph Prompt Care. Petitioner complained of right shoulder pain. Though she informed Dr. Cipolla she did some lifting at work, Dr. Cipolla documented, "No specific injury reported." Upon exam, Petitioner had right shoulder tenderness, but she had normal range of motion with no swelling. Dr. Cipolla assessed Petitioner with right shoulder pain. (Rx. 6). Dr. Cipolla wrote an off work slip for Petitioner on October 8, 2012 indicating Petitioner was off work that day due to injury. (Rx. 7).

Petitioner testified she contacted her COB supervisor, Bobby Moews, on Monday, October 8, 2012. (Tr. 32). Petitioner testified she told Mr. Moews she injured her shoulder at COB setting up for a wedding and would not be coming to work that day. (T. 33).

In contrast, Mr. Moews testified Petitioner contacted him on October 8, 2012 and specifically told him she injured her shoulder the day before, which would have been on Sunday, October 7, 2012. (T. 54) Petitioner did not work at COB on October 7, 2012. (Rx. 2). In fact, she worked a 4-hour shift at BHA instead. (Rx. 13). Petitioner denied working at BHA on October 7. 2012. (T. 35). Mr. Moews testified Ms. Jackson did not mention anything on October 8, 2012 about sustaining a shoulder injury at COB. (T. 54).

After Petitioner's absence on Monday, October 8, 2012, she returned to full 6-hour shift on Wednesday, October 10, 2012. (Rx. 2). Petitioner testified she gave an off work slip to Mr.

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Moews when she returned to work. (T. 39). Petitioner also worked regular 6-hour shifts on Thursday, October 11, 2012 and Friday, October 12, 2012. (Rx. 2).

Mr. Moews testified he saw Petitioner on a daily basis that week. Mr. Moews testified Petitioner was not favoring her right shoulder, did not complain about right shoulder pain, and she did not tell Mr. Moews she injured her shoulder at COB at all during that week. (T. 54-55).

Petitioner continued to work full shifts on Monday, October 15, 2012, Wednesday, October 17, 2012, and Thursday, October 18, 2012. (Rx. 2).

Betty McCain, claims adjuster at Alternative Service Concepts, testified she had a telephone conversation with Petitioner on October 15, 2012. (T. 68). On that date, Ms. McCain testified Petitioner told her she was injured at work setting up for a wedding on October 5, 2012. (T. 69).

Mr. Moews testified he did not receive notice that Petitioner had been injured until about October 15, 2012. Mr. Moews requested Petitioner contact Medcor right away. Mr. Moews testified it is his policy to instruct employees to call Medcor right away after a work injury is reported to him. (T. 58-59).

Consistent with Mr. Moew's testimony, Petitioner called Medcor on October 15, 2012. She reported she had sustained a work accident about ten days prior, which would have been on October 5, 2012. She gave a history of setting up for a wedding in the pavilion. She stated she injured her right shoulder while lifting a round table off of a cart. (Rx. 3).

Though Petitioner worked on October 5, 2012, there was not a wedding set-up that day. Mr. Moews testified weddings are set up the day before. Since there was not a wedding on October 6. 2012, there would not have been a wedding set up on October 5, 2012. (T. 56-57).

On October 17, 2012, Petitioner was seen by Dr. Mary Yee Chow at OSF Occupational Health. Petitioner provided a history of feeling a pop in her right shoulder while she was moving chairs and tables on October 1, 2012. Petitioner stated her right arm was extended above her head when she was rolling tables "up on" carts. Petitioner reported her right shoulder became sore several days later. (Rx. 8).

Upon exam, Petitioner has positive Hawkin's and Neer's tests. Speeds and O'Brien tests were negative. Petitioner also had tenderness with range of motion and palpation to the right shoulder. Dr. Chow assessed Petitioner with right shoulder pain. (Rx. 8).

Dr. Chow recommended a right shoulder MRI. She assigned work restrictions of no activities above chest height and no repetitive movements with the right arm. (Rx. 8).

Though Petitioner informed Dr. Chow she injured her shoulder on October 1, 2012, Petitioner did not work on October 1, 2012. (Rx. 2).

Petitioner testified that Dr. Chow documented an accident date of October 1, 2012 because it was the same date she met with Dr. Chow. (T. 39). In actuality, Petitioner met with Dr. Chow on October 17, 2012, which is clearly not the same date as October 1, 2012. (Rx. 8).

Mr. Moews testified he talked to Petitioner on about October 17, 2012. He informed Petitioner that her allegation that she was injured on October 5, 2012 did not make sense given that there was not a wedding set up that day. (T. 57). Mr. Moews stated that Petitioner claimed that a date of accident of October 5, 2012 was not what she meant. Instead, Petitioner told Mr. Moews that she was injured on October 1, 2012 while she was "tearing down" for a wedding. (T. 58).

Mr. Moews testified Petitioner's story did not add up because Petitioner did not work on October 1, 2012. (T. 58). Petitioner's work scheduled confirms that she did not work at COB on October 1, 2012. (Rx. 2).

Petitioner testified she requested her work schedule so she could determine which date she had injured her shoulder. Petitioner admitted she may have messed up the dates. (T. 17-18). Ms. McCain also testified Petitioner told her she messed up the dates. (T. 73).

Petitioner followed up with Dr. Spaniol on November 19, 2012. Petitioner reported she injured at COB while setting up for a wedding in Miller Park on September 28, 2012. Petitioner gave a history of feeling her right shoulder pop while she was setting up tables. Petitioner stated she waited to get treatment because she was hoping the injury would get better with time. (Rx. 10).

Upon exam, Petitioner had tenderness over the anterior humeral head of the right shoulder. She had reduced range of motion and pain with abduction, internal rotation, and external rotation. Dr. Spaniol assessed Petitioner with a right shoulder strain and a possible rotator cuff tear. He recommended an MRI. Dr. Spaniol opined Petitioner's shoulder injury was related to work. (Rx. 10).

On November 27, 2012, a right shoulder MRI was performed. The MRI showed at least a 50% partial-thickness anterior-sided rotator cuff tear. (Px. 5).

Dr. Spaniol referred Petitioner to see Dr. Brett Keller, an orthopedic surgeon, at Central Illinois Orthopedic Surgery. Petitioner presented to Dr. Keller on December 14, 2012. Petitioner gave a history of injuring her right shoulder at COB wile she was lifting and setting up tables for a wedding. Upon exam, Petitioner had right shoulder tenderness anteriorly and laterally. She had reduced range of motion, a positive impingement sign, and a positive drop arm test. Dr. Keller assessed Petitioner with right shoulder pain, and he administered a right shoulder injection. (Px. 14).

Petitioner followed up with Dr. Keller on January 10, 2013. Petitioner continued to complain of right shoulder pain. Dr. Keller diagnosed Petitioner with a right shoulder partial-thickness rotator cuff tear based on the results of the right shoulder MRI. Dr. Keller recommended surgery. (Px. 14).

Dr. Keller performed a right shoulder arthroscopy with subacromial decompression and debridement of a very small bursal-sided partial-thickness rotator cuff tear on February 27, 2013. The rotator cuff tear was visualized by looking down from the subacromial space. Unlike the MRI findings, the tear was clearly less than 50%. In addition, the MRI report documented Petitioner had an articular rotator cuff tear (Px. 5), but the surgical report noted there was no tear in the articular side of the rotator cuff. In addition, the biceps tendon was normal. (Px. 7).

Petitioner attended post-operative appointments with Dr. Keller. On May 9, 2013, Dr. Keller noted Petitioner's incisions were well-healed. Petitioner had a negative drop arm test. Dr. Keller recommended Petitioner continue physical therapy and perform a home exercise program. He released Petitioner to return to work with no restrictions on May 10, 2013. He recommended Petitioner advance activities as tolerated. (Px. 14).

On May 29, 2013, Petitioner was discharged from physical therapy for noncompliance. The discharge summary indicated Petitioner had failed to return phone calls. As of May 29, 2013, Petitioner had attended a total of thirteen sessions and had cancelled five sessions. (Px. 8).

Petitioner returned to see Dr. Keller on February 3, 2014 with complaints of right shoulder pain. She stated the pain was worse when lifting things with her right arm. Dr. Keller noted Petitioner's incisions were well-healed. Drop arm and impingement tests were negative. She had some reduced range of motion in the right arm. Dr. Keller administered a right shoulder injection. (Px. 9).

As of the time of trial, Petitioner testified she was working two jobs, one at BHA and one at the Postal Service. Petitioner testified she had residual symptoms in her right shoulder and had some mild difficulties performing activities at work and at home. Despite this, she did not present any evidence that she was working modified duty at either job. (T. 20-23).

Dr. Keller testified by means of an evidence deposition on November 1, 2013. Dr. Keller testified Petitioner has injured her right shoulder as a result of a lifting injury at COB while she was setting up tables for a wedding. (Px. 1, pps. 6, 30-32). Dr. Keller opined Petitioner's right shoulder injury was causally related to the alleged September 28, 2012 work accident at COB. (Px. 1, p. 20).

Dr. Keller admitted her did not analyze Petitioner's medical records from Dr. Cipolla, Dr. Spaniol, or Dr. Chow. (Px. 1, p. 21). Dr. Keller stated he did not know for certain whether Petitioner injured herself at work. He stated that he was just basing his opinion on the history she provided, but he acknowledged that Petitioner could be lying to him. (Px. 1, p. 21).

Dr. Keller opined he expects individuals with a rotator cuff tear to begin experiencing pain within 48 to 72 hours after the injury. (Px. 1, pps. 24-25). Dr. Keller testified his causation opinion is predicated on having an accurate history and that his causation opinion may change if he had an inaccurate history. (Px. 1, p. 25).

Dr. Cohen performed a record review and authored a report at Respondent's request. Dr. Cohen testified at an evidence deposition on January 22, 2014.

Dr. Cohen testified that Petitioner's right shoulder MRI report is clearly inconsistent with the surgical findings. He indicated that the surgical report showed a very small partial thickness rotator cuff on the opposite bursal side of the rotator cuff rather than a more than 50% partial thickness rotator cuff tear on the articular side as the MRI report documented. (Rx. 14, p. 8).

Based on the histories of the accident provided in the medical records, Dr. Cohen explained that Petitioner's activities of lifting tables and chairs would not have caused a rotator cuff tear unless she was lifting tables and chairs at or above shoulder height. As such, Dr. Cohen opined Petitoiner did not sustain a right shoulder rotator cuff tear on September 28, 2012. (Rx. 14, pps. 12-13, 15-17). He opined that Petitioner's right shoulder injury was more related to the preexisting chronic acromial spur that was not caused by work. (Rx. 14, pps. 12-13).

Dr. Cohen questioned Petitioner's subjective complaints and symptoms as well as the necessity of surgery for the partial thickness rotator cuff tear. (Rx. 14, pps. 13-15). He explained that Dr. Keller administered a cortisone injection on December 14, 2012. At the subsequent appointment with Dr. Keller on January 10, 2013, Dr. Keller documented Petitioner was "getting worse" and that the injection provided "minimal relief." (Px. 14; Rx. 14, pps.13-14). Dr. Cohen testified this was strange because he expected a cortisone injection to at least provide temporary relief for a partial-thickness rotator cuff tear or impingement syndrome symptoms because the injection contains numbing medication. (Rx. 14, p. 14).

Dr. Cohen opined that Petitioner's rotator cuff tear would have likely resolved without surgery. Dr. Cohen explained that more than four to six weeks of physical therapy would be needed to nonsurgically treat a partial-thickness rotator cuff tear. As such, Petitioner would have only needed surgery for the acromial spur, which is "clearly not related to the event of September 28, 2012." Dr. Cohen explained that the spurs develop slowly over time as a result of ongoing problems like tendonitis and inflammation. Dr. Cohen indicated that the spur is a chronic finding rather an acute or traumatic finding. (Rx. 14, pps. 12-13).

As of the date of his deposition, Dr. Cohen opined Petitioner does not require any additional treatment for her right shoulder given that she was discharged from physical therapy and from Dr. Keller's care. Furthermore, she was non-compliant with physical therapy. Dr. Cohen opined Petitioner does not require any restrictions, especially since Dr. Keller released Petitioner to return to full duty work. (Rx. 14, p. 15).

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision relating to ***"C., Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?"***, the Arbitrator makes the following findings:

Petitioner lacks credibility because there were various inconsistences between Petitioner's testimony, the testimonies of Mr. Moews, Ms. McCain, and Mr. Turner, and Petitioner's medical records regarding when and how she injured her shoulder.

Petitioner testified she was setting up tables for a wedding at Miller Park Pavilion on Friday, September 28, 2012. (Tr. 11). The COB Event Calendar confirms that a wedding set up happened on September 28, 2012. (Rx. 4).

Petitioner's COB job description lists that event set ups involve rolling round tables "off [of] a cart." (Rx. 1). Despite Petitioner's claim that she was "setting up" for a wedding, Petitioner's description of the activities she was performing when the accident allegedly occured coincide with a wedding tear down. According to the COB job description, an event tear down involves putting tables onto a cart. (Rx. 1).

When Petitioner testified at trial, she stated she needed to brace large round tables against a pillar in order to roll the tables "onto" a cart. (Tr. 11-12). Petitioner testified that while she was "rolling the table up," she reached with her arm above her head and felt her shoulder pop. (T. 12).

Likewise, Mr. Turner testified he saw Petitioner "putting tables away" rather than setting up tables. (T. 46, 50). He testified Petitioner told him she injured her right shoulder while she was "trying to flip tables onto a rack." (T. 48).

Dr. Chow's note from October 17, 2012 documents that Petitioner was rolling tables "up on" carts. (Rx. 8).

Given that there was not a wedding tear down on September 28, 2012 (Rx. 4), there is not any reason why Petitioner would have been loading tables onto a cart.

Petitioner reported to Medcor on October 15, 2012 that she was injured on approximately October 5, 2012 while she was lifting tables "off of cart." (Rx. 3). This is not consistent with her testimony that she was injured while rolling tables up on a cart. Also, there was no wedding on October 6. (RX 4)

Mr. Moews testified he talked to Petitioner on October 17, 2012. Petitioner told Mr. Moews she was injured on October 1, 2012 while tearing down for a wedding rather than her previous claim that she was injured on October 5, 2012 while she was setting up for a wedding. (T. 58). Clearly, Petitioner's description of the accident on October 17, 2012 is the exact opposite of her prior description.

Not only is Petitioner's description of the accident inconsistent with setting up for a wedding, but the timeline when Petitioner's accident occurred does not make sense. The pavilion was not available for a wedding set up until approximately 12:00 p.m. on September 28, 2012. Zumba did not end until 11:30 a.m. (Rx. 4), and Mr. Moews testified it takes about 30 minutes after the end of Zumba before anyone can get into the pavilion to set up for a wedding. (T. 60).

Mr. Moews testified that it takes a minimum of one a half hours for two people to set up for a wedding. (T. 60). Obviously, it would take longer than that to set up for a wedding with only one person. Petitioner testified she did not have any help that day. (T. 13). She also testified it took her two hours to set up for the wedding. (T. 37). Given that Petitioner would not have been able to access the pavilion until 12:00 p.m., there was not enough time for her to spend two hours setting up for a wedding prior to the end of her shift. The timeline provided by Petitioner is inconsistent and does not match up with other evidence

Mr. Moews testified he did not receive notice that Petitioner had injured her right shoulder at COB until approximately October 15, 2012. (T. 59). He testified he instructed Petitioner to call Medcor right away. (T. 59). In contrast, Petitioner testified she gave notice of her work accident to Mr. Moews on October 8, 2012. (T. 32-33). Petitioner also testified she called Medcor within a day or two after she was told to call. (T. 38). Medcor was contacted on October 15, 2012, a week after her conversation with Mr. Moews. (Rx. 3).

In addition to inconsistencies regarding how the accident happened and when she gave notice, Petitioner gave several different dates to COB and her doctors about when she was injured. However, the initial dates cited by Petitioner do not make sense in light of Petitioner's work schedule and the activities that were being performed those days. Petitioner did not settle on an alleged accident date of September 28, 2012 until after she had conveniently requested her work schedule from her employer.

Petitioner testified she experienced immediate pain after the work accident on September 28, 2012 and continued to experience pain from that point forward. (Tr. 37). Petitioner specifically confirmed she was experiencing pain in her right shoulder on October 2, 2012. (Tr. 37). Despite this, she did not report her right shoulder pain to Dr. Spaniol when she met with him on October 2, 2012. (Rx. 5).

Petitioner admitted she expects her doctors to accurately document what she tells them, and she stated she tells doctors what hurts as well as how and when she hurt herself. (T. 30-31). Given that Dr. Spaniol's exam notes from October 2, 2012 do not document anything about right shoulder pain (Rx. 5), it is clear that Petitioner did not report her shoulder pain. Furthermore, it is unlikely that Petitioner was even injured on October 2, 2012 in light of the fact that Dr. Spaniol's upper extremity exam was normal. (Rx. 5).

Petitioner worked at COB on October 3, 2012, October 4, 2012, and October 5, 2012. (Rx. 2). Mr. Moews testified Petitioner did not provide any notice of a work accident or make any complaints of shoulder pain during this time period (T. 54-55), which makes Petitioner's allegations that she was injured on September 28, 2012 questionable. Furthermore, Petitioner's

BHA timesheet she reflects she was able to work at BHA on October 5, 2012, October 6, 2012, and October 7, 2012.

Petitioner first sought medical treatment for her right shoulder on October 8, 2012. On that date, Petitioner presented to Dr. Cipolla at OSF St. Joseph Primary Care with complaints of right shoulder pain. Dr. Cipolla documented, "No specific injury reported." (Rx. 6). Dr. Cipolla filled out an off work slip for Petitioner which documented that Petitioner sustained an "injury on 10/8." (Rx. 7).

Petitioner testified she called Mr. Moews on October 8, 2012 and told him she needed to see a doctor because she had injured her right shoulder at COB during a wedding set up. (Tr. 33). In contrast, though Mr. Moews confirmed he talked to Petitioner on October 8, 2012, he stated Petitioner told him she hurt her shoulder the day before, on Sunday, October 7, 2012. She did not mention anything about injuring her shoulder at work. Petitioner did not work at COB on October 7, 2012, but she did work at BHA on that date as evidenced on her BHA timesheet. (Rx. 2; Rx. 13). During her testimony, Petitioner denied working at BHA on October 7, 2012. (T. 35).

Ms. McCain testified she spoke to Petitioner on October 15, 2012. On that date, Petitioner told her she injured her right shoulder while setting up for a wedding on October 5, 2012. (T. 69).

Petitioner also called Medcor on October 15, 2012. Consistent with what she told Ms. McCain, Petitioner reported she injured her right shoulder while setting up for a wedding in the pavilion ten days prior, which would have been on October 5, 2012. (Rx. 3).

It is impossible for Petitioner to have injured her right shoulder while setting up for a wedding on October 5, 2012 because there was not a wedding set up on October 5, 2012. Mr. Moews testified that wedding set ups occur the day before a wedding. (T. 56-57). The COB Event Calendar does not list a wedding on October 6, 2012. (Rx. 4). Therefore, there was no wedding set up on October 5, 2012.

Mr. Moews testified that when he confronted Petitioner about the above inconsistency, Petitioner claimed that she knew there was no wedding set up that day. She stated that she was actually injured on October 1, 2012 while doing a wedding take down. (T. 57-58). Dr. Chow's treatment note from October 17, 2012 also documents that Petitioner was injured on October 1, 2012.

Petitioner could not have been injured at COB on October 1, 2012 because she did not work that day. (Rx. 2).

Petitioner testified that Dr. Chow's note listed an accident date of October 1, 2012 because that was the date she was seen by Dr. Chow. (T. 39). Clearly, Petitioner's reasoning does not make sense given that she first saw Dr. Chow on October 17, 2012 rather than on October 1, 2012. (Rx. 8).

Petitioner admitted at trial that she may have "messed up the dates." Petitioner admitted she requested her work schedule so she could identify the date in which she was allegedly injured at COB. (T. 17-18).

Petitioner did not provide a history of injuring her right shoulder at work while setting up tables for a wedding on September 28, 2012 until she met with Dr. Spaniol on November 19, 2012. From this point forward, Petitioner maintained she was injured on September 28, 2012 while setting up for a wedding.

Mr. Turner testified Petitioner's injured her shoulder on September 28, 2012. However, he testified that he saw Petitioner after her alleged shoulder injury. He did not actually see it happen. (T. 46). He also said she reported she was injured when flipping a table up onto a rack, a function not associated with setting up for a wedding. In addition, Mr. Turner admitted he is friends with Petitioner's son and rode to work with the Petitioner on the date of the alleged accident.. (T. 47).

Based on the evidence presented at trial, the Arbitrator finds Petitioner failed to prove she sustained accidental injuries which arose out of and in the course of employment for Respondent.

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STATE OF ILLINOIS)
)
COUNTY OF PEORIA)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Slaughter,
Petitioner,

vs.

No.: 13 WC 06125

Illinois State Police,
Respondent.

ORDER

Petition for Penalties and Attorneys' Fees Pursuant to Sections 19(k), 19(l), and 16 of the Illinois Workers' Compensation Act having been filed by Petitioner herein and due notice having been given, this cause came on for hearing before Commissioner Luskin on August 10, 2016 in Peoria, Illinois. The Commission having jurisdiction over the persons and subject matter and after being advised in the premises, finds:

The claimant in this matter suffered an undisputed accident on February 6, 2013 which resulted in a right ankle fracture. The petitioner underwent surgery with hardware implantation on February 13, 2013. He thereafter began therapy and rehabilitation. A surgical procedure to remove the hardware was performed on July 10, 2013. He returned to work on July 30, 2013. On May 13, 2014, the claimant returned to his physician with recurrent symptoms. An MRI was prescribed and demonstrated chondromalacia and edema. However, he continued his regular job duties at that time. See generally PX5.

The claimant proceeded to arbitration on July 23, 2015 before Arbitrator Douglas McCarthy. The only issue placed in dispute was the nature and extent of the injury. In a decision filed September 8, 2015, Arbitrator McCarthy awarded the claimant permanent partial disability of 40% loss to the right foot. PX5. The claimant's attorney received the Arbitrator's decision on September 14, 2015. PX5.

The respondent did not make payment at the time of the issuance of the decision. On April 29, 2016, the claimant filed a penalties petition based on the delay in payment. See Commissioner's Exhibit I and RX2. It is not clear from any correspondence or representation what, if anything, happened between September 14, 2015 and April 29, 2016.

For the respondent, the case was, at the time of the hearing, assigned to Assistant Attorney General Gabriel Casey. AAG Casey left the employ of the Attorney General's office following the case proceeding to hearing, but the date of his departure was not made clear in the record. However, a letter from the petitioner's counsel to the Attorney General's office dated May 2, 2016 and advising of the failure to pay the award as well as the penalties petition noted that the file had been previously assigned to AAG Casey, so presumably his departure had occurred prior to that point. PX4, RX1. AAG Kristina Dion, who represented the respondent at the time of the instant penalties petition, introduced an email without objection by the claimant authored by her indicating that she had no knowledge of the case before June 6, 2016. RX3.

A follow-up letter from the claimant to the respondent dated June 9, 2014 noted that payment had still not been received by the claimant. PX3. Thereafter, a check for the award was drafted and issued by the respondent, the check date being June 24, 2016. PX1, RX9.

Petitioner argues for entitlement to penalties under §19(k) and §19(l), as well as §16 attorney's fees for unreasonable and vexatious delay in payment of the lump sum settlement. Respondent argues that any delay was due to inadvertence and non-malicious oversight. The Commission notes the case of *Jacobo v. Illinois Workers' Compensation Commission, 959 N.E. 2d 772 (3rd Dist., 2011),* for its holding that §19(l) penalties are in the nature of a late fee and are mandatory, "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay."

The Commission, having reviewed the exhibits introduced by each party and having heard the representations by each counsel, finds credible the respondent's argument that any delay was due to inadvertence rather than malevolence. Once the Assistant Attorney General became personally aware of the situation, a check was drafted within three weeks. The Commission finds, therefore, that Section 19(k) penalties and Section 16 fees are not appropriate.

Having so noted, the claimant is correct in his assertion that there has been a significant delay in payment. In theory, given the extent of the delay, Section 19(l) penalties could accrue at least from the last date a Petition for Review could be filed (October 14, 2015). Had demands for payment with a warning that penalties could be demanded absent satisfaction of the award been issued immediately following the receipt of the Arbitrator's decision, such evidence could support an early date to begin assessment of penalties. However, no such evidence was introduced.

The Commission finds that a claimant may not artificially inflate the value of potential penalties by not acting in a timely fashion. The Commission finds that April 29, 2016, when the claimant first asserted that penalties were appropriate, is the proper date to begin assessment of the penalties. Section 19(l) penalties would thereafter accrue until the respondent issued payment of the award that was due.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner additional compensation of $1,710.00, representing $30.00 per day for 57 days for the period commencing April 29, 2016 (when the penalties petition was filed) through June 24, 2016 (when the award payment check was drafted), as provided in Section 19(1) of the Act.

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: SEP 16 2016

Joshua D. Luskin

r-08/10/16
jdl/jl
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Ruth W. White

Charles J. DeVriendt

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

Fidel Ramirez,
Petitioner,

vs.

NO: 13WC 11079

Peer Bearing Company,
Respondent,

16IWCC0601

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, 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 July 1, 2015, is hereby affirmed and adopted.

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

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

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

DATED: SEP 16 2016

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

RAMIREZ, FIDEL
Employee/Petitioner

Case# **13WC011079**

PEER BEARING COMPANY
Employer/Respondent

16IWCC0601

On 7/1/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE
DEREK S LAX
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0238 WOLF & JACOBSON LTD
WILLIAM B JENSEN
25 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

16IWCC0601

STATE OF ILLINOIS)
)SS.
COUNTY OF Lake)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Fidel Ramirez,
Employee/Petitioner

v.

Peer Bearing Company
Employer/Respondent

Case # **13** WC **11079**

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 **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **May 26, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 4, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$32,136.00**; the average weekly wage was **$618.00**.

On the date of accident, Petitioner was **70** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Petitioner failed to prove that his accident arose out of and in the course of his employment and is not entitled to the payment of medical bills, temporary total disability benefits, or prospective medical treatment.

The Arbitrator finds assuming arguendo an accident occurred, no causal connection exists to the current condition of ill being. The Arbitrator adopts the opinions of Illinois Bone and Joint Institute physician Dr. Kornblatt in making this finding and Order. Respondent exhibit #4 is underscored in this Order. No prospective surgery is awarded herein.

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

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

HO1 George J. Andros
Signature of Arbitrator

June 29, 2015
Date

ICArbDec19(b)

JUL 1 - 2015

Fidel Ramirez v. Peer Bearing Company
13 WC 11079

IN SUPPORT OF THE ARBITRATOR'S DECISION THE ARBITRATOR MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner testified his job duties for respondent required that he lift boxes containing bearings from a pallet, carry the boxes to a table, unpack the boxes, take the bearings out of the boxes, place the bearings onto a tray, and then push the tray along a conveyor belt. Petitioner testified that on Monday, March 4, 2013, he was lifting a box that weighed 60 to 70 pounds by the box's straps when one of the straps broke and as he reached for the falling box he felt a pain in his lower back. He did not report the accident on the day it occurred. Petitioner continued to work his regular shift for the weeks of March 4, 2013 to March 8, 2013 and March 11, 2013 to March 15, 2013. RX #14.

Juan Ramos, petitioner's supervisor, testified that boxes petitioner lifted generally weighed 20 to 30 pounds and occasionally up to 50 pounds. He further testified that for the period from March 4, 2013 to March 15, 2013, petitioner did not tell him of an accident and he had an opportunity to see petitioner on a daily basis during which time he never saw petitioner demonstrating any pain behaviors.

On Sunday, March 17, 2013, petitioner was seen at Lutheran General Hospital where he complained of right knee, low back, and flank pain. RX #10, P. 15. He claimed the low back and flank pain had been present over the past couple of weeks but had worsened over the last several days. RX #10, P. 15. He denied numbness or pain radiating into his legs and reported "no known trauma." *Id.* A CT scan showed no evidence of kidney stones. *Id.* at 47. X-rays of his right knee showed evidence of joint disease. *Id.* at 46. A CT scan of his lumbar spine showed narrowing of the right foramen due to an asymmetric disc protrusion. *Id.* At 48. He was discharged with orders to follow up with his family physician. *Id.* at 18.

On Monday March 18, 2013, petitioner testified he was seen by his family physician, Dr. Gonzalez where he complained of low back pain and noted he had been at the emergency room. RX

#11, P. 114-115. The records do not reflect the etiology of the symptoms. Dr. Gonzalez ordered blood tests and wanted to see the notes from the emergency room visit. *Id.*

Petitioner testified he reported the accident to Roberto Arce on March 18, 2013. On March 20, 2013, petitioner and his son went to respondent's facility where petitioner had a discussion with Christina Buu, a Human Resources Generalist, and Juan Ramos. Ms. Buu testified she asked petitioner why he had not reported the accident at the time of it occurred and he replied he thought he was suffering from liver pain. Petitioner denied telling Ms. Buu he thought he was suffering from liver pain. Petitioner testified that Ms. Buu asked petitioner to go to Advocate Occupational.

Petitioner was seen at Advocate Occupational from March 20, 2013 to March 24, 2013. RX #9. At his initial visit, petitioner reported suffering low back pain after lifting a box at work. *Id.* He reported his pain was getting better and was 2 out of 10. *Id.* An examination revealed negative straight leg raise and petitioner was able to squat without pain. *Id.* He was allowed to work with restrictions, which he testified he did. *Id.* On March 24, 2013, physicians at Advocate ordered physical therapy. *Id.*

Petitioner then came under the care of Dr. Sinai, a chiropractor. From March 25, 2013, to June 5, 2013, petitioner saw Dr. Sinai 29 times. PX #6. At his initial visit, he reported the accident and complained of low back pain on his left side traveling down both legs with numbness in his left leg and thigh. *Id.* Straight leg raises were positive on the left side. *Id.* Petitioner is seeking payment of $1,311.61 from Dr. Sinai for the treatment provided. PX #1. It is unclear from Dr. Sinai's records and the bills as to specific chiropractic treatment provided. Petitioner also testified that he has gone to more than a 100 physical therapy sessions at Rehabilitation, Inc. No medical records related to the treatment were provided, however petitioner is claiming entitlement to payment of $46,477.19 representing 136 visits covering the period from March 27, 2013 to March 26, 2014. PX #1. Respondent conducted a utilization review of the chiropractic and physical therapy sessions

performed and concluded that 6 chiropractic and 6 physical therapy sessions were medically necessary and the balance of the treatment was not medically necessary. RX #5.

Dr. Sinai referred petitioner to Dr. Herman. Petitioner first saw Dr. Herman on April 30, 2013. Dr. Herman ordered an MRI, which was done on May 3, 2013 and showed evidence of degenerative spondylosis at L3-4, L4-5 and L5-S1 and retrolisthesis at L4-5 and L5-S1. PX #5. On June 27, 2013, Dr. Herman reviewed the MRI and recommended petitioner undergo a laminectomy, discectomy and fusion at L5-S1. *Id.* In his office notes of September 12, 2013 he opined there was a causal relationship between petitioner's accident and the need for surgery because there was no evidence of a pre-existing condition and he had suffered radiculopathy since the incident. *Id.*

Petitioner testified that on September 18, 2013, he underwent eye surgery and on his way home from the hospital after surgery he suffered a stroke and had to be admitted to the hospital for a couple of days.

Petitioner further testified that Dr. Sinai referred him to Innovative Pain for consideration of injections. He was first seen at Innovative Pain on May 9, 2013 and underwent a bilateral transforaminal epidural steroid injection on May 23, 2013. PX #7. A Game Ready Cold Therapy Unit was also prescribed. *Id.* Respondent conducted a utilization review regarding the epidural steroid injection and Cold Therapy Unit, which concluded that the injection and the Cold Therapy unit were not medically necessary. RX #6.

On February 3, 2014, petitioner underwent facet injections at L4-L5 and L5-S1. *Id.* At the time of the injection, another Game Ready Cold Therapy Unit was prescribed. *Id.* On March 12, 2014 and March 19, 2014, petitioner underwent medial branch blocks at L3-4, L4-5 and L5-S1. *Id.* Respondent conducted a utilization review with respect to the injections and the Cold Therapy Unit, which concluded the facet injection of February 3, 2014 was medically necessary but the medial branch blocks done on March 12, 2014 and March 19, 2014 and the Cold Therapy Unit were not. RX #7.

Petitioner testified that he is a "little better" after undergoing physical therapy and injections as outlined above.

Petitioner testified he sought a second opinion with Dr. Erickson, who ordered a discogram. A discogram was done on September 19, 2014 that showed evidence of concordant pain at L4-5 and L5-S1. PX #8. Respondent conducted a utilization review regarding the discogram, which concluded the testing was not medically warranted because provocative discography accuracy remains uncertain and may cause disc degeneration. RX #8.

Respondent had petitioner examined by Dr. Kornblatt on May 15, 2013; August 1, 2013; and December 18, 2014. At his initial visit, petitioner presented without complaints of radiculopathy. RX #1. Dr. Kornblatt reviewed the May 3, 2013 MRI and noted it showed evidence of mild pre-existing lumbar degenerative disc disease with moderate desiccation at L3-4, L4-5 and L5-S1; slight disc narrowing at L5-S1; a small central annular protrusion at L5-S1 without evidence of herniation; facet arthropathy at L5-S1 with no evidence of instability. *Id.* He further opined that on March 4, 2013 petitioner suffered a lumbosacral strain, was not a candidate for surgery or injection therapy because of the absence of radicular symptoms, should undergo aggressive physical therapy followed work conditioning program, and could return to work with restrictions of lifting up to 30 pounds occasionally and 15 pounds frequently. *Id.* Following his examination of August 1, 2013, Dr. Kornblatt continued to maintain that petitioner had suffered a lumbosacral strain that had resolved. RX #2. He further opined that petitioner should undergo two weeks of work conditioning followed by an FCE and then resume gainful employment. *Id.* Dr. Kornblatt further explained in his addendum report of March 6, 2013 that petitioner's on-going complaints of low back pain were not related to his work accident, which amounted to a lumbosacral strain, rather they were related to his self-limiting inactivity and pre-existing degenerative disc disease. RX #3. Dr. Kornblatt last saw petitioner on December 18, 2014. RX #4. He noted the treatment petitioner had undergone and the surgical recommendations that had been made by Dr. Herman and Dr. Erickson. *Id.* He opined that petitioner's symptoms were related to

multilevel lumbar degenerative disc disease and his deconditioned state but not to the March 4, 2013 accident. *Id.* Dr. Kornblatt further opined that his physical examination did not reveal any objective findings referable to petitioner's lumbar spine and there was no indication that petitioner was a surgical candidate. *Id.*

Christina Buu testified that on May 30, 2013 and September 10, 2013 she sent petitioner letters offering him a light duty job within the restrictions outlined by Dr. Kornblatt in his reports of May 15, 2013 and August 1, 2013. RX #13 & #14.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

The Arbitrator concludes that petitioner did not suffer an accident that arose out of and in the course of his employment. In reaching this conclusion, the Arbitrator relies upon petitioner's testimony, the medical records from Lutheran General Hospital and Dr. Gonzalez, and the testimony of Jose Ramos. Petitioner testified that he was injured on March 4, 2013 but did not report the accident at the time of its occurrence. Instead, he continued to work a full 40-hour work week for the weeks of March 4, 2013 to March 8, 2013 and March 11, 2013 to March 15, 2013 during which time he performed his regular job duties, which required him to lift boxes, unpack them, place bearings into trays, and then push the trays along a conveyor belt. During this period of time, Jose Ramos, petitioner's supervisor, testified that he saw petitioner on a daily basis and never saw him exhibiting any evidence of pain or suffering from low back pain.

On Sunday, March 17, 2013, petitioner was first seen at Lutheran General Hospital, where he complained of low back and flank pain, without radiation of pain. He gave a history of low back pain for several weeks that had worsened over the past several days. He specifically denied suffering a trauma that would explain his complaints. Similarly, when seen by Dr. Gonzalez on March 18, 2013, he failed to give a history of an accident.

In short, petitioner claims an injury occurring on March 4, 2013, however he continued to work for two additional weeks in a job that required him to lift boxes and stand during which time he did not report the injury and his supervisor never saw any evidence that he was in pain. Moreover, when first seen for medical treatment he denied suffering a trauma. The Arbitrator finds this evidence compelling and relies upon it to conclude that petitioner did not suffer an accident that arose out of and in the course of his employment.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (F), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

The Arbitrator concludes that petitioner failed to establish that his current condition of ill-being is causally related to his purported accident. In reaching this conclusion, the Arbitrator relies upon the medical records of Lutheran General and Advocate Occupational and adopts the opinions of Dr. Kornblatt.

When seen at Lutheran General on March 17, 2013, petitioner complained of low back pain and denied any radiculopathy. RX #10, P.15. When seen at Advocate Occupational on the March 20, 2013, he reported some left buttock and anterior thigh pain that came and went but the bulk of his pain was in his back. RX #9, P. 5. His examination revealed negative straight leg raises. *Id.* He reported his pain level was 2 out of 10 and his condition was improving. RX #9, P. 3 & 5. Petitioner was allowed to work in a light duty capacity and on March 20, 2013 was ordered to begin physical therapy. *Id.* at 8.

The Arbitrator adopts the opinions of Dr. Kornblatt as more pursasive than opinions of Dr. Herman. In reaching this conclusion, the Arbitrator notes that Dr. Kornblatt opined that based on the history provided by petitioner he suffered a lumbosacral strain. RX #1 & #2. He noted that petitioner's complaints when seen at Lutheran General on March 17, 2013 or at his examinations of May 15, 2013 or August 1, 2013 did not reveal any findings of radiculopathy and the only acute injury he had suffered was a lumbosacral strain. *Id.* Moreover, his review of the CT scan

conducted on March 17, 2013 and the MRI conducted on May 3, 2013 demonstrated mild pre-existing lumbar degenerative disc disease without evidence of herniation or instability. *Id.* Dr. Kornblatt's findings are similar to the findings noted when petitioner was initially seen at Lutheran General on March 17, 2013 and Advocate Occupational on March 20, 2013, namely no radiculopathy and an improving condition.

The Arbitrator does not find the opinions of Dr. Herman credible because they are based on an inaccurate understanding regarding the onset of petitioner's symptoms. As outlined in his office notes of September 12, 2013, Dr. Herman opined that petitioner's injuries were more than a lumbosacral condition because he had experienced radiculopathy since the day of the accident. PX #5. The records from Lutheran General of March 17, 2013 refute Dr. Herman's onset of symptoms.

It is well settled in Illinois workers' compensation law that an incomplete or inaccurate history given to a doctor invalidates that doctor's causal connection opinions. *Mhoon v. Provident Hospital, 07 IWCC 733, citing Horath v. Indus. Comm., 96 Ill.2d 349, 70 Ill. Dec 741 (1983).* In the instant case, the opinions of Dr. Herman are based on an inaccurate understanding as to whether petitioner suffered radiculopathy or when it purportedly began. Hence, Dr. Herman's opinions do not carry any weight with the Arbitrator.

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (J) HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

Petitioner is seeking payment of outstanding medical bills totaling $165,151.48. The Arbitrator concludes that respondent is not responsible for the payment of the bills, because, as noted above, petitioner failed to establish that he suffered an accident that arose out of and in the course of his employment and his current condition of ill-being is casually related to the accident. The Arbitrator further notes that the bulk of the treatment petitioner is seeking payment relates to treatment for which Utilization Reviews were conducted.

Section 8.7(i)(4) of the Illinois Workers' Compensation Act provides:

> When a payment for medical services has been denied or not authorized by an employer or when authorization for medical services is denied pursuant to utilization review the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the utilization review pursuant to subsection (a) is reasonably required to cure or relieve the effects of his or her injury. (820 ILCS 305/8.7(i)(4).)

Petitioner did not provide any evidence to meet its burden that the persons conducting the utilization reviews should have varied from the standards of care, and for this reason as well the following bills are denied pursuant to the respective utilization review:

1. Rehabilitation, Inc. for treatment provided from April 10, 2013 to March 26, 2014 pursuant to RX #5. (Physical Therapy).
2. Dr. Sinai for treatment provided from April 10, 2013 to May 31, 2013 pursuant to RX #5. (Chiropractic Care).
3. Northwest Chicago Medical for treatment provided on May 23, 2013 totaling $6,000.00 pursuant to RX #6. (Injection).
4. Network Medical Equipment for treatment provided from May 23, 2013 to July 1, 2013 totaling $12,775.00 pursuant to RX #6. (Game Ready Cold Therapy Unit).
5. Northwest Chicago Medical for treatment provided on March 12, 2014 and March 19, 2014 pursuant to RX #7. (Injections).
6. Network Medical Equipment for treatment provided from February 3, 2014 to March 16, 2014 totaling $15,175.00 pursuant to RX #7. (Game Ready Cold Therapy Unit).
7. Pinnacle for treatment provided on March 12, 2015 and March 19, 2014 pursuant to RX #7. (Injections).
8. Dr. Desai for treatment provided on March 12, 2015 and March 19, 2014 pursuant to RX #7. (Injections).
9. Northwest Chicago Medical for treatment provided on September 19, 2014 pursuant to RX #8. (Discogram).

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (K) IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

Petitioner is seeking approval for payment of a laminectomy, discectomy, and fusion at L5-S1 as recommended by Dr. Herman. The Arbitrator concludes that petitioner is not entitled to payment for the surgery recommended by Dr. Herman. In reaching this conclusion, the Arbitrator adopts the opinions of Dr. Kornblatt and finds them more credible than Dr. Herman's. Dr. Kornblatt opined that petitioner was not a surgical candidate and had suffered a lumbosacral strain. His review of the CT scan of March 17, 2013 and the MRI from May 3, 2013 did not reveal any pathology that would

warrant surgery. Moreover, the MRI of May 3, 2013, corroborates Dr. Kornblatt's opinion that petitioner suffered from pre-existing, age related degenerative disc disease given the evidence of multi-level degenerative spondylosis.

The Arbitrator further notes that Dr. Herman opined that petitioner suffered from a herniated disc at L5-S1, which is the disc level where he wants to operate. The Arbitrator notes that Dr. White, who read the report, observed at the L5-S1 disc level evidence of disc desiccation, decreased disc height without stenosis, a diffuse bulge, facet joint arthrosis and mild to moderate neural foraminal narrowing but no indication of a herniation or instability. PX #5. Similarly, Dr. Kornblatt noted no evidence of a herniation or instability at the L5-S1 disc level. RX #1. The Arbitrator finds that surgery at the L5-S1 disc level is not warranted.

The Arbitrator further notes that Dr. Erickson has more recently recommended a two level fusion from L4-S1 based on the results of the recent discogram. The Arbitrator does not find the results of the discogram compelling for the reasons outlined in the utilization review and adopts the opinions of Dr. Kornblatt outlined in his December 18, 2014 report, where he indicated he had seen no evidence supporting surgical intervention. RX #4. Dr. Kornblatt further commented that even if the repeat MRI showed evidence of spinal stenosis, unlike the MRI from May 2013, it would be related to the normal progression of lumbar disc disease of a 70 year old man would not be related to his purported lifting episode.

Lastly, the Arbitrator is aware that in September 2013 petitioner suffered a cerebrovascular accident while driving home following an eye surgery, which required a hospitalization of two days. The Arbitrator has concerns that the risks of a fusion surgery are greater than the potential benefits in light of Dr. Kornblatt's opinion that if petitioner were to undergo surgery his prognosis for recovery would be guarded. RX #4.

16IWCC0601

IN SUPPORT OF THE ARBITRATOR'S DECISION RELATING TO (L) WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY BENEFITS, THE ARBITRATOR MAKES THE FOLLOWING CONCLUSIONS OF LAW:

The Arbitrator finds that petitioner is not entitled to payment of temporary total disability benefits because petitioner failed to establish that he suffered an accident that arose out of his employment or that his condition was causally related to his alleged accident. Moreover, petitioner is not entitled to temporary total disability benefits given respondent repeatedly offered petitioner light duty restrictions within the restrictions outlined by physicians at Lutheran General Hospital, Advocate Occupational, and Dr. Kornblatt. The Arbitrator further notes that petitioner testified he returned to work after being seen at Advocate Occupational in March 2013 and reported he had an easy time doing his job.

The Arbitrator adopts the findings of Dr. Kornblatt, who concluded petitioner could work with restrictions, which respondent provided in March 2013 and again offered in letters to petitioner dated May 30, 2013 and September 10, 2013, and concludes petitioner is not entitled to payment of temporary total disability benefits.

Dated and Entered_____

_____

George Andros, 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

Darek Pijanowski,

Petitioner,

16IWCC0595

vs.

NO: 13 WC 22059

Marcin Zubrycki d/b/a Zubrycki Construction,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary 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 November 9, 2015, 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.

16IWCC0595

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

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

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

DATED: SEP 16 2016
o9/13/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

16IWCC0595

PIJANOWSKI, DEREK
Employee/Petitioner

Case# **13WC022059**

MARCIN ZUBRYCKI D/B/A ZUBRYCKI CONSTRUCTION
Employer/Respondent

On 11/9/2015, 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 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4442 LAW OFFICE OF TIMOTHY TAKASH
111 W WASHINGTON ST
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CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
BARNALI ROY-MOHANTY
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

16IWCC0595

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)

Darek Pijanowski
Employee/Petitioner

v.

Marcin Zubrycki D/B/A Zubrycki Construction
Employer/Respondent

Case # **13** WC **22059**

An *Application for Adjustment 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 **9/29/2015 and 10/27/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **6/11/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$52,000.00**; the average weekly wage was **$1,000.00**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent children.

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

Respondent shall be given a credit of **$80,381.35** for TTD, $-- for TPD, $-- for maintenance, and $-- for other benefits, for a total credit of **$80,381.35**.

The parties agreed that the issue of medical bills will be deferred to a future date and hearing.

ORDER

Medical benefits
Petitioner failed to prove that the treatment recommended by Dr. Gireesan, including fusion surgery at L5-S1 and L1-L2, is reasonable and necessary pursuant to Section 8 of the Act. Petitioner reached MMI on May 17, 2014. All benefits are denied.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $666.67/week for 48 3/7 weeks, commencing 6/12/2013 through 5/17/2014, at which time Petitioner reached MMI, as provided in Section 8(b) of the Act.

Petitioner reached MMI on 5/17/2014. Respondent paid benefits from 6/12/2013 through 10/4/2015. Respondent shall be given a credit of $80,381.35 for TTD paid.

Maintenance
Petitioner failed to prove that he is entitled to maintenance benefits once he reached MMI on 5/17/2014. Benefits are hereby denied.

Credits
Respondent shall be given a credit of $80,381.35 for TTD paid.

Penalties
Petitioner withdrew his penalties petition. Accordingly, no penalties are awarded.

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

November 9, 2015
Date

ICArbDec19(b)

NOV 9 2015

16IWCC0595

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darek Pijanowski,	)	
	)	
Petitioner,	)	
	)	
v.	)	No. 13 WC 22059
	)	
Marcin Zubrycki)		
D/B/A Zubrycki Construction	)	
	)	
Respondent.	)	

RIDER

An Application for Adjustment of Claim was filed in this matter. The case was heard by Honorable David Kane, Arbitrator of the Workers' Compensation Commission, in the city of Chicago, on a 19(b) hearing on September 29, 2015 and October 27, 2015. After hearing the proofs and reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues below and includes those findings in this document.

I. Findings of Fact

Petitioner moved to the United States in 1996. He testified that he does not speak, read or write English; however, has been able to maintain employment since 1996 through the date of the alleged accident. Based on Petitioner's testimony, there is no clear evidence that he is legally able to work in the United States.

On June 11, 2013, Petitioner, Darek Pijanowski, was employed as a Bricklayer for Respondent, Zubrycki Construction. He worked for Respondent for only two seasons. On that date, he alleges that he fell off scaffolding, sustaining injury to his back. Petitioner initially presented to Advocate Illinois Masonic and diagnostics taken revealed no abnormalities. (Px. 1; Illinois Masonic Records).

On July 8, 2013, MRI's taken at MRI Lincoln Imaging Center revealed disc bulges at L1-2 and L5-S1. Disc degeneration and spondylolysis was also found. (Px. 2, pg. 48-49; Dr. Nasilowski's Records). Petitioner subsequently underwent physical therapy and was eventually referred for an orthopedic consultation.

On September 6, 2013, Petitioner initially presents to Dr. Girresan who diagnoses him with discogenic low back pain (primary) and L1-L2 aggravated as a result of the work accident. The doctor further noted spondylolysis at L5-S1 but does not indicate that this condition was aggravated by the work accident. A review of the MRI revealed no evidence of disc herniations. On this initial evaluation, Dr. Gireesan recommended a FCE to determine his restrictions or second option to undergo fusion surgery. (Px. 4, pg. 2-4; Dr. Gireesan's Records).

On October 17, 2013, Petitioner presented for Respondent's Section 12 examination with Dr. Kornblatt, who is a board certified orthopedic surgeon. Dr. Kornblatt specializes in spine surgery, and has presented and published a number of topic and articles specific to spinal conditions. (Rx. 5; CV of Dr. Michael Kornblatt). The doctor diagnosed Petitioner with pre-existing L1-L2 degenerative disc disease and L5 spondylolysis. The doctor opined that Petitioner's condition was long standing and not a result of the work accident. The doctor diagnosed Petitioner with work-related thoracic and lumbar strain and contusion, as well as an occult fracture that would be related to the work accident. (Rx. 2; Respondent's Section 12 Examination Report).

On January 30, 2014, Dr. Kornblatt reviewed additional records from Dr. Nasilowski and Dr. Gireesan and diagnosed Petitioner with bilateral pars defect at L5 "suggesting either healed post-traumatic changes or pars defect" not secondary to trauma as it relates to the work accident. The doctor recommended a FCE. (Rx. 3; Respondent's Section 12 Report).

On May 17, 2014, Petitioner underwent a valid FCE, which found him capable of functioning at a medium to heavy demand level. (Rx. 1; FCE Report).

On May 20, 2014, Petitioner returned to Dr. Gireesan who recommended fusion surgery. (Px. 4, pg. 81). Since that time, he has had follow-up appoints on a monthly basis and other than pain medication and the recommendation for surgery, Dr. Gireesan has not prescribed active treatment. (Px. 4).

On June 26, 2014, Petitioner returned to Dr. Kornblatt for a repeat Section 12 examination and the physical examination revealed: straight spine, gait intact, negative straight leg raise, negative FABER and Patrick's

tests. At this time, Dr. Kornblatt opined that the work accident resulted on L2, L3 and L4 transverse process fracture and left 9th and 19th rib fractures. Petitioner's L5 spondylolisthesis was pre-existing, which was temporarily aggravated and resolved within six months of the date of accident. The doctor found no evidence of radiculopathy and opined that he was not a candidate for surgery. Petitioner at reached MMI and could return to work with restrictions within the FCE. (Rx. 4, Respondent's Section 12 Examination Report).

The parties agreed to obtain a third opinion from Dr. Edward Goldberg, who is a board certified orthopedic surgeon who specializes in spinal condition. The doctor is the Assistant Professor and Attending for orthopedic surgery at Rush University Medical Center. He has multiple awards, publications and presentations regarding spinal conditions. (Rx. 8; CV of Dr. Edward Goldberg).

On October 29, 2014, Petitioner presented to Dr. Goldberg for evaluation. The doctor had the opportunity to review the medical records from Dr. Nasilowski, Dr. Gireesan, Dr. Kornblatt, MRI films, and FCE. A Polish interpreter was present. On examination, Petitioner denied radicular pain. He was minimally tender at the lumbar and thoracic regions. Waddell's test was negative. Straight leg raise was negative. He presented with 5/5 motor strength. Dr. Goldberg diagnosed Petitioner with longstanding degenerative disc disease at L5-S1 with spondylolisthesis The doctor noted that spondylolisthesis arises at childhood and the bone scan did not indicate an acute process to suggest an acute fracture resulting in his condition. Dr. Goldberg did not recommend surgery; rather that Petitioner obtain a discography. Petitioner could return to work per the FCE. (Rx. 6; Respondent's Section 12 Examination Report).

On January 22, 2015, Dr. Goldberg was sent a copy of the discography for comment, in addition to updated medical records. Upon review of the discogram, the doctor found no reproduced concordant pain a L1-L2 and L5-S1. Dr. Goldberg opined that his isthmic spondylolisthesis was present since childhood and unrelated or aggravated by the work accident. The doctor further opined that he was not a surgical candidate. (Rx. 7; Respondent's Section 12 Addendum Report).

The evidence deposition of Dr. Goldberg was taken by agreement of the parties on July 29, 2015. Dr. Goldberg is a board certified orthopedic surgeon who is licensed to practice in Illinois. He has been practicing since 1990 and specializes in spinal condition and spinal surgery. During the deposition, the doctor credibly testified regarding diagnosis, causation, treatment and his rationale behind his opinions. (Rx. 9, Deposition Transcript).

In summary, relative to diagnosis, the doctor testified that Petitioner's conditions are pre-existing. Specifically, Petitioner has a condition known as pars defect of the lumbar spine, which is a condition that begins at childhood. Further, the bone scan correlates that this condition began in the early stages of Petitioner's life, well before the date of accident.

Based on the doctor's physical evaluation and review of the diagnostics, he opined that Petitioner's condition was not acute or traumatic. Additionally, the discograph found not reproduction of pain at the L1-2 and L5 disc levels. The doctor testified that Petitioner sustained a lumbar strain and transverse process due to the work accident. He opined that the pars defect and spondylolisthesis was unrelated to the work accident.

Relative to treatment, the doctor testified that Petitioner did not demonstrate any symptoms at L1-2 and L5, which was corroborated by the discography. Accordingly, the doctor opined that Petitioner is not a candidate for fusion surgery notwithstanding his opinion regarding causation.

Dr. Goldberg generally concurred with Dr. Kornblatt's opinions. He found the FCE to be valid. Based on the job description provided by the FCE, the doctor opined that Petitioner would be able to return to work within the medium/heavy demand level. The doctor opined that Petitioner had reached MMI.

On March 30, 2015, Petitioner presented for an initial vocational assessment with counselor Patricia Sharkey. Based on Petitioner's education, physical restrictions, language skills and transferable work skills, Ms. Sharkey opined that there was a stable labor market for him to return. Ms. Sharkey noted that Petitioner does not have a green card, permanent residency car or US citizenship; accordingly, Petitioner is not currently able to legally work in the United States. She noted that one of the barriers in Petitioner finding employment was his illegal working status. (Rx. 10; Initial Vocational Assessment).

On April 28, 2015, a labor market survey was obtained to identify employment opportunities based on Petitioner's education, physical restrictions, language skills and transferable work skills; notwithstanding his ability to legally work in the United States. Several occupations, including Deli Cutter Slicer, Production Laborer, Assembler, Delivery Driver, Window Cleaner, Linen Room Attendant, Cleaner Housekeeping and Cleaner I, were utilized in the survey. In summary, available jobs were found in the salary range of $8.25 to $10.00 per hour. Multiple employers showed

willingness to hire a Polish-only speaking applicant. (Rx. 11; Labor Market Survey).

Petitioner testified that he currently has low back pain and takes medication. Other than follow-up appointments with Dr. Gireesan, he has not actively treated since completing work conditioning on May 20, 2014. (Px. 4, pg. 81). He would like to undergo surgical intervention. He testified that Dr. Girreesan "guaranteed" that the surgery will improve his condition.

II. Conclusions of Law

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition is causally related to the injury, the Arbitrator finds the following:

The Arbitrator finds Dr. Kornblatt's and Dr. Goldberg's opinions more compelling. Based on the medical records, including the diagnostics, Petitioner's pars defect condition and spondylolisthesis is pre-existing and unrelated to the work accident. Petitioner sustained a temporary aggravation of a pre-existing condition consistent with transverse process. Petitioner's work-related condition has resolved and he has reached MMI as of the date of the FCE on May 17, 2014.

In support of the Arbitrator's decision relating to issue (J), whether the medical services provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Respondent has paid for the reasonable and related medical treatment pursuant to the medical fee schedule or other negotiated agreement, whichever is less. Petitioner has reached MMI and is not entitled to additional medical treatment/benefits.

In support of the Arbitrator's decision relating to issue (K), whether Petitioner is entitled to any prospective medical care, the Arbitrator finds the following:

Section 8(a) of the Act limits the employer's liability to pay all *necessary* medical treatment, which is *reasonably required to cure or relieve* from the effects of the accidental injury (emphasis added).

On September 6, 2013, Petitioner initially treated with Dr. Gireesan and the doctor discussed surgery. The Arbitrator does not find Dr. Girreson's treatment protocol reasonable. Petitioner went for an evaluation with Dr. Kornblatt and Dr. Goldberg, and both doctors had similar opinions. All three doctor's did not find evidence of radicular symptoms and the diagnostics, including the discogram did not correlate any positive finding is the disc levels that Dr. Gireesan is recommending surgery. The Arbitrator finds Dr. Kornblatt's and Dr. Goldberg's opinions more convincing. Furthermore, Petitioner's reliance on the surgery, in that he believes it will guarantee improvement is misplaced.

It is the Arbitrator's duty to ensure that an injured worker is provided with reasonable and necessary medical treatment required to cure or relieve his condition. Based on the above, the Arbitrator is not convinced

that the surgical recommendation by Dr. Gireesan is reasonable and necessary. The Arbitrator finds the opinions of Dr. Kornblatt and Dr. Goldberg more credible.

Accordingly, the Arbitrator finds that Petitioner reached MMI on May 17, 2014 and prospective care is hereby denied. Although the Arbitrator views Petitioner's condition as having stabilized, the parties have not requested the Arbitrator to address permanency.

In support of the Arbitrator's decision relating to issue (L), whether Petitioner is entitled to TTD and/or maintenance benefits, the Arbitrator finds the following:

On May 17, 2014, Petitioner reached MMI. Petitioner is entitled to TTD benefits from June 12, 2013 through May 17, 2014. Respondent paid benefits through October 4, 2015. Accordingly, Respondent is due a credit for overpayment of TTD from May 17, 2014 through October 4, 2015.

Relative to maintenance benefits, Petitioner has not proven his burden that he is entitled to benefits. While an initial vocational assessment and labor market survey was obtained indicate that there was a stable labor market for Petitioner to return, he has not made a diligent job search and has no intention of returning to work. Furthermore, Petitioner's inability to legally work in the United States automatically takes Petitioner out of the workforce and he is not entitled to vocational rehabilitation. Accordingly, he is not entitled to maintenance benefits.

In support of the Arbitrator's decision relating to issue (N), whether Respondent is due any credit, the Arbitrator finds the following:

Respondent paid benefits from June 12, 2013 through October 4, 2015. Respondent shall be given a credit of $80,381.35 for TTD paid.

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

Yehanes Negash,

Petitioner,

vs.

NO: 13 WC 26526

16IWCC0580

S & C Electric Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extend of Petitioner's 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. For the reasons set forth below, the Commission modifies the Arbitrator's Decision by increasing the Petitioner's permanent partial disability award to 30% loss of use of his right hand.

After the Petitioner sustained a work accident involving his right hand on June 25, 2013, he underwent several surgeries. He testified that since these surgeries he still continues to have issues with his daily activities such as cooking, chopping up food, washing dishes, washing his body, and removing snow from his car. He has pain when he moves his hand and when he makes a fist. During the wintertime, the cold bothers his hand. (Tr. 12, 27-29)

The Petitioner testified that when he returned to work for the Respondent, he did not return to his former position. He is no longer able to work with heavy tools such as the air gun and big wrench due to his limited motion, and because they are too heavy for him now. At the time of trial he was working as a material handler. The Petitioner experiences difficulty lifting some parts, but he is able to obtain assistance from co-workers when needed. When he lifts the

16IWCC0580

heavy items, the middle finger of his right hand is the most bothersome. He is able to lift up to 25lbs. (Tr. 16-23, 25-27).

The Commission notes that the date of accident of this case is June 25, 2013. Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), this factor is moderately relevant because only one of Petitioner's damaged fingers was analyzed in the report prepared pursuant to this section. A moderate amount of weight is afforded to this factor because the report includes the evaluation of the finger that experienced the most damage. The report, completed by Dr. Michael Vender, contained the following:

- Petitioner has 3 scars on his hand from the surgery: one is 2 cm, one is 5-6 cm, and one is 4-5 cm.
- Based on a diagnosis of fracture to the right middle finger with residuals, his residual impairment is right middle 40%, or 7% of the upper extremity.

Dr. Vender further analyzed Petitioner's right middle finger rating:

- Petitioner's diagnosis: "Crush injury right hand; fracture right middle finger proximal phalanx – s/p ORIF; right middle finger extensor tendon laceration s/p repair.
- Dr. Vendor's final rating: "Impairment secondary to right middle finger range of motion loss = 7% upper extremity."

With regard to subsection (ii) of §8.1b(b), this factor is moderately relevant. The Petitioner works as an assembler, a position that requires manual labor. His lingering issues - including his diminished grip strength and inability to do certain tasks - have affected his ability to do his job per his testimony. A moderate amount of weight is afforded to this factor because the Petitioner depends on the use of his right hand for his job.

With regard to subsection (iii) of §8.1b(b), this factor is also moderately relevant. As the Petitioner was 30 years of age at the time of his accident, he may likely deal with the lingering issues of his injury, both at work and in his personal life, for many years to come. The Petitioner testified to some concerns about how his lingering issues will affect his future as a husband and father. Therefore, a moderate amount of weight is afforded to this factor.

With regard to subsection (iv) of §8.1b(b), this factor has lower relevance because there is little evidence that Petitioner's future earning capacity is affected by his injury. He returned to work full-duty, and even works overtime. The Petitioner testified to having been interested in attending barber school and that his injury derailed that plan. However, there was no evidence that Petitioner actually enrolled in a barber school. Furthermore, with the limited evidence on this matter, the Commission would only be able to speculate as to whether the Petitioner's future earning capacity could be affected in his primary occupation; it declines to do so. Therefore, lesser weight should be afforded to this factor.

With regard to subsection (v) of §8.1b(b), this factor is highly relevant because there is evidence in the Petitioner's medical records that corroborates his diagnosis, his operations, and his recovery. Because there is evidence that substantiates his disability, this factor should be afforded greater weight. The Petitioner's diagnosis was the following per his surgeon on June 28, 2013:

- Open fracture, crush injury to right hand, right middle finger, and proximal phalanx.
- Bursting laceration to right hand and middle fingers.
- Extensor tendon laceration to right middle finger.

The Petitioner had four procedures listed on the June 28, 2013 surgical record including operations on his right middle finger and right index finger. On April 9, 2014, the hardware was removed. On July 21, 2014, the day the Petitioner was released back to work full-duty, his surgeon wrote the following: Petitioner's scars are well-healed, he hasn't achieved full range of motion, but he can make a fist. He has some residual swelling. He lacks terminal flexion and extension of digits, but is neurovascularly intact.

Based on the above factors, and the record taken as a whole, the Commission finds that Petitioner sustained permanent partial disability to the extent of 30% loss of use of the right hand pursuant to §8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $344.40 per week for a period of 13 and 1/7 weeks (June 26, 2013 through September 25, 2013), that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $309.96 per week for a period of 61.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 30% loss of use of his right hand.

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

16IWCC0580

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP - 8 2016

TJT/gaf
O: 7/26/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEGASH, YEHANES
Employee/Petitioner

Case# **13WC026526**

S & C ELECTRIC
Employer/Respondent

16IWCC0580

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

If the Commission reviews this award, interest of 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRAUM RUFFOLO & MARZAL LTD
AMARIS AYALA
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

0481 MACIOROWSKI SACKMANN & ULRICH
ADRIANA QUIROZ
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

16IWCC0580

☐	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

YEHANES NEGASH
Employee/Petitioner

Case #13 WC 26526

V.

S & C ELECTRIC
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 21, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

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 June 25, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- At the time of injury, the petitioner was 30 years of age, married with no children under 18.
- The petitioner agreed that there are no unpaid bills for the necessary medical services provided to the petitioner.
- The petitioner agreed that the respondent paid $4,256.45 in temporary total disability benefits.
- The respondent agreed that the petitioner is entitled to temporary total disability benefits for 13-1/7 weeks, from June 26, 2013, through September 25, 2013.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $344.40/week for 13-1/7 weeks, from June 26, 2013, through September 25, 2013, which is the period of temporary total disability for which compensation is payable. The respondent paid $4,256.45 in temporary total disability benefits and is given a set-off for that amount.
- The respondent shall pay the petitioner the sum of $309.96/week for a further period of 26.65 weeks, as provided in Section 8(e) of the Act, because the injuries sustained

caused the permanent partial disability to petitioner to the extent of 13% loss of use of his right hand.

- The respondent shall pay the petitioner compensation that has accrued from June 25, 2013, through December 21, 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.

Robert E. Williams

Signature of Arbitrator

January 20, 2015
Date

JAN 21 2016

FINDINGS OF FACTS:

On June 25, 2013, the petitioner, an assembler, sustained an injury to his right hand. He received emergency care at St. Francis Hospital in Evanston for his right hand and middle and index fingers. The petitioner saw Dr. Baxamusa who performed an irrigation and debridement, open reduction, internal fixation and bone graft of his right middle finger proximal phalanx fracture, an extensor tendon repair of his right middle finger and a radial and ulnar digital microneurolysis of his right index finger on June 28th. Dr. Baxamusa's post-operative diagnosis was an open fracture and crush injury of the proximal phalanx of the right middle finger, a bursting laceration of the right index and middle fingers and an extensor tendon laceration of the right middle finger.

In August, the petitioner was treated for depression by his primary care physician, Dr. Howard Marten, and received counseling for one month through an employee assistance program. On April 9, 2014, Dr. Baxamusa removed the implanted pin in the petitioner's right middle finger and performed an extensor tenolysis and an interphalangeal joint capsulotomy of his right middle finger. Dr. Baxamusa noted on May 22nd that the petitioner reported doing quite well. The petitioner reported continued improvement on June 23rd. He was released to work beginning June 30th with a ten-pound lifting restriction. On July 21st, the petitioner reported being very happy with the results. Dr. Baxamusa noted that a full range of motion had not been achieved and a mild PIP contracture but that the petitioner was able to make a fist and had stable fingers. His examinations also revealed mild residual swelling, no tenderness, a lack of terminal flexion and extension of the digits and an intact neurovascular. The doctor opined that x-rays revealed a healed proximal phalanx with removed hardware and nicely consolidating

screw holes. Dr. Baxamusa released the petitioner to work without any restrictions on July 22nd.

FINDING REGARDING THE AMOUNT OF WAGES:

The wage statement in evidence shows that the petitioner worked overtime every Saturday for 51 weeks, which he testified was mandatory. The petitioner proved that his overtime hours were mandatory and consistent. His overtime earnings for the 52 weeks preceeding his injury at one-and-a-half of his hourly rate was $2,405.18. The overtime earnings at the regular hourly rate is $1,603.45, which added to his base wages of $25,259.77 is $26,863.22. In the year preceding the injury, the petitioner earned $26,863.22; the average weekly wage was $516.60.

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 right index and middle fingers is causally related to the work injury on June 25, 2013.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

An impairment rating of 40% of the right middle finger, 8% of the hand or 7% of the upper extremity pursuant to the 6th edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment was provided by Dr. Vender. Pursuant to the release of his doctor, the petitioner returned to his previous capacity of an assembler and currently performs the full duties of a material handler without any restrictions.

There is no evidence concerning the impact of the petitioner's injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(ii) through

(iv) of the Act, nor can any effect be reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of pain, an inability to use small tools, sensitivity to cold, difficulty using his fingers to manipulate heavy air guns and wrenches, lifting over 25 pounds, increased pain in cold weather and with cooking, showering and washing dishes and depression. The petitioner's inability with using heavy air guns and wrenches appears to be corroborated by Dr. Baxamusa's findings of a residual loss of terminal flexion and extension of his index and middle digits and is relevance. It is not known whether the impairment rating by Dr. Vender considered and included the difficulties the petitioner has with heavy items or the loss of flexion and extension of his index and middle fingers. Therefore, the petitioner's additional disability with his right hand pursuant to Section 8.1(b)(v) is 5%.

The respondent shall pay the petitioner the sum of $344.40/week for a further period of 26.65 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 13% loss of use of his right hand.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bret Michaels,

Petitioner,

vs. No. 13 WC 35036

16IWCC0620

Czarnowski Display Services, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, wage calculations, benefit rates, temporary disability and permanent disability/wage differential, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner's application for adjustment of claim alleges that on March 15, 2013, Petitioner sustained accidental work-related injuries to his right leg and other parts of the body. Petitioner, a union carpenter, testified that he worked for Respondent from November 4, 2012, through March 15, 2013, earning $41.52 an hour. His hours depended on whether there was a show at McCormick Place for which Respondent put up displays. During a show, Petitioner worked at least 40 hours a week. When the show ended, Petitioner did not work for Respondent until the next show. During such downtimes, Petitioner looked for work through the union hall. Petitioner introduced into evidence two earnings statements/pay stubs from Respondent. The first document, for the week from November 19, 2012, through November 25, 2012, states Petitioner worked 32 regular hours and 16 overtime hours. Petitioner was paid an hourly wage of $41.52 for the regular hours. The second document, for the week from February 25, 2013,

through March 3, 2013, states Petitioner worked 36 regular hours, 16 overtime hours and 16 double-time hours. Petitioner was paid an hourly wage of $41.52 for the regular hours.

Petitioner further testified that before working for Respondent, he worked as a carpenter for Big Run Fence through October of 2012. Respondent introduced into evidence a wage statement from Big Run Fence spanning the time period from May 13, 2012, through January 30, 2013. The wage statement shows Petitioner was a seasonal employee who earned $11.00 an hour. Petitioner denied concurrently working for Respondent and Big Run Fence, explaining the paychecks he received from Big Run Fence in December of 2012 and January of 2013 were late payments for the work he performed in October of 2012.

Petitioner further testified that on March 15, 2013, he injured his right knee on the job when he tripped over some wrinkled plastic carpet covering. Petitioner described the mechanism of injury as follows: "[I]t caused me to step back on my right knee and [I] twisted it. And as soon as I got up, it was, 'Pop, pop, pop' and pain from there on."

Petitioner received initial treatment at Ingalls Occupational Health Program (Ingalls). The attending nurse practitioner at Ingalls noted the following mechanism of injury: "[The patient] felt three distinct 'popping' sensations when right foot was planted and knee twisted while at work." An MRI performed March 18, 2013, showed an anterior cruciate ligament (ACL) tear and a large complex tear of the body and posterior horn of the medial meniscus. Petitioner was referred to Dr. Neal Labana. Dr. Labana, who did not treat knee injuries, referred Petitioner to Dr. Carl Dilella.

The medical records from Dr. Dilella note the following history: "[The patient] states while at work setting up displays at McCormick Place, he sustained a rather violent twisting injury to his right knee. This was followed immediately by painful swelling in the right knee and difficulty with weightbearing." Dr. Dilella noted the MRI showed "a complete ACL disruption and a complex tear of the medial meniscus." On May 16, 2013, Dr. Dilella performed an arthroscopic ACL reconstruction, partial medial meniscectomy, and microfracture of the lateral femoral condyle chondral lesions. On May 20, 2013, Petitioner began postoperative physical therapy.

During early follow-up visits, Dr. Dilella noted that Petitioner was making good progress in physical therapy. However, on August 27, 2013, Petitioner complained to Dr. Dilella of increased pain in the knee and described performing strenuous exercises in physical therapy that were contrary to Dr. Dilella's physical therapy recommendations. Dr. Dilella instructed Petitioner to switch to a different physical therapy provider. On September 17, 2013, Dr. Dilella noted that Petitioner switched from the Ingalls Flossmoor facility to Ridge Rehabilitation. Petitioner reported the physical therapy at Ridge Rehabilitation was very beneficial, and the knee pain slowly subsided. On physical examination, Dr. Dilella noted residual weakness in the knee.

On October 29, 2013, Dr. Dilella noted the workers' compensation carrier denied "the most recent block of supervised therapy." Physical examination findings were as follows: "There is no palpable effusion today in the knee. He can actively extend the knee to 0° and actively flex to 130°. Varus valgus stability is intact. There is no medial or lateral joint line tenderness present. Anterior and posterior drawer tests reveal normal stability today." Dr. Dilella noted the most recent physical therapy notes documented full active and passive range of motion and normal strength. Dr. Dilella therefore advised Petitioner to attempt to return to work full duty. "In the interim, he will also be fitted for an ACL supporting brace." Dr. Dilella expected Petitioner would reach maximum medical improvement (MMI) in six weeks.

On November 5, 2013, Dr. Mark Levin at Barrington Orthopedic Specialists examined Petitioner at Respondent's request. Petitioner complained of increased pain in the knee since the physical therapy incident, rating the pain a 4-10/10 and reporting significant functional limitations. Dr. Levin noted that Petitioner walked with a limp. Physical examination findings were as follows: "His quadriceps measurement circumferentially four fingerbreadths superior to the patella measures 54.5 cm on the right compared to 54 cm on the left. His midcalf circumference is 37.5 cm on the right compared to 36.5 cm on the left. *** He has a trace effusion, but has noted tenderness over both the anteromedial joint line, as well as the anteromedial facets of the patella. He has full extension with flexion to 135 degrees. He has a trace anterior drawer, but has a firm Lachman with equivocal pivot shift. He has markedly positive McMurray and Apley grind test recreating medial knee pain. He is tender when one palpates directly over the medial collateral ligament and medial joint line. To valgus stressing, there is a 1+ opening medially on the right knee." Dr. Levin reviewed the MRI images from March 18, 2013, noting "there was a tear of the anterior cruciate ligament with changes in the lateral femoral condyle consistent with an acute chondral injury from an ACL injury as well. There does appear to be a tear in the posterior horn of the medial meniscus."

Dr. Levin opined: "Based upon this patient's history, physical exam, radiographs, and medical records, it appears that [the patient] did sustain a work injury consistent with an ACL tear and medial meniscal tear. He did undergo appropriate orthopedic intervention. It appears that at this therapy though, he has had some increasing symptoms." Dr. Levin recommended a repeat MRI and stated that Petitioner did not presently appear capable of returning to work as a union carpenter.

Also on November 5, 2013, Petitioner followed up with Dr. Dilella, complaining of painful clicking along the medial compartment and some feeling of instability. Physical examination was unremarkable, except for slight tenderness overlying the medial femoral condyle and medial joint line. Dr. Dilella stated: "I do believe this patient's recovery was completely uneventful until an episode he described while undergoing therapy at approximately the three month mark. He believes the knee simply did not feel the same after a rather aggressive physical therapy session." Dr. Dilella took Petitioner off work and ordered an MRI. The MRI, performed November 29, 2013, showed an intact ACL graft and no definitive evidence of a new meniscus tear. On December 3, 2013, Petitioner followed up with Dr. Dilella, complaining of

persistent pain. Physical examination was unremarkable, with the exception of slightly positive anterior drawer test. Dr. Dilella agreed with the radiologist's reading of the MRI. He recommended additional physical therapy, followed by work hardening, and released Petitioner to return to work on light duty.

On January 14, 2014, Petitioner followed up with Dr. Dilella, reporting increased strength and range of motion after completing a course of physical therapy. Physical examination was unremarkable. Dr. Dilella recommended work hardening and again prescribed an ACL supporting hinged brace. A work hardening progress report from Ridge Rehabilitation dated February 17, 2014, notes increased active range of motion, strength, endurance and functional activity. However, the report further notes: "Pt. continues to complain of increased pain with some increased activity." Dr. Dilella discontinued work hardening at that point.

On March 4, 2014, Petitioner followed up with Dr. Dilella, reporting a dramatic improvement in strength and being ready to return to work. Physical examination was normal. Dr. Dilella stated: "I reviewed the work hardening notes documenting excellent progression of his recovery. Unfortunately, he has not been supplied with an ACL supporting brace that I prescribed on a previous visit." Dr. Dilella gave Petitioner a new prescription for an ACL supporting brace and released him to return to work full duty. Dr. Dilella instructed Petitioner to follow up in six weeks, at which point he expected Petitioner to be at MMI.

Petitioner testified that Respondent stopped paying temporary total disability benefits on or about March 17, 2014. Shortly thereafter, Petitioner began working for Aurelio's Pizza, earning $9.00 an hour. After two and a half days, the owner/manager of Aurelio's Pizza told Petitioner to stop working after Petitioner stated he was supposed to have a knee brace. The owner/manager did not feel comfortable with Petitioner working without the brace. Petitioner testified the delay in receiving the ACL brace was because of the nurse case manager. Petitioner finally received the brace on April 14, 2014.

On April 15, 2014, Petitioner followed up with Dr. Dilella, reporting "attempting to resume full duty status work." Dr. Dilella noted: "He states he is still having some discomfort over the lateral compartment of the knee with heavy exertion and heavy activity." Physical examination was unremarkable, with the exception of some tenderness overlying the lateral femoral condyle. Dr. Dilella stated: "I had a lengthy discussion today with the patient regarding his ability to perform full duty work. At this point, my recommendation is that he undergo a FCE [functional capacity evaluation] to objectively determine work activities that he can or cannot perform. In addition, I will have the therapist perform a PPI rating to assess him." Dr. Dilella instructed Petitioner to follow up after the FCE.

Petitioner testified that during the visit on April 15, 2014, he expressed to Dr. Dilella that he did not feel he could return to work for Respondent at McCormick Place. Petitioner explained: "Sometimes you're walking over a mile and a half, two miles before you get to the job site. By that time, I would have been spent. There was no way I was going to do it. I know

my body. I know my limitations." Petitioner did not attempt to find a job through the union hall. Petitioner explained: "I was confident that I would not be able to fulfill the demand of what they needed, and it would make me look bad. And I didn't want that." Petitioner forwarded the FCE prescription to his nurse case manager. However, Respondent never scheduled the FCE. Petitioner did not return to Dr. Dilella. Petitioner resumed working for Aurelio's Pizza until May 15, 2014, when he went to work as a maintenance person for Providence Village Woods, a retirement community.

On October 20, 2014, Dr. John Cherf, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner rated his knee pain a 1-10/10 and his knee function at 75 percent. He denied instability. He reported that bending and climbing stairs exacerbate the symptoms and stated that he cannot return to work as a union carpenter. Physical examination findings were as follows: "[The patient] has a full squat, nonantalgic gait. He has no atrophy with his thigh circumference, 10 cm superior to the proximal pole of the patellae, of 56 cm bilaterally. His maximum calf circumference is 48 ½ cm right and 49 cm left. He has no effusion and full range of motion. There is no soft tissue swelling, erythema, or ecchymosis around the right knee. ¶ Patellar/Extension Mechanism Examination: Grade 1 crunching crepitation, otherwise normal. ¶ Ligamentous Examination: [The patient] has a negative Lachman. His pivot shift on internal and external rotation is 1, 2. His anterior drawer and internal, neutral, and external rotation is 1, 2, and 1. He has 1+ laxity at valgus and 20 degrees right knee flexion and 1+ laxity at varus at 20 degrees right knee flexion. He has no posterior laxity. This ligamentous examination is asymmetrical with a negative Lachman, negative pivot shift, and negative varus and valgus testing in his left knee. ¶ Meniscus/Joint Line Examination: [The patient] has 2+ mid and 2+ posteromedial joint line tenderness and 2+ mid and 2+ posterolateral joint line tenderness." The remainder of the examination was unremarkable. X-rays showed asymmetrical tricompartmental degenerative changes.

Dr. Cherf opined that Petitioner was at MMI and stated: "[The patient] may return to work full-time, full duty with no restrictions when considering his right knee in a work-related right knee injury on March 15, 2013. However, [the patient] has osteoarthritis of his right knee secondary to a chronic anterior cruciate ligament deficient knee that is independent of the work-related right knee injury on March 15, 2013. A valid Functional Capacity Evaluation may be considered to determine any restrictions that would be the result of this arthritis. [The patient] should not require any restrictions when considering the work-related right knee injury in question." Dr. Cherf's impairment rating was 2 percent of the lower extremity or 1 percent of the person as a whole, based on his opinion that Petitioner had a preexisting ACL deficient knee, and the accident caused only "a possible medial meniscal tear."

On December 5, 2014, Petitioner was examined by Dr. Michael Gross at the request of his attorney.[1] Petitioner reported working in maintenance and that his restrictions included limited stair climbing, standing on ladders and squatting. He also reported that an FCE had been prescribed, but never performed. Dr. Gross noted the following complaints: "At the time of the

[1] Dr. Gross's specialty is not identified.

examination, [the patient] complained of right knee pain, increased with any pressure and with weather changes. He stated that he cannot stand on a ladder as it is too painful. He stated that he has to have three points of contact all of the time when on a ladder or he will get fined, and his knee problems make this difficult. He stated that due to his right knee pain, he stands with all of his weight on his left leg. He complained of right knee pain for a couple of days after going up stairs, putting weight on his knee. He stated that he uses elevators at work most of the time. He stated that he has right knee pain worse up than down on stairs. He complained that his right knee gets numb after sitting for about thirty minutes. He stated that he sits more to his left side, due to right knee pain. He stated that he avoids squatting, due to right knee pain. He complained that his right knee feels like it is going to buckle if he kneels on it, so he always kneels on his left knee. He stated that when walking he has to lift and position his right foot, as he cannot rock back and forth and put it in certain directions, due to pain. He complained of pain when jogging, and for a couple of days afterwards. He complained that on an average day, his right knee swells 40% of the time. He stated that his right knee always aches after work. He stated that he uses ice for the swelling. He complained that his right knee buckles at least twice a week. He complained that he has gained over 50 lbs. since this injury. He stated that he does much lighter work and that he does his entire job differently. He stated that after a day of hard work, he has to sit in his driveway for a half hour before he can get out of his car, due to pain and stiffness, and his knee pain continues for a couple of days."

On physical examination, "[t]here was atrophy of the right quadriceps and vastus lateralis muscles. Squatting was performed to one-half of normal. He used the left leg more to get up afterward." Dr. Gross further noted slight tenderness over the medial joint line and inferior to the knee. There was tenderness over the lateral joint line and also inferior and superior to the lateral collateral ligament. There was tenderness in the posterolateral and posteromedial complex of the knee. Dr. Gross stated these findings indicate inflammation. There was also slight pain to patellar pressure. Dr. Gross measured the circumference of the right calf to be 14 ¼ inches as compared to the left calf at 14 ½ inches, considering the difference to be a sign of atrophy on the right. He measured the circumference of the right knee to be 15 ¼ inches as compared to the left knee at 15 inches, considering the difference to be a sign of swelling. Dr. Gross also noted the difference in flexion at 145 degrees on the right and 160 degrees on the left. Dr. Gross continued: "The drawer and Lachman tests revealed laxity on the right; but were intact on the left. The right abduction test was positive medially. The right adduction test was positive laterally. The right McMurray test was intact bilaterally. The right Apley traction test was positive medially. The right Apley pressure test was intact. ¶ The quadriceps muscle strength was four out of five on the right, and five out of five on the left. The lower extremity reflexes were intact. ¶ There was a positive Tinel test at the lateral arthroscopic site. There was also a positive Tinel test as the medial arthroscopic site. There were paresthesias over the right leg below the knee." Dr. Gross stated these findings indicated "ligament involvement" and "nerve dysfunction."

Dr. Gross diagnosed "[r]esiduals of a soft tissue and ligament injury of the right knee," status post ACL and medial meniscus surgery. Dr. Gross opined the condition of ill-being was

permanent and causally connected to the work accident. Dr. Gross further opined that Petitioner "has a major loss of use of the right lower extremity, on an industrial basis," and "has permanent restrictions as a result of the injury which limit climbing, standing on ladders and squatting, and prevent him from performing his work as a union carpenter." Dr. Gross's impairment rating was 30 percent of the lower extremity or 12 percent of the person as a whole.

Petitioner testified regarding his condition at the time of the arbitration hearing that he wears the knee brace when he does a lot of walking or anything physically demanding. Petitioner's job with Providence Village Woods involves light maintenance, such as "unplugging toilets, tightening sinks, *** light sockets." Petitioner does not perform snow or ice removal. He works 40 hours a week at the rate of $12.00 an hour. Petitioner does not feel he can do carpentry because he cannot carry much weight, climb a ladder, or be on his feet for a long period of time. Petitioner continued: "It just takes it all—once I use [the knee], very very demanding, I'm out of commission for three to four days easily. My knee swells up. I wake up every morning, and I have to work it out for fifteen to twenty minutes before I can even begin my day." Petitioner stated he can safely walk only on flat surfaces. If he steps on an incline, he feels a pins and needles sensation. Sometimes the knee buckles when he walks. Petitioner stated he can only do minimal squatting and worries about being able to get back up. Petitioner stated the management at Providence Village Woods is "compassionate" about his situation.

The Commission affirms the Arbitrator's finding that Petitioner's right knee condition is causally connected to the work accident. Further, the Commission affirms the Arbitrator's average weekly wage determination of $1,660.80. The Arbitrator based the average weekly wage calculations on a 40 hour workweek at the non-overtime rate. The Commission finds the Arbitrator's average weekly wage determination is supported by the record and comports with the decisions in Sylvester v. Industrial Commission, 197 Ill.2d 225 (2001) and Illinois-Iowa Blacktop, Inc. v. Industrial Comm'n, 180 Ill. App. 3d 885 (1989).

The Commission clarifies the Arbitrator's Decision with regard to temporary disability benefits. Petitioner is entitled to temporary total disability benefits from March 16, 2013, through April 14, 2014, when he received the ACL brace and reached MMI. No further temporary benefits are awarded.

The Commission modifies the Arbitrator's Decision with regard to credit and permanent disability. In accordance with the parties' stipulation in the request for hearing form, the Commission awards Respondent a credit of $33,779.29 for the temporary total disability benefits paid. The Commission vacates the Arbitrator's award of additional credit for the wages Petitioner earned while working for Aurelio's Pizza.

Turning to the issue of permanent disability, the Commission disagrees with the award of wage differential benefits. The Commission is not persuaded by the opinions of Dr. Gross. Dr. Gross based his opinions on Petitioner's subjective complaints. Dr. Gross's opinion that Petitioner cannot return to work as a union carpenter has no independent clinical judgment as its

basis. The Commission further notes Dr. Cherf's opinion that Petitioner sustained only minimal permanent disability is contrary to the weight of the evidence.

The Commission relies on the opinions of Dr. Dilella, Petitioner's treating surgeon. Dr. Dilella's records describe in detail Petitioner's injuries, the surgery and postoperative setback from improperly aggressive physical therapy. However, after additional physical therapy and work hardening with a different provider, Petitioner reported a dramatic improvement. On March 4, 2014, Dr. Dilella gave Petitioner a new prescription for an ACL supporting brace and released him to return to work full duty. On April 15, 2014, Petitioner reported to Dr. Dilella "attempting to resume full duty status work." Dr. Dilella noted: "He states he is still having some discomfort over the lateral compartment of the knee with heavy exertion and heavy activity." The Commission notes that Petitioner did not describe any such heavy exertion or activity in March or April of 2014. Because of Petitioner's subjective complaints, Dr. Dilella ordered an FCE. Petitioner did not undergo an FCE and did not return to Dr. Dilella. Petitioner admitted that he never tried to return to work as a union carpenter, even though Dr. Dilella released him to return to work full duty. Rather, Petitioner found a permanent job doing light maintenance, earning significantly less per hour than he did when he worked for Respondent, but more than he did while working for Big Run Fence. Because the record contains considerable evidence of symptom magnification and self-limiting behavior, the Commission finds an award of wage differential or loss of trade benefits is inappropriate.

Rather, the Commission awards permanent partial disability benefits for a specific loss under section 8(e) of the Act. Our determination of specific loss benefits is governed by section 8.1b(b), which provides:

> "In determining the level of permanent partial disability, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order." 820 ILCS 305/8.1b(b).

Regarding factor (i), the reported level of impairment, the Commission notes Dr. Cherf provided an impairment rating of 2 percent of the lower extremity, while Dr. Gross provided an impairment rating of 30 percent of the lower extremity. As noted, the Commission found significant flaws in both doctors' reports. The Commission questions whether either impairment rating comports with section 8.1b(a) of the Act. The Commission therefore gives little weight to either impairment rating.

Regarding factor (ii), the occupation of the injured employee, the Commission notes that Petitioner was a union carpenter. The record indicates Petitioner specialized in lighter carpentry work, such as fences and displays, rather than rough carpentry. Petitioner complains he can no longer walk long distances to/on the job site, be on his feet for a long period of time, walk on uneven surfaces, carry much weight, climb a ladder, or squat/kneel. However, Dr. Dilella had released Petitioner to return to work full duty, utilizing an ACL brace for support. Petitioner did not attempt to find a job through the union hall. Petitioner's occupation at the time of the arbitration hearing was in light maintenance. Petitioner testified he is able to perform the job duties of a light maintenance person because his employer is understanding about his limitations. As discussed, the Commission has found that Petitioner magnified his symptoms and excessively self-limited his activities. Nevertheless, the Commission notes that both occupations, carpentry and light maintenance, involve physical labor. The Commission gives considerable weight to this factor.

Regarding factor (iii), the age of the employee at the time of the injury, the Commission notes that Petitioner, who was 33 years old at the time of the accident, has a long work life ahead of him. On the other hand, Petitioner's younger age indicates a good prognosis for continuing recovery. Thus, the evidence cuts both ways. The Commission gives greater weight to Petitioner's long work life expectancy.

Regarding factor (iv), the employee's future earning capacity, the Commission has rejected Petitioner's claim of impairment in earning capacity due to loss of trade. Accordingly, the Commission gives no weight to this factor.

Lastly, the Commission considers factor (v), evidence of disability corroborated by the treating medical records. The Commission notes that Petitioner sustained a complete ACL disruption and a complex tear of the medial meniscus. The surgery performed by Dr. Dilella involved an arthroscopic ACL reconstruction, partial medial meniscectomy, and microfracture of the lateral femoral condyle chondral lesions. Petitioner obtained a good result with the surgery. However, he experienced a postoperative setback from improperly aggressive physical therapy. After additional physical therapy and work hardening with a different provider, Petitioner reported a dramatic improvement. Physical examination findings near the time of MMI were fairly benign, given the nature of the injuries. Petitioner's subjective complaints, as discussed, were out of proportion to the objective findings. Nevertheless, it cannot be denied that Petitioner sustained very significant injuries to the right knee. The Commission gives considerable weight to the nature of the injuries, while also noting Petitioner's good recovery.

Having carefully considered and weighed the enumerated factors, the Commission finds the injuries sustained caused a 40 percent loss of use of the right leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 8, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $1,107.20 per week for a period of 56 3/7 weeks, from March 16, 2013, through April 14, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall have a credit of $33,779.29 for the temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of wage differential benefits is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $712.55 per week for a period of 86 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of the right leg to the extent of 40 percent thereof.

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

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

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

DATED: SEP 2 7 2016
o-08/25/2016
SM/sk
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Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MICHAELS, BRET
Employee/Petitioner

Case# **13WC035036**

16IWCC0620

CZARNOWSKI DISPLAY SERVICES INC
Employer/Respondent

On 9/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC LTD
ROBIN FITT
30 N LASALLE ST SUITE 2126
CHICAGO, IL 60602

0532 HOLECEK & ASSOCIATES
JEFF GOLDBERG
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

16IWCC0620

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

BRET MICHAELS
Employee/Petitioner

v.

CZARNOWSKI DISPLAY SERVICES, Inc.
Employer/Respondent

Case # **13** WC **35036**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **LYNETTE THOMPSON SMITH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **6-24-15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0620

FINDINGS

On March 15, 2013, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$86.361.60**; the average weekly wage was **$1,660.80**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $0.00 for TTD, **$33,779.29** for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $33,779.29.

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 $1,107.20 for 56&2/7 weeks, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner $26,740.95 as underpayment of temporary total disability, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner benefits of $787.12 per week from May 15, 2015, for the duration of Petitioner's disability, pursuant to Section 8(d)(1) of the Act.

Respondent shall be given a credit of $35,503.69.

No attorney's fees or penalties are awarded, pursuant to the Act.

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

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

FINDINGS OF FACT **16IWCC0620**

The disputed issues in this matter are: 1) causal connection; 2) average weekly wage; 3) temporary total disability benefits; 4) temporary permanent disability benefits; 5) 8(d)1 benefits; 6) penalties; 7) attorney's fees; and 8) the nature and extent of Petitioner's injuries. *See,* AX1.

Testimony of Petitioner

Alan Michaels ("Petitioner") started working for Czarnowski Display Services ("Respondent"), on November 4, 2013, as a union carpenter making $41.52 per hour. He belonged to the Chicago Regional Council of Carpenters, Local 434; and worked for the respondent from November 4, 2012 to March 15, 2013. Tr. pp. 13-14, Transcript incorrectly states the start date as November 4, 2013.

Petitioner testified that on March 15, 2014, he stepped back on wrinkled plastic, which was covering carpet, twisting his right knee and hearing it pop. Petitioner had no prior disability with his right knee before this accident.

Petitioner was driven from the scene of the accident, i.e., McCormick Place, by a friend, to Ingalls Occupational Health and presented to Dr. Dawn Antony. He saw her on March 15, and 18, 2014. Dr. Anthony ordered an MRI on his right knee. After the MRI was reviewed, Dr. Anthony referred Petitioner to an orthopedic doctor, Dr. Neil LaBana, who Petitioner saw only once. Dr. LaBana specialized in hand and wrist injuries only and therefore referred Petitioner to Dr. Carl Dilella at Bone and Joint Specialists. Tr. pp. 15-17.

Petitioner continued treatment with Dr. Carl Dilella from his initial visit until Petitioner's last visit on April 15, 2014. Dr. Dilella performed surgery on Petitioner's right knee on May 16, 2013, at Ingalls Memorial Hospital. Before Petitioner's surgery he had pre-operative physical therapy at Ridge Orthopedic Rehabilitation Specialists. Petitioner's surgery consisted of an (ACL) anterior cruciate ligament reconstruction, a meniscus tear repair as well as cartilage damage repair. Following his surgery, Petitioner continued to see Dr. Carl Dilella until his last visit on April 15, 2014, when Dr. Dilella ordered a functional capacity evaluation, ("FCE") and a PPI rating. Tr. pp. 17-18.

Petitioner testified that he gave the prescription to Respondent's nurse case manager and told her that he wanted to perform the FCE. Petitioner also gave Dr. Dilella's prescription requesting the FCE to his attorneys to write his employer and obtain authorization. Despite these actions, the FCE was never performed.

Petitioner was initially released by Dr. Dilella on March 4, 2014. Petitioner went back to see Dr. Dilella on April 15, 2014, with complaints. Dr. Dilella then reordered the FCE, on April 15, 2014, to determine Petitioner's ability to perform various job functions. Tr. pp. 23.

The respondent stopped paying Petitioner temporary total disability benefits ("TTD"), on March 17, 2014. Petitioner found a job with Aurelio's Pizza in March 2014 and after working for 2-1/2 days, he

told his supervisor that he needed a brace for his right knee. He was told that he could not work without the brace. Dr. Dilella had prescribed a hinged, ACL support brace for his right knee on March 4, 2014, which Petitioner subsequently received on April 14, 2014. The nurse case manager initially told Petitioner he could order this brace over-the-counter and she did not have to authorize it. Actually, the brace required the doctor's prescription and only after Petitioner's lawyer notified the insurance carrier; was he finally able to get the brace on April 14, 2014. He started working again, on that date, at Aurelio's Pizza. Tr. 24-27.

Petitioner continued to work at Aurelio's from April 14, 2014 until he procured a permanent position with Providence Village Woods in Crete, Illinois, on May 15, 2014. He currently works there doing a light maintenance job i.e., unplugging toilets, tightening sinks and light sockets. He makes $12.00 per hour and works 40 hours per week.

He testified that he is unable to do physically demanding jobs and cannot carry much weight on his shoulders. He cannot touch anything to his right knee and cannot stand on it for an extended length of time. When he uses the right knee, it swells up. He has to exercise his knee for 15-20 minutes before he can begin his day. He is unable to safely climb ladders and cannot run. He has to place his foot in the direction he is going and the surface has to be flat, otherwise he feels pins and needles in the side of his foot. He squats on a minimal basis. He has problems bending his right knee at the present and if he puts the wrong amount of weight on it, the knee will buckle. He testified that he never had any of these problems before his accident of March 15, 2013. Tr. pp. 28-31.

Petitioner finished work hardening on February 24, 2014 however, was not released by Dr. Dilella until March 4, 2014. On April 15, 2014, Dr. Dilella was under the mistaken impression Petitioner had received the brace that had been prescribed on March 4, 2014. Petitioner told Dr. Dilella that he could no longer do the carpentry job at McCormick Place because he had to walk 1-1/2 to 2 miles just to get to the job site. At that visit, Dr. Dilella prescribed a functional capacity evaluation ("FCE") to determine Petitioner's physical limitations. It has not been authorized by Respondent, to date. Tr. pp. 31-34.
When Petitioner worked as a union carpenter, he would occasionally work three or four days for Respondent; go to the union pool and be picked up by another company that needed a carpenter. When he was hired by Respondent, as far as Petitioner knew, he would be working full time, unless Respondent did not have a display to put up. If laid off, he would attempt to get another carpenter job through the union pool.

Petitioner testified that before working with Respondent, he worked for the Big Run Fence Company, as a carpenter, until October 2012. Respondent had a wage statement, which showed that the petitioner worked five day, 40 hour per week. The statement shows that he received a check on December 3, 2012, in the amount of $361.00, which he testified was money owed to him from a previous job in October 2012. Similarly, the check he received dated January 28, 2013, in the amount of $131.00, was for money he was owed from October 2012. Tr. pp. 33-35.

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Cross Examination of Petitioner

Petitioner worked for Big Run Fence 52 weeks before his accident at Respondent's place of business. Petitioner testified that he worked a full 40 hours for Respondent, if not more. The number of hours and weeks Petitioner worked for Respondent depended on the size of the show. When a show ended, Petitioner waited for the next show. There were periods when Petitioner did not work for Respondent a full week however; and during that time, Petitioner would be in the carpenter's labor pool, vying for work.

Petitioner treated primarily with Dr. Dilella and told Dr. Dilella all his complaints each time he saw him. He underwent a course of physical therapy and four weeks of work hardening.

On March 4, 2014, Dr. Dilella examined Petitioner to measure and check his knee. Dr. Dilella was aware of Petitioner's work hardening program through the therapist's report, and wanted to see how Petitioner's condition had progressed. Dr. Dilella said Petitioner did not need any more therapy at that time and noted that he was not on any pain medication. Tr. pp. 44-47.

On April 14, 2014, Petitioner again presented to Dr. Dilella, who examined his knee. Dr. Dilella wanted him to have an FCE, to determine what type of work Petitioner could perform and what his limitations were. As stated earlier, this FCE was never performed.

On December 5, 2014, Petitioner also saw Dr. Michael D. Gross, by request of Petitioner's attorney. Petitioner testified that this doctor performed a very thorough examination of Petitioner's right knee. Petitioner testified that he had no knowledge of Dr. Gross' report and that Dr. Gross never gave him an off work slip. A review of Dr. Gross' report, received in evidence, indicates that Dr. Gross opined that Petitioner could no longer work as a union carpenter and was curious as to why Petitioner had not had an FCE report which he could review. Tr. pp. 48-50.

On October 20, 2014, Petitioner presented for an examination, to Dr. Brian Cherf at Weiss Memorial by request of the Respondent. Petitioner testified that Dr. Cherf did a poor job of examination.

Petitioner has not been back to the union hall since working for Respondent and does not think that he would not be able to fulfill the demands of a union carpenter. Petitioner testified that his current employer is very compassionate to his needs and let him sit down, when needed. Petitioner takes out garbage and does not have to shovel snow. Tr. pp. 50-54.

Petitioner does his home exercises as prescribed but not continuous therapy. He did not produce tax returns or pay stubs as evidence as to what he is currently being paid.

Redirect examination of Petitioner

Petitioner was shown Petitioner's Exhibit 9, which he testified was a check stub from Respondent, showing his overtime and double time hours, at a rate of $41.52. Petitioner's Exhibit 8 was also identified as a copy of his carpenter's union card. Tr. pp. 53-56.

Petitioner testified that the insurance carrier for Respondent also requested that he see another Section 12 examiner, i.e., Dr. Mark Levin on November 5, 2013 in Elk Grove Village. Petitioner remembers Dr. Levin telling him that he did not think he was capable of working as a union carpenter and Petitioner would only be capable of working in a light duty capacity; with no repetitive bending, squatting, stooping or climbing activities. Petitioner stated that when he saw Dr. Levin, the insurance company was trying to get him back to work because they felt that his recovery was taking too long. At the time Petitioner saw Dr. Mark Levin, Dr. Dilella had not released Petitioner to return to work.

Petitioner's Medical History

The records of Dr. Dawn Anthony and Ingalls Occupational Health were admitted as Petitioner's Exhibit 1. The records document a history of an "accident at work on March 15, 2013, and severe pain in the right knee on any movement, limited range of motion, severe pain on palpation, severe pain in posterior knee, possible Baker's Cyst as well as positive anterior/posterior drawer and Lachman tests together with an antalgic gait and inability to fully squat due to severe pain." The MRI, performed on March 18, 2013, notes under impression: 1) Anterior cruciate ligament tear associated with osseous contusions involving the lateral femoral condyle and posterior aspect of the lateral tibial plateau; 2) large complex tear involving the body and posterior horn of the medical meniscus.

On March 19, 2013, Dr. Anthony took him off work and prescribed a hinge knee sleeve, crutches and ice for his knee as needed. She also prescribed Ibuprofen and told Petitioner that an occupational health case manager was going to contact him regarding an orthopedic consult. Petitioner's one visit with Dr. Neil LaBana, at Premier Orthopaedic and Hand Center, continued Petitioner's "off work" status, if no work was available within his restrictions, i.e., no driving, seated work only, no squatting, kneeling, or climbing stairs and ladders.

The records cover Dr. Dilella's care and treatment from March 15, 2013 to Petitioner's last visit on April 15, 2014. The MRI of Petitioner's right knee, dated March 18, 2013, has under impression: "anterior cruciate ligament tear associated with osseous contusions involving the lateral femoral condyle and posterior aspect of the lateral tibial plateau; and a large complex tear involving the body and posterior horn of the medical meniscus". Dr. Dilella's history of March 25, 2013 notes, "33 year old male who sustained a rather violent twisting injury to his right knee". The history also notes the "injury happened at work setting up displays at McCormick Place". The doctor's notes on performing the anterior drawer and Lachman tests indicated that they are graded 3+ for obvious gross instability of the knee. Dr. Dilella's initial impression was 1) right knee ACL tear and 2) right knee medical meniscus tear.

Dr. Dilella then prescribed three to four weeks of pre-operative physical therapy before proceeding with an ACL reconstruction, as well as addressing a medial meniscus tear. Dr. Dilella's operative report is contained in Petitioner's Exhibit 5, the Ingalls Memorial Hospital records. The operative report dated May 16, 2013 indicates under procedures:

1. Right knee arthroscopic ACL reconstruction;
2. Right knee arthroscopic partial and medial meniscectomy;

3. Right knee arthroscopic microfraction for lateral femoral condyle chondral lesions.

It also indicates under implants:

1. AlloSource bone patella bone allograft tendon.
2. Mitek RigidFix bioabsorbable femoral pins.
3. Mitek Milagro 9 x 223 mm tibial interference screw.

Dr. Dilella, under indications for surgery, comments "the MRI confirmed a complete tear of the ACL in addition to a torn posterior horn of the medial meniscus. There was also the suggestion of cartilage injuries on the lateral femoral condyle. The doctor notes in the operative report that based on Petitioner's "high demand job, he opted to proceed with elective surgery." The operative procedure is detailed indicating the severity of the injury to the right knee, which included a partial medial meniscectomy, an obvious complete disruption of the ACL, which was debrided, leaving a small sump for attachment of the previously prepared bone patella bone Allograft tendon. Finally, the operative report indicates the doctor found 2.5 x 0.5 cm full-thickness chondral lesions on the mid-portion, weight bearing aspect of the lateral femoral condyle. The extent of Petitioner's injury is supported by the pathology addressed by Dr. Dilella in surgery.

The balance of Dr. Dilella's records indicate subsequent physical therapy and care, which continued until Petitioner was released to attempt a return to work, in a full duty capacity, on March 4, 2014; the same date, Dr. Dilella gave Petitioner a prescription for a hinged, ACL supporting brace for his right knee, due to the AC tear S/P reconstruction. The respondent initially refused to authorize and pay for this brace, as the nurse case manager was under the mistaken belief that the brace could be obtained over-the-counter. Petitioner testified that after his attorney wrote Respondent and had Dr. Dilella's prescription forwarded a second time, they authorized and paid for the hinged ACL supporting brace.

On Petitioner's final visit, April 15, 2014, Dr. Dilella prescribed an FCE of the right knee and a PPI rating to find out what work activities Petitioner could do and what were Petitioner's limitations. Respondent has never authorized this evaluation even though Petitioner provided Respondent's nurse case manager with the doctor's prescription and sought authorization on several occasions. PX4.

Ridge Orthopedic Rehabilitation Specialists, S.C. records document Petitioner's physical therapy and work hardening from September 11, 2013 to February 24, 2104. The therapist's assessment on February 17, 2014 reads "Patient currently presents with increased AROM, strength, endurance, functional activity. Patient continues to complain of increased pain with some increased activity. Patient has been participating in our Work Hardening program and has attended physical therapy for this on a daily basis for four hours. He works to his full current capacity and upgrades his program consistently. He continues to await an ACL brace."

The records document that the therapist Petitioner had been doing work hardening for four hours per day at that time. Further, the therapist indicates that Petitioner had not met the goal of being able to return to work and was awaiting Dr. Dilella's orders. On February 17, 2014, her assessment was, "Patient continues to complain of increased pain with increased activity" and writes "please advise if continued therapy is recommended to continue progress." Petitioner's functional limitations are detailed on the February 17, 2014 progress report. "Patient reports severe difficulty with making sharp turns while running fast. Moderate difficulty with usual hobbies, squatting, heavy household activities, walking 2 blocks/1 mile, sitting/standing for 1 hour."

Petitioner's records from Ingalls Memorial Hospital document his pre-operative, physical therapy care from March 29, 2013 to April 24, 2013. Petitioner continued to have gross instability of his right knee, which required surgery on May 16, 2013. Petitioner had a total reconstruction of the anterior cruciate ligament with a patellar bone allograft and operative repairs of his medical meniscus and chondral cartilage lesions in the right knee. PX5.

Testimony regarding Petitioner's wages

Petitioner's testified that he started working for Respondent on November 4, 2013 and that he worked 40 hours or more per week. His first paycheck was for the period from November 19, 2012 to November 25, 2012. For this week Petitioner's check states that he worked 32 hours regular time and 16 hours overtime, for total hours that week of 48 hours. Petitioner testified that he earned $41.52 per hour as a union carpenter for each hour worked. Petitioner's gross wages for this period amount to $2,325.12.

Petitioner's second check is for the pay period February 25, 2013 to March 3, 2013. It shows Petitioner worked 36 hours regular time and 16 hours overtime and 16 hours double time for total hours of 72 hours. Petitioner was paid $41.52 per hour for each regular hour, $62.28 for each overtime hour worked and $83.04 per hour for each double time hour. Petitioner's total gross wages for this week amounted to $3,819.84. Petitioner was paid as a union carpenter and has testified that he made union scale for each hour worked for Respondent. This testimony was credible and unrebutted. PX9.

IME report of Dr. John Cherf

The first four pages of Dr. Cherf's report are a review of Petitioner's medical records together with a physical examination of Petitioner's right knee. The doctor then opines that Petitioner can return to work full duty with no restrictions, regarding his work-related injury of March 15, 2013. He further states that "Mr. Michaels has osteoarthritis of his right knee secondary to a chronic anterior cruciate ligament deficient knee that is independent of the work related right knee injury of March 15, 2013." The Arbitrator notes that Petitioner had no prior knee problems before his accident of March 15, 2013 and in addition to the anterior cruciate ligament injury and the meniscus injury, Dr. Dilella found 2.5 x 0.5 cm full-thickness chondral lesions on the mid-portion, weight bearing aspect of the lateral femoral condyle. These were debrided using a full-radius shaver to achieve vertical edges. Based upon the full thickness nature of the lesions, an inter-operative decision was made to pursue a micro-

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fracture technique. A 45 degree micro-fracture AWL was then used to perform the micro-fracture procedure. Dr. Cherf's opinion that these conditions were not related to the work injury is not persuasive. Dr. Cherf also states that there would be a need for a valid FCE to determine any restrictions but then states that this is only to determine any restrictions resulting from the arthritis. RX1.

IME report of Dr. Mark Levin

On November 5, 2013, Respondent's first Section 12 examiner, Dr. Mark N. Levin, recommended a current MRI scan of the right knee, to evaluate whether there had been additional injury to the ACL grafts or new pathology in the medial joint line. Dr. Levin indicates that as of the date of his exam, i.e., November 5, 2013, Petitioner "does not appear capable of working as a union carpenter and would be capable of working light duty with no repetitive bending, squatting, stooping or climbing activities." On page 3 of his report, after reviewing the MRI study of March 18, 2013 and his CD-ROM, it notes "shows that there was a tear of the anterior cruciate ligament with changes in the lateral femoral condyle consistent with an acute chondral injury from an ACL injury". PX6.

IME report of Dr. Michael Gross

On December 5, 2014, Dr. Michael Gross performed an independent medical examination ("IME") by request of Petitioner. Dr. Gross reported "slight" tenderness of the medial joint line and inferior right knee. He also reported tenderness of the right lateral joint line and tenderness inferior and superior to the right lateral collateral ligament. The doctor found tenderness in the posterolateral and posteromedial complex of the right knee. He reported measurements comparing the right lower extremity to the left lower extremity. He found a ¼ inch difference between the right and left calf (right smaller than the left), which he characterized as atrophy. He found a ¼ inch difference between the right and left knee (right greater than the left), which he characterized as atrophy. He reported a ¼ inch difference between the right thigh and the left thigh (right greater than the left), which he did not characterize as anomalous. PX7.

The Drawer and Lachman tests, according to Dr. Gross, revealed laxity on the right. There was a positive abduction and adduction and the McMurray test was normal. The Apley traction test on the right was positive and the right Apley pressure test was normal. Dr. Gross noted 0` to 145` degrees flexion of the right knee, 0 to 160` degrees on the left. Dr. Gross found a positive Tinel test at the lateral arthroscopic site and parenthesis over the right leg below the knee. Further, Dr. Gross reported that squatting was performed to one-half of normal; and he reported atrophy of the right quadriceps and vastrus lateralis muscles.

Dr. Gross found the petitioner to have suffered a "major loss of use of the right lower extremity, on an industrial basis." He also found that the petitioner has permanent restrictions which "limit" climbing, standing on ladders and squatting, and also prevents the petitioner from performing his duties as a union carpenter.

Dr. Gross found petitioner's injury a Class 2 or moderate problem (moderate laxity) and a Class 1 mild problem (per regional grid) and assessed a final Grade of C for both modifiers. Dr. Gross found the

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moderate problem warranted a 22% lower extremity impairment rating and further found the mild problem to warrant a 10% lower extremity impairment rating, for a total lower extremity impairment rating of 30% lower extremity impairment or 12% whole person impairment rating. Dr. Gross did not state that he was credentialed to perform AMA impairment rating certifications or whether he was board certified in orthopedics.

CONCLUSIONS OF LAW

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See generally, *Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also *Seiber v*

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Industrial Commission, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill. App. 3d 665, 674 (2009).

Petitioner had no prior condition of ill-being in his right knee prior to his accident of March 15, 2013, when he was injured in an accident while working for Respondent as a union carpenter at McCormick Place. All of Petitioner's medical records describe the accident as violent and twisting, which occurred when Petitioner tripped over wrinkled plastic, which had not been properly taped down over the carpeting. The only doctor who does not relate Petitioner's problems in his right knee to the subject accident is Dr. John Cherf. Dr. Cherf's report states that the anterior cruciate injury is unrelated and not consistent with the history of injury but rather results from a chronic, osteoarthritis deficient anterior cruciate ligament. The Arbitrator finds Dr. Cherf's opinion to be unpersuasive and concludes that Petitioner's problems in the right knee were caused by his accident of March 15, 2013. The Arbitrator also finds and concludes that Petitioner has proven, by a preponderance of the evidence that his current condition of ill-being in the right knee is related to his accident on March 15, 2013.

G. What were Petitioner's earnings?

Section 10 of the Workers' Compensation Act states, in pertinent part:

> The compensation shall be computed on the basis of the "Average weekly wage" which shall mean the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks ending with the last day of the employee's last full pay period immediately preceding the date of the injury, illness or disablement excluding overtime, and bonus divided by 52; but if the injured employee lost 5 or more calendar days during such period, whether or not in the same week, then the earnings for the remainder of such 52 weeks shall be divided by the number of weeks and parts thereof remaining after the time so lost has been deducted. Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages shall be followed. Where by reason of the shortness of the time during which the employee has been in the employment of his employer or of the causal nature or terms of the employment, it is impractical to compute the average weekly wages as above defined, regard shall be had to the average weekly amount which during the 52 weeks previous to the injury, illness or disablement was being or would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer.

Petitioner testified that he worked as a union carpenter when he went to work for Respondent. Prior to that time, Petitioner had worked for Big Run Fence as an unskilled laborer working as a carpenter for $11.00 per hour, five days a week. It is Respondent's position that Petitioner's wages working for the prior employer i.e., Big Run Fence, should be taken into consideration when calculating Petitioner's average weekly wage because they occurred within the prior 52 weeks of Petitioner's accident. The Arbitrator does not agree. RX3.

Respondent offered no evidence as to what Petitioner's wages actually were while he worked for Respondent from November 4, 2012 to March 15, 2013. Petitioner testified that he worked the entire time period as a union carpenter, earning $41.52 per hour for each regular hour worked. On cross-examination, Petitioner stated he was working a full 40 hours a week for Respondent during the shows, if not more. When a show ended, he waited for the next show and when he did not work a full week, he would go into the carpenter's labor pool, vying for more work.

Petitioner's Exhibit 9 consists of two checks from Respondent, showing that Petitioner's pay, for the week beginning February 25, 2013 and ending March 3, 2013, was for 68 hours; and his hourly wage for regular time was $41.52 per hour, with overtime hours at $62.50 per hour, and double time hours at $83.04 per hour. His gross wages for that one week amounted to $3,819.84 and his total hours worked that week amounted to 72 hours. Petitioner's second check in Exhibit 9 was pay for the week of November 19, 2012 to November 25, 2012; showing 32 regular hours at $41.52 per hour and 16 overtime hours at $62.28 per hour. The total hours Petitioner worked that week was 48 hours with gross earnings of $2,325.12. It should be noted that the only testimony offered on earnings was Petitioner's testimony, which is unrebutted.

Petitioner had not worked for Respondent for a full year before the accident. Petitioner's employment covered the period from November 4, 2012 to March 15, 2013, approximately five months. The entire time, Petitioner worked as a union carpenter making $41.52 per hour and working at least 40 hours weeks; sometimes more when he worked shows. Under Section 10, in that his employment with this employer was less than 52 weeks; the Statute states "Where the employment prior to the injury extended over a period of less than 52 weeks, the method of dividing the earnings during that period by the number of weeks and parts thereof during which the employee actually earned wages, shall be followed.

In the subject matter however, there was no evidence submitted as to Petitioner's total earnings during the five (5) months that he worked for Respondent therefore, given Petitioner's testimony and the partial earning records from this employer, Petitioner's average weekly wages were no less than $41.52 per hour for a 40 hour week or an average weekly wage of $1,660.80. Petitioner's TTD rate should be $1,107.20 per week.

Evidence could have been submitted reflecting the earnings of a person in the same grade as Petitioner, working for 52 weeks and the same number of hours per week by the same employer. It was not.

The Arbitrator concludes Petitioner's average weekly wage should have been based on a 40 hour week at $41.52 per hour for an average weekly wage of $1,660.80. The Arbitrator finds this to be consistent with Section 10 of the Illinois Workers' Compensation Act and in full accordance with the act and case law as set forth in the *Ronald Sylvester, Appellee v. The Industrial Commission, et al. (ACME roofing and Sheet Metal Company, Appellant)* 197 Ill 2d 225, 756 n.e.2d 822, 258 Ill dec. 548. In *Sylvester* the Illinois Supreme Court clearly held "The clear meaning of the language in the Statute is that the time an employee does not work must be factored out of the calculations of the average weekly wage." In addition, as in the subject case, the respondent in *Sylvester* also failed to offer any evidence of what "would have been earned by a person in the same grade employed at the same work for each of such 52 weeks for the same number of hours per week by the same employer."

K. What temporary benefits are in dispute?

Temporary total disability/ Temporary permanent disability

The Arbitrator finds Petitioner was temporarily and totally disabled from March 16, 2013 through April 14, 2014. During this period, Petitioner only worked 2-1/2 days for Aurelio's Pizza making $9.00 per hour; and worked a total of 20 hours for wages of $180.00. Petitioner began this job and worked until he was told he could not work without the knee brace, which had been prescribed previous to March 4, 2014 by Dr. Carl P. Dilella, Petitioner's surgeon. The end result of the nurse case manager's mistake was Petitioner not being able to work until April 14, 2014. Petitioner then worked continuously for Aurelio's Pizza for 40 hours per week from April 15, 2014, until he obtained full time employment with his current employer, Providence Village Woods in Crete, Illinois on May 15, 2014. Petitioner's total time off work covers the period from March 16, 2013 to April 14, 2014, a period of 56-2/7 weeks. Respondent should have paid Petitioner for this period based on Petitioner's average weekly wage of $1,660.80 as found herein, $1,107.20 per week for 56-2/7 weeks in temporary total disability or $62,224.64.

Respondent is entitled to a credit for the 2-1/2 days of wages Petitioner had at Aurelio's Pizza before he was told he could not work without the prescribed brace or a credit of $180.00. In addition, Respondent is entitled to a credit for the time Petitioner worked at Aurelio's from April 14, 2014 to May 14, 2014 or 30 days or 4-2/7 weeks of wages at $360.00 per week or an additional credit of 4.29 weeks x $360.00 or $1,544.40. Finally, Respondent did pay in temporary total disability benefits, $33,779.29. Respondent's total credits therefore amount of $180.00, plus $1,544.40 and $33,779.29 for total credit of $35,503.69. The Arbitrator finds Respondent owed $62,244.64 in temporary total disability benefits and is entitled to a credit of $35,503.69. Respondent owes Petitioner $26,740.95 in unpaid TTD.

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

Petitioner is unable to return to work as a union carpenter in the opinions of Drs. Mark Levin and Michael Gross. Dr. Carl Delila, initially released Petitioner to attempt to return to work on March 4,

2014, using a ACL hinged brace, which was not authorized until April 14, 2014. Dr. Dilella indicated, on several occasions, that he needed the petitioner to perform an FCE, to determine what activities Petitioner could perform on the job. When Petitioner was initially released to attempt to return to full duty work on March 4, 2014, his rehabilitation specialist had him performing only four hours of work hardening and was waiting for Dr. Dilella's orders. Of particular note, Dr. John Cherf also indicated that Petitioner needed an FCE, not because of the March 15, 2013 accident, but because of his osteoarthritis of his right knee, which he claims is secondary to a chronic anterior cruciate deficient knee, that is independent of the work related accident.

8(d)1 benefits

The Arbitrator has already found Dr. Cherf's report to be unpersuasive. Petitioner was a relatively young man, age 32, at the time of the accident, with no prior right knee injuries or treatment. In addition, all of the doctors who reviewed the MRI of March 18, 2013, concluded that the anterior cruciate ligament tear, the medical meniscus tear and the lateral lesions of the lateral condyle, were traumatically induced.

Most importantly, the petitioner testified he is physically unable to work as a union carpenter, at the present time, due to his numerous restrictions, which are detailed herein. Petitioner is now working in a light maintenance position at Providence Village Woods in Crete, Illinois; in a permanent position and testified that his employer is sympathetic to his numerous physical limitations. Petitioner earns $12.00 per hour and works 40 hours per week. His average weekly wage at present is $480.00. The differential between his wages when working as a union carpenter making $41.52 per hour and working 40 hours per week is substantial. Petitioner's pre-injury average weekly wages amounted to $1,660.80. His current wages at Providence Village Woods amounts to $480.00 per week. The differential in his wages amounts to $1,180.80 per week. Petitioner is therefore entitled to 8(d)(1) benefits in the amount of two-thirds (2/3) of the different or .6666 x $1,180.80 or $787.12 per week from May 15, 2015, for the duration of his disability. The Arbitrator awards 8(d)(1) benefits from May 15, 2015 for the duration of Petitioner's disability, pursuant to the statute.

M. Should penalties or fees be imposed upon Respondent?

Illinois courts have refused to assess penalties under sections 19(k) and (l) of the Act where the evidence indicates that the employer reasonably could have believed that the employee was not entitled to the compensation withheld. *See, Board of Education v. Industrial Commission*, 93 Ill.2d 1, 442 N.E.2d 861 (1982); *See also, Avon Products, Inc. v. Industrial Commission*, 82 Ill. 2d 297 (1980) and *Brinkmann v. Industrial Commission*, 82 Ill. 2d 462 (1980). "Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay, and the standard we hold him to is one of objective reasonableness in his belief." *Id. See also, City of Chicago v. Industrial Commission*, 63 Ill. 2d 99 (1976).

The Illinois Supreme Court has explicitly found an obligation on the part of Respondents to diligently obtain information regarding a Petitioner's claim in *Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1,

66 Ill. Dec. 300, 442 N.E.2d 861 (1982). In *Board of Educ.*, the court found that the Chicago Board of Education "had or should reasonably have had in its possession" sufficient evidence, that "would have disclosed that the grounds for challenging temporary total disability liability were insubstantial at best," and therefore fees and penalties were warranted. The Supreme Court also found that the Board's "failure to obtain that information did not entitle the Board to assert later that it acted in good faith because it was ignorant of the evidence in favor of the employee." *See, Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982).

Petitioner requested penalties and fees for failure to timely authorize the knee brace as prescribe by Dr. Dilella and refusing to authorize an FCE. Petitioner also seeks penalties for alleged underpayment of TTD, based on an AWW of $654.93.

Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

The Arbitrator finds and concludes that the respondent's behavior does not rise to the level of unreasonable and vexatious and that Respondent made a good faith effort to pay TTD to Petitioner therefore, no penalties or attorney's fees will be awarded.

16IWCC0620

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13WC35036
SIGNATURE PAGE

Signature of Arbitrator

September 8, 2015
Date of Decision

SEP 8 - 2015

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bobbie Ray Chambers,

Petitioner,

vs.

NO: 13 WC 35903

Raynor Garage Doors,

16IWCC0577

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, 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, 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.

16IWCC0577

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

DATED: SEP - 8 2016
TJT:yl
o 8/30/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

CHAMBERS, BOBBIE RAY
Employee/Petitioner

Case# **13WC035903**

13WC035904
13WC035905

RAYNOR GARAGE DOORS
Employer/Respondent

16IWCC0577

On 8/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICES PETER F FERRACUTI
KYLE P JEFFERSON
110 E MAIN ST
OTTAWA, IL 61350

2837 LAW OFFICES JOSEPH MARCINIAK
MICHELLE R POWELL
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

16IWCC0577

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)

Bobbie Ray Chambers
Employee/Petitioner

v.

Raynor Garage Doors
Employer/Respondent

Case # **13** WC **35903**

Consolidated cases: **13 WC 35904**
13 WC 35905

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 11, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0577

FINDINGS

On the date of accident alleged, **April 29, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this alleged accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$35,672.00**; the average weekly wage was **$686.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

Respondent shall be given a credit of **$36,686.88** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$36,686.88.**.

ORDER

Petitioner's Claim for compensation is 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

August 5, 2015
Date

AUG 11 2015

13 WC 35903
ICArbDec19(b)

16IWCC0577

FACTS:

The Petitioner has filed three claims for compensation which were consolidated for hearing. Claim Number 13 WC 35904 alleges an injury to the Petitioner's left foot on March 26, 2010, Claim Number 13 WC 35903 alleges an injury to the Petitioner's left wrist and left elbow on April 29, 2011, and Claim Number 13 WC 35905 alleges an injury to the Petitioner's right foot on October 19, 2013. Each of these claims is the subject of a separate Arbitration Decision.

On April 29, 2011 the Petitioner was employed by the Respondent as a maintenance worker, having been so employed for approximately 16 years. The Petitioner testified that his job duties included fixing, repairing, maintaining, and moving machinery, and that just prior to March 26, 2010 he was assigned to work on the "foam line". The Petitioner described that the "foam line" was the area of the Respondent's facility where chemical foam was injected into the garage doors that the Respondent manufactured, and that his job on the "foam line" included cleaning the room where the foam was injected as well as cleaning the heads of the injection machinery.

The Petitioner testified that on April 29, 2011, he was cleaning heads on the foam line. The Petitioner testified that this was "repetitive" work which required him to disassemble the heads, clean them, and then reassemble them. The Petitioner testified this was tedious work, as the heads were small enough to fit in your hand and each head had 6 parts which needed to be cleaned. The Petitioner testified that it took approximately one hour to disassemble, clean, and reassemble each head and that he used a ratchet to disassemble and reassemble the heads and a drill to clean the ports. The Petitioner testified that he is right hand dominant.

The Petitioner testified that he gradually began to experience pain and numbness with decreased motion in his left hand and arm. The Petitioner testified that he reported these symptoms to one of his foremen, either Steve Deming or Dave Jandrey, but that he did not recall to which one or when he made such a report. The Petitioner testified that he then sought treatment with Dt. Hanlon, who diagnosed him with carpal tunnel syndrome and epicondylitis.

An Accident Report indicating a date of loss of April 29, 2011 was admitted into the records as Respondent's Exhibit 9. The Petitioner signed the report on May 2, 2011 indicating that he had declined medical treatment. The report references an injury to the left foot only after climbing up and down a step ladder. There is no reference in the report to any injury to the left arm or hands.

On January 17, 2012 the Petitioner sought treatment at KSB Corporate Health where he was seen by Dr. Lyman tieman. Dr. Tieman noted a history of an injury on January 11, 2012 when the Petitioner was pushing and pulling a machine and felt a pop in his left forearm and a burning sensation in his left groin area. Dr. Tieman diagnosed the Petitioner with a strain of the left forearm and the left groin.

16IWCC0577

The Petitioner then sought treatment with Dr. Shawn Hanlon at CGH Medical Center on February 15, 2012. Dr. Hanlon noted a history of injury on January 11, 2012 when, while moving a machine at work, the Petitioner felt something tear in his forearm and elbow. Dr. Hanlon's assessment was lateral epicondylitis due to a traumatic work injury. Dr. Hanlon injected the Petitioner's elbow.

The Petitioner returned to Dr. Hanlon on March 7, 2012 and reported that the injection helped for only a couple of days. Dr. Hanlon noted that the Petitioner had chronic lateral epicondylitis which seemed to be triggered by the pushing incident he reported. Dr. Hanlon noted a possible entrapment neuropathy and he prescribed an EMG and nerve conduction velocity test for the Petitioner. Dr. Hanlon then diagnosed the Petitioner as having lateral epicondylitis as well as left carpal tunnel syndrome. On June 13, 2012, the Petitioner underwent a left carpal tunnel surgery and left lateral epicondylectomy. Post-surgically, the Petitioner began a course of physical therapy and he continued to follow up with Dr. Hanlon.

On April 1, 2013, the Petitioner followed up with Dr. Hanlon and reported that he continued to have numbness and twitching as well as weakness in his left hand. Dr. Hanlon advised that the Petitioner was either very slow to recover from the surgeries and had reached maximum medical improvement, or there was something else wrong with him. Dr. Hanlon recommended a repeat EMG and nerve conduction velocity test for the Petitioner.

On April 11, 2013, the Petitioner was seen by Dr. Sanjay Patari at the request of the Respondent. Dr. Patari noted a history of injury on January 11, 2012 when the Petitioner was pushing and pulling a machine and developed pain in the left forearm, and subsequently developed pain in the left hand. Dr. Patari found the Petitioner to be at maximum medical improvement for the left elbow and recommended a corticorsteriod injection in to the left carpal tunnel. Dr. Patari opined that the Petitioner would be at maximum medical improvement for the left carpal tunnel after 3 weeks. Dr. Patari authored two addendum reports at the Respondent's request on July 31, 2013 in which he reported that he had reviewed the EMG as well as the surveillance video of Petitioner showing him walking and repairing a fence at his home. Dr. Patari opined that the Petitioner was at maximum medical improvement and able to work full duty.

The Petitioner returned to Dr. Hanlon on November 7, 2013 with complaints of numbness and of frequently dropping things. At that time, Dr. Hanlon noted that the EMG and nerve conduction velocity test had been completed and showed no evidence of any focal nerve entrapment. Dr. Hanlon indicated that he had no explanation for the Petitioner's ongoing symptoms and he suggested a workup of the cervical spine including a cervical spine x-ray and a cervical spine MRI.

The Petitioner testified that he continues to have numbness in the left upper extremity, but has been unable to get approval for the testing recommended by Dr. Hanlon.

16IWCC0577

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 the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet that burden here. Specifically, the Arbitrator finds that the Petitioner failed to prove that an accident arising out of and in the course of his employment with the Petitioner occurred on April 29, 2011, and failed to prove any condition of ill-being which is causally related to the accident alleged. In so finding, the Arbitrator notes that the Petitioner's testimony is unsupported and contradicted by the medical records and other evidence introduced into the record.

The Arbitrator notes that the Petitioner testified to a gradual onset of symptoms in his left wrist and elbow while cleaning the heads on the foam line on April 29, 2011. The medical records contain no history which conforms to the Petitioner's testimony but, rather, contain a history of a specific injury on January 11, 2012 when the Petitioner was pushing and pulling a machine and felt a pop in his left forearm and a burning sensation in his left groin area. Additionally, the accident report introduced into the record by the Respondent references an April 29, 2011 injury to the left foot after climbing up and down a step ladder. There is no reference in the report to any injury to the left arm or hands.

Similarly, the Arbitrator notes that there is no medical opinion in the record which relates the Petitioner's condition of ill-being to any repetitive work activities. Rather, the medical records indicate that the Petitioner's left elbow condition was related to a specific injury while moving a machine on January 11, 2012. The Petitioner testified that his left wrist and hand symptoms began gradually on April 29, 2011 and the Petitioner gave no testimony regarding any injury on January 11, 2012.

Additionally, the Arbitrator notes that the Petitioner testified that on April 29, 2011 he experienced pain in his left wrist and elbow. The medical records demonstrate that the Petitioner reported only left forearm and elbow symptoms when he initially sought medical treatment on January 17, 2012 at KSB Corporate Health and with Dr. Shawn Hanlon at CGH Medical Center on February 15, 2012. Dr. Hanlon's records indicate that the Petitioner's left wrist complaints did not develop until sometime after his initial treatment.

The Arbitrator finds the Petitioner's testimony to be entirely unreliable and unpersuasive in the instant matter and finds that there is no other evidence in the record which supports a conclusion that the Petitioner sustained an injury to his left upper extremity

16IWCC0577

on April 29, 2011.

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 arising out of and in the course of his employment with the Respondent occurred on April 29, 2011. The Arbitrator further finds that the Petitioner failed to prove any condition of ill-being in his left arm, elbow, wrist, or hand, which is causally related to the alleged accident of April 29, 2011.

In light of the Arbitrator's findings and conclusions relating to the issues of accident and causation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied and no benefits are awarded herein.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bobbie Ray Chambers,

Petitioner,

vs.

NO: 13 WC 35904

16IWCC0578

Raynor Garage Doors,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2015, 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.

16IWCC0578

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

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

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

DATED: SEP - 8 2016
TJT:yl
o 8/30/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

CHAMBERS, BOBBIE RAY
Employee/Petitioner

Case# **13WC035904**

13WC035903
13WC035905

RAYNOR GARAGE DOORS
Employer/Respondent

16IWCC0578

On 8/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICES PETER F FERRACUTI
KYLE P JEFFERSON
110 E MAIN ST
OTTAWA, IL 61350

2837 LAW OFFICES JOSEPH MARCINIAK
MICHELLE R POWELL
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

16IWCC0578

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)

Bobbie Ray Chambers
Employee/Petitioner

v.

Raynor Garage Doors
Employer/Respondent

Case # **13** WC **35904**

Consolidated cases: **13 WC 35903**
13 WC 35905

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 11, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0578

FINDINGS

On the date of accident, **March 26, 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 $**35,672.00**; the average weekly wage was $**686.00**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

ORDER

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

August 5, 2015
Date

13 WC 35904
ICArbDec19(b)

AUG 11 2015

16IWCC0578

FACTS:

The Petitioner has filed three claims for compensation which were consolidated for hearing. Claim Number 13 WC 35904 alleges an injury to the Petitioner's left foot on March 26, 2010, Claim Number 13 WC 35903 alleges an injury to the Petitioner's left wrist and left elbow on April 29, 2011, and Claim Number 13 WC 35905 alleges an injury to the Petitioner's right foot on October 19, 2013. Each of these claims is the subject of a separate Arbitration Decision.

On March 26, 2010 the Petitioner was employed by the Respondent as a maintenance worker, having been so employed for approximately 16 years. The Petitioner testified that his job duties included fixing, repairing, maintaining, and moving machinery and that just prior to March 26, 2010 he was assigned to work on the "foam line". The Petitioner described that the "foam line" was the area of the Respondent's facility where chemical foam was injected into the garage doors that the Respondent manufactured, and that his job on the "foam line" included cleaning the room where the foam was injected as well as cleaning the heads of the injection machinery.

The Petitioner testified that on March 26, 2010 he was cleaning the foam room while standing on a ladder. The Petitioner testified that he was on the ladder all day and that he was required to reach while standing on the ladder in order to clean the room. The Petitioner testified that as he was reaching, he put pressure on his left foot. The Petitioner testified that while he was working on the ladder, he began to experience a sharp pain in his left foot. The Petitioner testified that, prior to that date he had no pain or problems in his left foot.

The Petitioner testified that he told one of his co-workers, Al Henson, about his foot pain but he thought it would resolve on its own, so he did not report the incident to his supervisor at that time. The Petitioner testified that he eventually reported the pain to his supervisor, Dave Jandry, but he could not recall when he did so. The Petitioner testified that after he reported his foot pain to Dave Jandry, he was directed to seek medical care at KSB.

The records of KSB Corporate Health Services demonstrate that the Petitioner was seen there by Dr. Lyman Tieman on April 1, 2010. The Petitioner was noted to have complaints of left foot pain and to have reported that he had been working on a ladder for a prolonged period of time with pressure on his foot. Physical examination was noted to demonstrate swelling with erythema and tenderness and x-rays were reported to demonstrate no evidence of fracture or dislocation. The assessment was acute arthritis of the left MPJ of the left foot and the Petitioner was prescribed prednisone and Motrin. The Petitioner was continued on regular full duty work. The Petitioner followed up on April 8, 2010 and April 22, 2010 and he was noted to have no improvement in his complaints. The Petitioner was then referred to Dr. York.

On May 10, 2010 the Petitioner saw Dr. Shane York who noted that the Petitioner reported that his pain started while he was working on a ladder on March 26, 2010. Dr. York

noted the negative x-ray and noted that repeat x-rays indicated a metatarsal fracture. Dr. York's impression was a second metatarsal neck fracture and he placed the Petitioner in a cam walker. Dr. York noted that "it does appear that this was a work-related injury after what was most likely initially a hairline injury to the bone." Dr. York indicated that by continually walking on the fracture, the Petitioner developed a periosteal reaction that could be seen as a normal phenomenon after such a fracture. Dr. York also indicated that he expected the Petitioner to be at maximum medical improvement from his injury within five weeks. On June 1, 2010 Dr. York noted that the Petitioner was doing better but his impression was now second and third metatarsal neck fractures.

On June 30, 2010 Dr. York noted that the Petitioner was doing well but complaining of some nerve-related pain in his foot. Dr. York's impression was second and third metatarsal neck fractures with near-full healing noted on x-ray. Dr. York released the Petitioner to return to work without restrictions as of July 1, 2010 and indicated that he could return if there should be any long-term issues.

On October 25, 2011, the Petitioner returned to KSB Corporate Health where he was seen by Dr. David Deets who noted complaints of pain and swelling in the left foot. It was noted that the Petitioner reported that he sustained a fracture of his left foot in April of 2010 and that he was treated with an air cast and "subsequently recovered". He was noted to report that "in April of this year he re-injured his foot while standing on a ladder and wrenched his foot. Since that time, he has had pain." X-rays were performed that following day and were reported to demonstrate demineralization of the osseous structures, no evidence of acute fracture or dislocation, development of a small osteophytic spur involving the fifth proximal metatarsal and a tiny calcaneal spur. Dr. Deets indicated that the Petitioner's x-ray looked perfectly normal and the assessment was post-fracture pain in the left foot. Dr. Deets referred the Petitioner back to the podiatrist he had seen previously.

On November 28, 2011 the Petitioner returned to Dr. York complaining of continuing pain in his left foot. Dr. York's impression was "Questionable interdigital neuroma, with reduced metatarsal space from healed fractures that were involved in a work-related injury", and he administered an injection into the second interspace that provided relief.

On February 24, 2012, Dr. York noted that an MRI of the Petitioner's left foot was negative for a soft tissue mass within the second interspace as well as negative for surrounding pathology but he clinically diagnosed the Petitioner as having a second interspace neuroma, with a history of second and third metatarsal fractures that had not improved with conservative treatment. Dr. York recommended surgical excision of a second interspace neuroma with implantation into muscle. Dr. York opined that the most likely mechanism of the nerve impingement is "resulting from the second and third metatarsal fractures greater than six months ago."

On October 30, 2012 the Petitioner underwent the neuroma excision surgery. Subsequent to the surgery, the Petitioner was admitted to the hospital for pericarditis which Dr. York indicated was unrelated to the foot condition. On March 12, 2013 Dr. York noted that

Petitioner continued to complain of pain and he recommended another MRI and a second opinion.

At the request of the Respondent, the Petitioner was examined by Dr. Paul Perona on April 25, 2013. Dr. Perona noted a history of a fall at work in November of 2011 which resulted in metatarsal fractures of the second and third metatarsal necks which healed uneventfully. Dr. Perona diagnosed the Petitioner with left foot pain and he recommended workup for recurrent stress fracture versus avascular necrosis of the second metatarsal head. Dr. Perona indicated that if the MRI was negative, he would recommend a repeat injection into the second metatarsal webspace and the arthritic great toe metatarsophalangeal joint. Dr. Perona noted that there was a temporal relationship in the onset of the Petitioner's symptoms following the metatarsal head fractures and that there can be a relationship between metatarsal fractures and an interosseous neuroma. Dr. Perona opined that the development of the neuroma could have been caused by the metatarsal fractures and he indicated that he felt that the development of the neuroma was 100% associated with the injury. Dr. Perona also opined that the Petitioner could return to work in a sit-down position.

On May 7, 2013, Dr. York noted that the second opinion suggested the possibility of a stress fracture and that the MRI was negative. Dr. York also referred the Petitioner for rheumatologic testing, which was normal, and an EMG/NCV study, which noted delayed latencies and amplitude involving the medial plantar nerve. On June 18, 2013 Dr. York recommended the Petitioner be seen by Dr. Faubel, a pain management physician.

In a supplemental report dated August 21, 2013, Dr. Perona indicated that he had reviewed the Petitioner's left foot MRI of April 30, 2013 as well as a surveillance CD of the Petitioner's activities dated July 3 through July 8 of 2013. Dr. Perona reported that his diagnosis was left foot pain, mild metatarsophalangeal synovitis of the second and third toes. Dr. Perona opined that the Petitioner's alleged work injury "led to some chronic pain in the left foot." Dr. Perona further opined that the Petitioner would benefit from continued treatment for chronic pain in the left foot with medication, and that the Petitioner could return to full duty work.

The Petitioner testified that he continued to experience pain in his left foot, and that on October 19, 2013 he was going down the basement steps of his home when his left foot gave out causing him to slip and injure his right heel. The alleged injury to the Petitioner's right foot is the subject of Claim Number 13 WC 35905 and is addressed by a separate Arbitration Decision. Following his fall at home, the Petitioner saw Dr. Brandon Gumbiner at KSB on October 21, 2013 and x-rays were reported to demonstrate nondisplaced fractures along the posterior aspect of the calcaneus.

On November 1, 2013 the Petitioner returned to Dr. York with continued complaints of pain in his left foot. Dr. York noted the Petitioner's recent fall and the calcaneal fracture and he continued to recommend that the Petitioner see Dr. Faubel for consideration of radiofrequency ablation for his left foot complaints. On November 22, 2013 Dr. York gave the Petitioner another injection in his left foot. The Petitioner continued to follow up with Dr. York

for his left foot on a monthly basis.

On April 14, 2014 the Petitioner saw Dr. Gumbiner for his right foot and complained of right knee pain since being casted for his right foot injury. On April 25, 2014, the Petitioner saw Dr. Gunderson at KSB and was diagnosed with right knee bursitis. The Petitioner was given an injection in his right knee.

The Petitioner continued to follow up with Dr. York on a monthly basis through October of 2014. Dr. York injected the Petitioner's left foot on July 14, 2014 and August 18, 2014, and Dr. York continued to prescribe radio frequency ablation for the Petitioner's left foot.

The Petitioner testified that on November 6, 2014, he was again going down his basement steps at home when his left foot gave out and he fell, suffering a displaced and broken hip. The Petitioner testified that he was taken to the emergency room and he underwent hip replacement surgery the next day.

The Petitioner testified that he last treated with Dr. York for his left foot approximately one month before trial and that Dr. York continued to prescribe radio frequency ablation for his left foot.

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 (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that on March 26, 2010 he was working on a ladder all day, exerting pressure on his left foot, when he began to experience a sharp pain in his left foot. The Petitioner testified that, prior to that date he had no pain or problems in his left foot. The Petitioner's testimony in this regard was not contradicted or rebutted.

The Petitioner testified that he eventually reported the pain to his supervisor, Dave Jandry, and that after he reported his foot pain to Dave Jandry, he was directed to seek medical care at KSB. The records of KSB Corporate Health Services demonstrate that the Petitioner was seen there on April 1, 2010.

On April 1, 2010 the Petitioner sought medical treatment at KSB Corporate Health Services where he was noted to have complaints of left foot pain and he reported that he had been working on a ladder for a prolonged period of time with pressure on his foot. Physical

examination was noted to demonstrate swelling with erythema and tenderness and x-rays were reported to demonstrate no evidence of fracture or dislocation. The Petitioner's complaints of foot pain continued and he was referred to Dr. York. The Petitioner saw Dr. York on May 10, 2010 and reported that his pain started while he was working on a ladder on March 26, 2010. Dr. York's impression was a second metatarsal neck fracture and he placed the Petitioner in a cam walker. Dr. York noted that "it does appear that this was a work-related injury after what was most likely initially a hairline injury to the bone."

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that on March 26, 2010 an accident did occur which arose out of and in the course of the Petitioner's employment with the Respondent. The Arbitrator further finds that timely notice of the accident was given to the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of accident are adopted and incorporated herein.

Following the Petitioner's injury on March 26, 2010, the Petitioner came under the care of Dr. Shane York who diagnosed the Petitioner as having a second metatarsal neck fracture. Dr. York indicated that he expected the Petitioner to be at maximum medical improvement from his injury within five weeks. On June 30, 2010 Dr. York noted that the Petitioner was doing well but complaining of some nerve-related pain in his foot. Dr. York's impression was second and third metatarsal neck fractures with near-full healing noted on x-ray. Dr. York released the Petitioner to return to work without restrictions as of July 1, 2010 and indicated that he could return if there should be any long-term issues.

After his release by Dr. York, the Petitioner returned to his full duty work and did not seek any further medical treatment for his left foot until he returned to KSB Corporate Health on October 25, 2011, more than fifteen months later. When the Petitioner was seen at KSB Corporate Health, it was noted that the Petitioner reported that he sustained a fracture of his left foot in April of 2010 from which he "subsequently recovered" and that "in April of this year he re-injured his foot while standing on a ladder and wrenched his foot". The Petitioner reported that "Since that time, he has had pain." The Petitioner's x-rays were reported to be normal and the assessment was post-fracture pain in the left foot.

The Petitioner then returned to Dr. York complaining of continuing pain in his left foot and Dr. York administered an injection that reportedly provided relief. A subsequent MRI of the Petitioner's left foot was negative but Dr. York clinically diagnosed the Petitioner as having a second interspace neuroma. On October 30, 2012 the Petitioner underwent the neuroma excision surgery. The Petitioner continued to have complaints following the surgery and Dr. York recommended the Petitioner be seen by a pain management physician. The Petitioner

continued to follow up with Dr. York with complaints of pain in his left foot and Dr. York ultimately prescribed radio frequency ablation for the Petitioner's left foot. The Petitioner testified that he last treated with Dr. York for his left foot approximately one month before trial and that Dr. York continued to prescribe radio frequency ablation for his left foot.

At the request of the Respondent, the Petitioner was examined by Dr. Paul Perona on April 25, 2013. Dr. Perona noted a history of a fall at work in November of 2011 which resulted in metatarsal fractures of the second and third metatarsal necks which healed uneventfully. Dr. Perona diagnosed the Petitioner with left foot pain and he recommended workup for recurrent stress fracture versus avascular necrosis of the second metatarsal head. In a supplemental report dated August 21, 2013, Dr. Perona reported that his diagnosis was left foot pain, mild metatarsophalangeal synovitis of the second and third toes. Dr. Perona opined that the Petitioner's alleged work injury "led to some chronic pain in the left foot." Dr. Perona further opined that the Petitioner would benefit from continued treatment for chronic pain in the left foot with medication, and that the Petitioner could return to full duty work.

The Arbitrator notes that following his release by Dr. York as of July 1, 2010 the Petitioner returned to regular full duty work and he continued to work for more than fifteen months before he sought any additional medical care for his left foot. When he did seek medical care at KSB Corporate Health on October 25, 2011, the Petitioner reported that he sustained a fracture of his left foot in April of 2010 from which he "subsequently recovered" and that "in April of this year he re-injured his foot while standing on a ladder and wrenched his foot". The Petitioner reported that "Since that time, he has had pain." The Arbitrator also notes that when the Petitioner was seen by Dr. Perona, the Respondent's examining physician, he reported a history of a fall at work in November of 2011 which resulted in metatarsal fractures of the second and third metatarsal necks which healed uneventfully.

The Arbitrator finds it to be significant that the Petitioner continued to work full duty and sought no medical treatment for more than 15 months following his release by Dr. York on July 1, 2010. Additionally, the Arbitrator finds it to be significant that when he was seen at KSB Corporate Health on October 25, 2011 the Petitioner provided a history of an injury in April of 2011 and that when he was seen by Dr. Perona on April 25, 2013 the Petitioner provided a history of an injury in November of 2011. While the Arbitrator notes the opinions of Dr. York and Dr. Perona, the Arbitrator finds those opinions to be unpersuasive in the instant matter as it is not clear to which of the Petitioner's "injuries" they are relating his conditions.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a result of the work accident of March 26, 2010, the Petitioner sustained second and third metatarsal neck fractures in his left foot. The Arbitrator further finds that the Petitioner reached maximum medical improvement from those injuries as of July 1, 2010 when he was released by Dr. York to return to regular full duty work. The Arbitrator also finds that the Petitioner failed to prove that any condition of ill-being in his left foot after July 1, 2010 is causally related to the accident of March 26, 2010.

16IWCC0578

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

The Arbitrator has found that the Petitioner reached maximum medical improvement from the injuries he sustained as a result of the Mach 26, 2010 accident by July 1, 2010. Thus, the Arbitrator finds that the care and treatment rendered to the Petitioner for his left foot condition from March 26, 2010 through July 1, 2010 was reasonable, necessary and causally related to the March 26, 2010 work accident and that the Respondent is liable for payment of the expenses incurred for that treatment, subject to the limitations of the Medical Fee Schedule provided for in the Act. The Arbitrator further finds that the Petitioner failed to prove that any medical care or treatment rendered to the Petitioner subsequent to July 1, 2010 is reasonable and necessary medical care which is causally related to the accident of March 26, 2010. The Arbitrator also finds that the Petitioner failed to prove that he is entitled to any prospective medical care or treatment as a result of the accident of March 26, 2010.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

In the Request for Hearing submitted by the parties (ARB X 2), the Petitioner did not specify the period of Temporary Total Disability to which he claims to be entitled as a result of the accident of March 26, 2010. Similarly, the Petitioner did not specifically testify as to the period of time, if any, that he was taken off work following the accident of March 26, 2010. Thus, the Arbitrator cannot determine what, if any, period of Temporary Total Disability benefits the Petitioner might be entitled to as a result of the accident of March 26, 2010. Following that injury, the Petitioner was released to return to regular work as of July 1, 2010 and he did return to regular full duty work at that time. The Arbitrator has found that the Petitioner reached maximum medical improvement from the injuries he sustained as a result of the Mach 26, 2010 accident by July 1, 2010 and that the Petitioner failed to prove that any condition of ill-being in his left foot after July 1, 2010 is causally related to the accident of March 26, 2010.

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 he is entitled to any period of temporary benefits as a result of the accident of March 26, 2010.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bobbie Ray Chambers,

Petitioner,

vs. NO: 13 WC 35905

Raynor Garage Doors,

16IWCC0579

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, 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 August 11, 2015, is hereby affirmed and adopted.

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

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

16IWCC0579

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

DATED: SEP - 8 2016
TJT:yl
o 8/30/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

CHAMBERS, BOBBIE RAY
Employee/Petitioner

Case# **13WC035905**

13WC035903
13WC035904

RAYNOR GARAGE DOORS
Employer/Respondent

16IWCC0579

On 8/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICES PETR F FERRACUTI
KYLE P JEFFERSON
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OTTAWA, IL 61350

2837 LAW OFFICE JOSEPH MARCINIAK
MICHELLE R POWELL
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

16IWCC0579

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)

Bobbie Ray Chambers
Employee/Petitioner

v.

Raynor Garage Doors
Employer/Respondent

Case # **13** WC **35905**

Consolidated cases: **13 WC 35903**
13 WC 35904

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 11, 2015.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0579

FINDINGS

On the date of accident alleged, **October 19, 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 alleged accident.

In the year preceding the injury, Petitioner earned **$35,672.00**; the average weekly wage was **$686.00**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

ORDER

Petitioner's claim for compensation is 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

August 5, 2015
Date

13 WC 35905
ICArbDec19(b)

AUG 11 2015

16IWCC0579

FACTS:

The Petitioner has filed three claims for compensation which were consolidated for hearing. Claim Number 13 WC 35904 alleges an injury to the Petitioner's left foot on March 26, 2010, Claim Number 13 WC 35903 alleges an injury to the Petitioner's left wrist and left elbow on April 29, 2011, and Claim Number 13 WC 35905 alleges an injury to the Petitioner's right foot on October 19, 2013. Each of these claims is the subject of a separate Arbitration Decision.

The Arbitrator's Findings and Conclusions as set forth in the Arbitration Decisions issued in Case Numbers 13 WC 35904 and 13 WC 35903 are adopted and incorporated herein.

On October 19, 2013 the Petitioner was employed by the Respondent as a maintenance worker, having been so employed for approximately 16 years. The Petitioner testified that his job duties included fixing, repairing, maintaining, and moving machinery, and that just prior to March 26, 2010 he was assigned to work on the "foam line". The Petitioner described that the "foam line" was the area of the Respondent's facility where chemical foam was injected into the garage doors that the Respondent manufactured, and that his job on the "foam line" included cleaning the room where the foam was injected as well as cleaning the heads of the injection machinery.

The Petitioner testified to an injury to his left foot on March 26, 2010. That injury is the subject of the Arbitration Decision issued in Case Number 13 WC 35904 and the findings and conclusions set forth in that Decision are adopted and incorporated herein. The Petitioner testified that, as a result of the injury of March 26, 2010, his left foot would give out on him occasionally causing him to injure other parts of his body. Specifically, the Petitioner testified that on October 19, 2013, while he was walking down the basement stairs at his home, his left foot gave out and he fell onto his right heel causing it to be injured. The Medical records demonstrate that the Petitioner sustained a right sided calcaneal fracture.

The Petitioner testified that he is no longer treating for his right foot condition and that his right foot is "not as bad" as his left foot.

The Petitioner also testified that his left foot went out on him on two subsequent occasions, once causing broken toes his right foot and once causing him to break his right hip. The Petitioner has apparently not filed claims for either of those injuries.

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

16IWCC0579

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 the elements of his claim by a preponderance of the credible evidence. The Arbitrator finds that the Petitioner failed to meet that burden here. Specifically, the Arbitrator finds that the Petitioner failed to prove that an accident arising out of and in the course of his employment with the Petitioner occurred on October 19, 2013, and failed to prove any condition of ill-being which is causally related to the accident alleged. In so finding, the Arbitrator notes that the Petitioner testified that his injury on October 19, 2010 occurred while he was descending the stairs at his home. There was no testimony or evidence presented from which it could be concluded that the Petitioner was either in the course of or in the scope of his employment with the Respondent at the time of the injury.

The Arbitrator also notes that in the Arbitration Decision issued case Number 13 WC 35904 the Arbitrator found that the Petitioner reached maximum medical improvement from his left foot injury of March 26, 2010 as of July 1, 2010 and that any condition of ill-being in the Petitioner's left foot after July 1, 2010 was not causally related to the accident of March 26, 2010. The Petitioner testified that it was the condition of his left foot that caused him to fall on the steps at his home on October 19, 2013. As the Arbitrator has found that the condition of the Petitioner's left foot after July 1, 2010 was not causally related to the accident of March 26, 2010, it must be concluded that the Petitioner's fall was caused by an idiopathic condition. As there is no testimony or evidence from which to conclude that the Petitioner was in the course or scope of his employment or was exposed to some increased risk of injury as a result of his employment at the time of his injury on October 19, 2013, the Petitioner's injury cannot be said to have arisen out of or in the course of the Petitioner's employment.

Similarly, as the Arbitrator found that any condition of ill-being in the Petitioner's left foot after July 1, 2010 was not causally related to the Petitioner's work injury of March 26, 2010, it cannot be concluded that the Petitioner's injury was causally related to the Petitioner's work injury of March 26, 2010.

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 arising out of and in the course of his employment with the Respondent occurred October 19, 2013. The Arbitrator further finds that the Petitioner failed to prove any current condition of ill-being which is causally related to the alleged accident of October 19, 2013 or the work accident of March 26, 2010.

In light of the Arbitrator's findings and conclusions relating to the issues of accident and causation, determination of the remaining disputed issues is moot.

The Petitioner's claim for compensation is denied and no benefits are awarded herein.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Angela Groshans,

Petitioner,

vs.

Nos. 13 WC 38074
15 WC 04249

DHS – Alton Mental Health Center (State of Illinois),

Respondent.

16IWCC0616

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, prospective medical care and temporary disability, and being advised of the facts and law, corrects and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

The Commission corrects the award of prospective medical care to refer to a disc replacement surgery at C5-C6, not C5-C5. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 20, 2015, is hereby corrected as stated herein, and otherwise affirmed and adopted.

16IWCC0616

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

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

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

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: SEP 27 2016
o-09/08/2016
SM/sk
44

Stephen Mathis

Mario Basurto

David L. Gore

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

GROSHANS, ANGELA
Employee/Petitioner

Case# **13WC038074**

15WC004249

DHS ALTON MENTAL HEALTH CENTER
Employer/Respondent

16IWCC0616

On 11/20/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICES OF MARK N LEE LTD
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4948 ASSISTANT ATTORNEY GENERAL
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0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANGEMENT
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 20 2015

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

16IWCC0616

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Angela Groshans
Employee/Petitioner

v.

DHS Alton Mental Health Center
Employer/Respondent

Case # **13WC 038074**

Consolidated cases: **15 WC 004249**

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

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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, **8/11/2013, 7/8/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$69,753.12**; the average weekly wage was **$1,453.19**.

On the date of accident, Petitioner was **31** years of age, ***single*** with **1** 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 identified in Petitioner's Exhibits 10 as provided in Section 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, C5-C5 disc replacement.

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

11/20/15
Date

ICArbDec19(b)

NOV 20 2015

Findings of Fact

Petitioner is a 33 year old nurse that has been employed at the Alton Mental Health Center for the State of Illinois for the past ten years. (Trans. Pg. 9-10) Petitioner testified she was employed at that facility on August 11, 2013 as a nurse. On that day, Petitioner testified she was attacked by a patient who threw blood in her face, struck her, and grabbed her hair taking Petitioner's face to the left and hitting her face against the wall. (Trans. Pg. 11-12) The patient was taken to the ground, but the patient never let go of Petitioner's hair, when both parties fell to the ground the Petitioner was underneath the patient's legs, but was facing the patient's abdomen. The Petitioner testified she twisted her lower back, mid back and neck. (Trans. Pg. 11-12) Petitioner testified that the Patient weighed about 170 pounds, 30 pounds heavier than the Petitioner. (Trans. Pg. 13)

After the injury, the Petitioner thought she had damaged her left eye but once the blood was rinsed out she had no vision troubles. However, Petitioner was having pain in her back and stabbing pain in her right side. (Trans. Pg. 13) The Petitioner then went to St. Anthony's Emergency Room in Alton. The Alton records submitted at the time of trial reported the Petitioner was flung around at work with complaints concerning her left eye, lower back and right rib. (PX-2)

Petitioner then followed up with her Primary care physician, Dr. Quadri, on August 13, 2013 with complaints of pain in her neck, mid back, and lower back. (PX-3) She was then referred to a Dr. Roller, a chiropractor, and saw him on August 16th, 2013. On the chiropractor's intake form, Petitioner reported that she had hurt herself in a similar manner in 2008 but also stated the pain was more severe now and Petitioner was able to return to work to full duty after one months' time due to her last injury. (PX-4) Petitioner testified the 2008 event was acute and short lived. (Trans. Pg. 17) Petitioner also testified the 2008 injury was a workers' compensation claim but she never filed a claim nor received a settlement.

Petitioner was then ordered by Dr. Quadri to complete physical therapy of which she only did one session because Dr. Gornet did not want her to start therapy at this point. (Trans. Pg. 18) Petitioner then saw Dr. Gornet on 9/30/2013 per the referral of Dr. Quadri. During that visit, Dr. Gornet reviewed her MRI and then an MRI of her cervical and lumbar. (PX-6, Trans. Pg. 19) Dr. Gornet also opined that Petitioner's current complaints were related to her August 11, 2013 attack. (PX-6)

Petitioner then underwent a series of epidural injections in her thoracic spine which did not help her symptoms. She later underwent radiofrequency ablation at T7-T8, and T9-T10 with Dr. Boutwell. This treatment did resolve the stabbing pain in Petitioner's thoracic spine. Dr. Gornet then ordered Petitioner to undergo injections in her cervical and lumbar and released Petitioner back to full duty on March 6, 2014. (PX-6, Trans. Pg. 22-23) Petitioner testified that she was still in pain and was reluctant to even think of surgery on her neck so she wanted to

return to work to see if she can tolerate her limitations. (Trans. Pg. 24) Petitioner then underwent a cervical injection on March 17, 2014 but with little positive impact. (Trans. Pg. 24)

On March 31, 2014 Petitioner sought a second opinion from Dr. Singh. Petitioner explained that she sought a second opinion because she wanted to explore other treatments plans for her neck pain, other than surgery, due to her being only 32 years old. (Trans. Pg. 24-25) Petitioner testified that Dr. Singh ordered she undergo work conditioning. Petitioner never did work conditioning and she only saw Dr. Singh once. Petitioner testified that she thought she never did work conditioning due to a letter by Dr. Singh stating she needed no further treatment. Dr. Singh records reflect that he did initially order work conditioning, reviewed the Petitioner's MRI's and opined she had no disc herniations in either her cervical spine or thoracic spine. Contained in the record is a letter by Dr. Singh which stated he revoked his treatment plan and then put Petitioner at MMI. (RX-8, Trans. Pg. 23-25)

On cross examination, Petitioner testified that even though, at the time of her Dr. Singh consult, she was trying to avoid surgical intervention she was still having pain in her cervical spine so she continued to pursue treatment with Dr. Gornet. (Trans. Pg. 48)

Petitioner testified that after her second opinion with Dr. Singh she returned to Dr. Gornet. Petitioner then underwent a series of injections on her lumbar spine. Petitioner testified these injections took the edge off of her lumbar pain and while she still has pain in her lumbar spine has not required any further intervention. (Trans. Pg. 28) On June 5th of 2014, Petitioner returned to Dr. Gornet and still had complaints of pain in her cervical spine. Dr. Gornet ordered a second cervical MRI at this point.

On July 8th of 2014, Petitioner testified she suffered a second injury at work. Petitioner described that she responded to a call on the patient who was combative. Petitioner testified she was grabbed and was flung down. Petitioner testified she felt an increase in the chronic pain in her neck after the incident. (Trans. Pg. 29)

Petitioner then followed up with Dr. Gornet on July 28th 2014 and reported this aggravation to Dr. Gornet. (Trans. Pg. 30) Dr. Gornet reviewed the most recent MRI scan and noted a small central herniation at C5-6 without significant cord compression. (PX-6) He continued her full work duty release and scheduled a follow up exam. (PX-6)

The final time Petitioner saw Dr. Gornet was on September 29, 2014. Dr. Gornet reported that Petitioner's cervical pain symptoms have become worse. Dr. Gornet opined that the 7/8/2014 injury aggravated Petitioner's underlying problem necessitating her need for surgery. (PX-6) Petitioner testified that this was the time Dr. Gornet made his official recommendation of surgery. (Trans. Pg. 32) Petitioner testified that at her insistence she did physical therapy at Alton Physical Therapy which she treated from September 11, 2014 until October 9th, 2014. (Trans. Pg. 32)

Petitioner testified that it was at this point she, in spite of her prior reluctance she opted to try surgery. Petitioner testified she is 33 years old and prior to her injury she was on a co-ed softball team, played volleyball, had a child and worked. But currently her work takes enough out of her to prevent her from playing volleyball, and she is currently looking to alleviate the pain to raise her standard of living. (Trans. Pg. 33) Further, Petitioner denied any prior chronic pain with the exception of her prior right shoulder treatment. (Trans. Pg. 34)

Petitioner also had a prior EMG on her back but it was a follow up for a hereditary numbness in her hands and feet. Petitioner testified the sensation is less severe and it never interfered with her work (Trans. Pg. 38)

On Cross examination Respondent's counsel read a medical note dated 5/6/2010 that described left sided neck pain, a full reading of that report also notes that the neck pain had mostly subsided in the next day. (Trans. Pg. 41 RX-4)

Dr. Gornet was deposed on January 19, 2015. Dr. Gornet testified when he first saw the Petitioner he reviewed her MRI of her thoracic spine. He testified that there was clearly a disc herniation with some cord compression at the T7-T8, and T9-10 level which he opined played a role in her mid-back pain. (PX-6, Pg. 11-12) Dr. Gornet reviewed the March 31, 2014 Dr. Singh report. Dr. Gornet testified he disagreed with both Dr. Singh's reading of the MRI's and with Dr. Singh's assessment of a muscle strain. Dr. Gornet opined that muscle strains should not persist for a year and that Petitioner's symptoms were consistent and classic of a disc injury. (PX-6, Pg. 19-20) A visual copy of the MRI was entered into evidence on the time of the deposition. Dr. Gornet circled a portion of the film and identified it as the disc herniation in question. (PX-6 PG. 26-27)

Dr. Gornet testified the Petitioner did not magnify her pain complaints and all of her treatment to date has been reasonable and necessary. (PX-6 Pg. 29) It was Dr. Gornet's opinion that the two incidents in question casually lead to Petitioner's need for treatment for her Lumbar, Thoracic, and surgical intervention. (PX-6 Pg. 27-28) After his proposed C5-C6 disc replacement, Petitioner would be able to return to work full duty with no restrictions. (PX-6 Pg. 28)

Petitioner saw Dr. Hsu on May 18, 2015. In the report Dr. Hsu performed a physical exam that resulted in negative Waddell's signs, negative Spurlings, Lihemittes, and Hoffman's sign. Dr. Hsu opined that Petitioner suffered from a cervical strain, lumbosacral strain, cervical spondylosis, and lumbar spondylosis. Dr. Hsu reviewed x-rays from August 2013 concerning Petitioner's lumbar, cervical, and thoracic. He also reviewed the MRI of the cervical spine dated November 25, 2013 and opined that was no sign of a significant herniation, stenosis, or instability.

Dr. Hsu, opined in the report that Petitioner did suffer two work related injuries that caused cervical and thoracolumbar strains. He based this opinion upon her MRI evaluation that Petitioner only suffered a soft tissue injury. Dr. Hsu believed her current symptoms are secondary to a pre-existing condition of cervical and thoracolumbar spondylosis, a non-work related

condition. He also opined that Petitioner need no further treatment and she has reached maximum medical improvement.

Conclusions of Law

The Arbitrator finds that Petitioner did suffer two work related injuries to her back, her medical treatment to date has been reasonable and necessary. Further Petitioner is entitled to have the C5-C6 disc replacement operation recommended by Dr. Gornet. These findings are based upon the following; Petitioner suffered two traumatic injuries both admitted by the Respodnet, has had consistent pain complaints since both dates of injuries, and Dr. Gornet's opinion regards to her treatment is more persuasive than that of Dr. Singh and Dr. Hsu.

Petitioner testified she suffered a severe assault on August 11, 2013 when a patient struck her, grabbed her hair and brought her to the ground twisting Petitioner's back in the process. Petitioner suffered a second injury on July 8th, 2014. In this injury she was still under the care of Dr. Gornet, working full duty but was picked up and thrown to the ground by a second patient. Petitioner testified and the records entered into evidence support that Petitioner's cervical pain complaints increased after this second assault. Petitioner's pain complaints have been consistent since the date of injury.

Petitioner testified she has had some back complaints in the past but nothing as severe as what she currently suffers. Further, Petitioner testified she was active in multiple sports which she can no longer perform. Petitioner appeared truthful and credible during her testimony.

Dr. Gornet's medical opinion was more persuasive than either Dr. Singh or Dr. Hsu. In his deposition Dr. Gornet had access to all of Petitioner's MRIs, his opinions were consistent with the impressions of the radiologist's summaries of the injuries. In addition, Dr. Gornet exhausted all conservative care measures, prior to recommending surgical intervention for Petitioner.

Dr. Singh opinions were formed prior to the second date of injury. In addition, Dr. Singh also reviewed all the MRI's on the claim but found no disc herniations in any of Petitioner's films. This is contrary to the findings of both Dr. Gornet and the radiologist who reviewed the films. In regards to the September 12, 2013 MRI of Petitioner's thoracic, the radiologist stated that there were several thoracic disc herniations with flattening of the right cord. Dr. Singh also recommended further treatment and then withdrew said recommendation without explanation.

Dr. Hsu did exam the Petitioner after both injuries but did not have copies of any of the MRI's other than the most recent report concerning Petitioner's cervical spine. Dr. Hsu did not review the original MRI's of Petitioner cervical, lumbar or thoracic but felt x-rays were enough to diagnosis the Petitioner with a cervical and lumbosacral strain which he related to the original injuries. Dr. Hsu also apparently believed the Petitioner's subjective pain complaints but did not believe they warranted surgical intervention. Dr. Hsu did not have a full set of records when he prepared his report and thus his opinions are not credible.

Therefore, the Arbitrator finds the current injury suffered by the Petitioner to be casually related to her August 11, 2013 and July 8, 2014 injuries. Further, Petitioner has exhausted all conservative treatment, including injections, therapy, and even returning to work full duty. At this point surgical intervention is warranted for her cervical.

Respondent agreed to pay all medical bills up until the date of March 31, 2014, and subject to finding causation the Respondent will pay all reasonably related medical bills to day. That being said, medical bills are awarded consistent with the findings above on subject, subject to any Section 8(j) credit and subject to the fee schedule.

Arbitrator Edward Lee

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

ANDRZEJ PAWINSKI,

Petitioner,

vs.

NO: 13 WC 41281

AT&T,

Respondent,

16IWCC0623

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FACTUAL BACKGROUND

Petitioner has worked for AT&T for 14.5 years as a lines person placing cable, carrying ladders, working off ladders, working off climbing hooks, and climbing and placing poles. (Testimony p. 12) On March 11, 2012, he was working on the west side of Chicago. During that time, someone told him a line was down. In an effort to see which line was down, he went into a gangway. (Testimony p. 13) In the gangway, he was attacked and beaten unconscious. (Testimony p. 13-14)

Petitioner came under the care of Dr. Nirav Shah for treatment of his right shoulder and left leg. Dr. Shah treated his shoulder and left knee between July 16, 2012, and May 13, 2013. (Testimony p. 15) On August 28, 2012, Dr. Shaw performed surgery on his right shoulder. (Testimony p. 16) After surgery Petitioner went to physical therapy. (Testimony p. 16) Dr. Shah performed left knee surgery on February 12, 2013. (Testimony p. 17) After knee surgery he went

back to Accelerated Rehab through May 10, 2013. Thereafter, he returned to work as a line person. (Testimony p. 19)

Petitioner testified that his right arm is shorter than his left, and he cannot raise it beyond 2/3 to 3/4 of the way up compared with the left. (Testimony p. 24) Sometimes three of his fingers go numb – the little, ring, and middle. If he gets symptoms where he gets numbness in his shoulder and pinching pain and he'll take over-the-counter medication like Bayer aspirin. (Testimony p. 25) After a hard day of climbing at work, off the hooks, he feels pain in his knee for which he takes over-the-counter Bayer aspirin and ices it after work. (Testimony p. 26)

For his psychological state, the doctors help him with the medication, but there are certain parts or certain areas where they try to send him to work and he tells his boss he doesn't feel comfortable. (Testimony p. 27) If he's told he has no choice and goes there, he's deathly afraid. He shakes and sweats when he goes into those areas, and he just looks around and looks behind his back all of the time and he can't concentrate on his job. He notified his job that that happens and said he would like not to go in those areas because of what happened to him. (Testimony p. 28)

ANALYSIS

In determining an award of PPD, the Commission shall base its determination on the following:

i) A PPD impairment report prepared by a physician licensed to practice medical in all of its branches;
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.

Respondent sent Petitioner for an AMA impairment rating. The physician, Dr. Karlsson, found a Class 0 impairment regarding Petitioner's leg, and found a Class 1 impairment of the right shoulder and gave Petitioner a corresponding impairment rating of 4% loss of man as a whole. (Respondent Exhibit 1) In considering the remaining factors, Petitioner was only 30 years old at the time of the accident, with several more working years ahead of him. He was working in a physically demanding job as a cable splicer when he was assaulted and knocked unconscious. He is currently working as a line man, which per Petitioner's testimony, may be even more physically demanding. (Transcript p. 12) Petitioner's medical records corroborated his injuries and he was consistent with his complaints throughout his treatment. Additionally, Petitioner appeared to be a compliant patient. Although Petitioner was released MMI to full-duty, he complains of some residual issues to his shoulder and knee. (Transcript pgs. 25-26)

Based on the entire record before the Commission, and our analysis of the statutory factors in assessing permanent partial disability awards, the Commission modifies the Arbitrator's ruling, and hereby decreases the PPD award from 35% to 22.5% loss of use of Petitioner's left leg, and 18% to 12.5% loss of the person as a whole for injuries to the right

shoulder area of the body. The Commission affirms the Arbitrator's ruling with regards to the PPD award of 10% loss of the person as a whole for psychological injuries.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 48.375 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the 22.5% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 62.5 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained to the right shoulder caused the 12.5% loss of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 50 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 10% loss of the person as a whole for psychological injuries.

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

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

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

DATED: SEP 2 9 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

CJD/dm
O: 9/13/16
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PAWINSKI, ANDRZEJ
Employee/Petitioner

Case# **13WC041281**

AT&T
Employer/Respondent

16IWCC0623

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:

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

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

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Andrzej Pawinski
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # **13** WC **41281**

16IWCC0623

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **November 16, 2015**. By stipulation, the parties agree:

On the date of accident, **July 11, 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 **$63,537.76**, and the average weekly wage was **$1,221.88**.

At the time of injury, Petitioner was **30** years of age, ***married*** with **1** dependent child.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**712.55**/week for **75.25** weeks, because the injuries sustained caused the **35%** loss use of the **left leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner additional permanent partial disability benefits of $**712.55**/week for **90** weeks, because the injuries sustained caused the **18%** loss of the person as a whole **for injuries to the right shoulder area of the body**, as provided in Section 8(d) 2 of the Act.

Respondent shall pay Petitioner additional permanent partial disability benefits of $**712.55**/week for **50** weeks, because the injuries sustained caused the **10%** loss of the person as a whole **for psychological injuries**, as provided in Section 8(d) 2 of the Act.

Respondent shall pay Petitioner compensation that has accrued from **July 11, 2012** through **November 16, 2015**, and shall pay the remainder of the award, if any, in weekly payments.

FINDINGS OF FACT

Petitioner Andrzej Pawinski was 30 years old and working for Respondent as a cable splicer on July 11, 2012 when he was attacked by an unknown assailant wielding an unknown object. (PX2.) He was struck from behind and knocked unconscious. (PX4.) Petitioner was discovered lying down on the ground by a coworker. (PX2.)

That same day, Petitioner was boarded and collared and taken to John H. Stroger Jr. Hospital. He had forehead abrasions, tenderness to palpation in his right shoulder, and midline tenderness in his cervical spine at C5-C6. Head and cervical spine CTs disclosed no acute processes, and right shoulder films were negative; Petitioner was ambulatory with no leg or hip pain. (PX2.)

Petitioner saw Dr. Nirav Shah at Parkview Orthopaedic Group. He complained of numbness and tingling in his hand, and pain in the anterolateral aspect of his right shoulder as well as deep in the shoulder. Petitioner reported that he was currently taking Ibuprofen and muscle relaxant. Dr. Shah noted no past medical history whatsoever other than a right knee arthroscope done in 2008. (PX4.)

Petitioner reported that he was having nightmares and mental difficulty coping with the attack. Dr. Shah noted that Petitioner was exhibiting symptoms of post-traumatic stress disorder. He stated: "From a psychiatric standpoint he has had some significant nightmares since this work comp injury as well as difficulty dealing with this mentally and crying occasionally." (PX4.)

Dr. Shah diagnosed Petitioner with possible labral instability, tear and/or impingement of the right shoulder; acute peripheral neuropathy or possible neurapraxia or traction injury occurring in the axillary posterior of the brachial plexus; and possible posttraumatic stress disorder. Dr. Shah took Petitioner off work. Dr. Shah ordered an MR-arthrogram of Petitioner's right shoulder, referred Petitioner to Dr. Russell Glantz for an EMG nerve conduction study, and referred Petitioner to Dr. Singh for psychiatric evaluation. (PX4.)

Petitioner presented to Dr. Glantz. Dr. Glantz opined that it was too soon to perform an EMG study. Dr. Glantz stated that it normally takes at least three weeks post-injury for all electromyelographic findings to be present. He scheduled Petitioner's EMG study. (PX4.)

Petitioner began to treat with psychotherapist Dr. Samantha Carillo, whom he would see once every 1 to 2 weeks. Dr. Carillo diagnosed Petitioner with post-traumatic stress disorder. (PX8.)

Petitioner underwent a right shoulder MRI arthrogram at Palos Community Hospital. The radiologist stated:

> The superior and anterior labrum appear detached from the glenoid. There is increased signal within the substance of the most of the posterior labrum. The posterosuperior labrum is expanded. Overall these abnormalities extend from about 9 to 3:00. There is a 5 mm diameter cystic structure along the anterosuperior labrum which does not fill with gadolinium. Biceps anchor is posteriorly positioned. Long biceps tendon is grossly unremarkable. (PX4.)

The radiologist also noted that fluid weighted sequences showed "nonfocal increase in signal in the infraspinatus tendon, particularly interstitial portions and the articular surface." The radiologist's impressions included a large superior, posterior and anterior labral tear; a small anterosuperior paralabral cyst; a probable developing paralabral cyst posterosuperior; and mild to moderate infraspinatus tendinosis. (PX4.)

Petitioner then underwent the EMG with Dr. Glantz. Dr. Glantz stated that despite clinical symptoms in Petitioner's right arm, the EMG study was normal. (PX4.)

Petitioner returned to Dr. Shah, who the reviewed the right shoulder MRI arthrogram. (PX4.) Dr. Shah stated that the MRI arthrogram:

> shows a large SLAP tear as well as a large posterolateral tear consistent with a likely shoulder dislocation versus subluxation from his assault injury at work. It shows a labral tear basically involving the entire posterior labrum, top of the labrum up to the superior anterior labrum almost 270-degree tear. It has an appearance of an acute injury. (PX4)

Dr. Shah noted that Petitioner exhibited positive SLAP and O'Brien signs, pain with posterior load shift, and pain globally in the shoulder. Dr. Shah noted improved rotator cuff strength isometrically, but with continued pain. He recommended surgery for Petitioner's shoulder consisting of arthroscopic stabilization, posterior stabilization, posterior Bankart repair and SLAP repair. Petitioner agreed to proceed with the surgery. Dr. Shah kept Petitioner off work, with instructions to perform home exercises. (PX4.)

Petitioner began to see a psychiatrist, Dr. Taylor Crawford, at Palos Behavioral Health Professionals. Petitioner stated that he felt something was wrong with him. Petitioner said that he felt he was distanced from himself; he had been having trouble sleeping since the attack, with persistent nightmares. He reported waking up screaming one night.He reported a persistent feeling of mental fogginess, and indicated that he was always thinking about the incident, though he denied having flashbacks while awake. He reported that his relationship with his wife had been affected, as his head felt "full" and he was tired all the time. Dr. Crawford diagnosed Petitioner with post-traumatic stress disorder, and prescribed 1000 mg of fish oil, as well as a trial of Praozin 2 mg if his sleep problems persisted after the surgery. (PX9.)

On August 28, 2012, Petitioner underwent surgery with Dr. Shah at Palos Surgicenter. Examining Petitioner under anesthesia, Dr. Shah visually confirmed an anterior load shift of 1+ and posterior load shift of 1+ compared to 0+ on the contralateral side. Using an arthroscope, he then visually confirmed a Bankart tear extending down to the 5 o'clock position; a type 2 posterior-superior SLAP tear posterior to the biceps anchor insertion; and significant synovitis-bursitis. Dr. Shah completed a Bankart repair followed by a SLAP posterior-superior labral repair, installing 5 BioComposite PushLock anchors and shaving the bone to provide a healthy surface for healing. Dr. Shah then completed a synovectomy and acromioplasty to address the synovitis-bursitis. (PX4.)

Petitioner returned to Dr. Shah for a follow-up examination, two days post-surgery. Dr. Shah discussed the surgical findings with Petitioner and instructed Petitioner to begin rehabilitation the following week. (PX4.)

On September 5, 2012, Petitioner presented for his first visit. Petitioner reported that he was performing home exercises daily and that his status was improving with intermittent pain. Petitioner was instructed to continue using an ultra sling at all times until 4 weeks post-surgery, with exceptions only for home exercises, physical therapy, and showering. Petitioner was scheduled for physical therapy 2 times per week for the next month, and instructed to continue home exercises 3 to 5 times per day. Petitioner remained off work. (PX4.)

Petitioner returned to Dr. Crawford. Petitioner reported that the nightmares had mostly stopped, but that he had one for the first time in 2 to 3 weeks. Petitioner reported that he still couldn't sleep. He would nap for 1 to 2 hours, then watch tv until he dozed off, but could only get 2 to 3 hours of sleep. He reported hallucinating and seeing shadows, as well as episodes of dizziness. Petitioner reported that he felt "empty," and had stopped socializing with others outside of his family. He reported that he was sad, and that he was finding it difficult to feel happy. Petitioner cried when he spoke about the trauma, and reported that this happens 2 to 3 times per day, about the same as before the surgery. He stated that he felt something was wrong with him. Dr. Crawford noted no evidence of delusions, but stated that Petitioner did seem to be having brief flashbacks. (PX9.)

Dr. Crawford noted Petitioner's decrease in disturbing dreams, but stated that this might be related to the analgesics he received for his surgery. Dr. Crawford noted Petitioner's persistent feelings of sadness and vulnerability. Dr. Crawford opined that Petitioner's episodes of dizziness might perhaps be secondary to the Prazosin. Dr. Crawford ordered a hold on the Prazosin for the next 3 weeks. Dr. Crawford prescribed Petitioner Celexa 20 mg and Oleptro. (PX9.)

Petitioner returned to Dr. Shah for follow-up. Dr. Shah opined that Petitioner was doing well. Dr. Shah found that Petitioner's range of motion, strength and endurance were improving, though Petitioner was not yet back at full strength. He opined that Petitioner was not yet at MMI. Dr. Shah instructed Petitioner to undergo thrice weekly physical therapy sessions for the next 8 weeks. Dr. Shah returned Petitioner to work on restricted duty. (PX4.)

Petitioner returned to Dr. Crawford. Petitioner reported some improvement; he was now sleeping 6 hours per night. He was no longer experiencing nightmares, though he did hear his name being called when no one was there. He still did not want to be in crowds. Dr. Crawford assessed Petitioner with PTSD and prescribed Lexapro 20 mg. (PX9.)

Petitioner followed up with Dr. Crawford on November 8, 2012. Petitioner reported that his sleep had improved; he was now sleeping 6 to 8 hours per night. With one exception, he was not experiencing nightmares, and no longer heard his name being called when no one was there. He was still uncomfortable in the store, but was able to go to the store. Petitioner's mood was "bland," with difficulty feeling happy. Dr. Crawford assessed

Petitioner with PTSD; Dr. Crawford stated that Petitioner was continuing to improve. Dr. Crawford prescribed Petitioner Lexapro 20 mg and Oleptro. (PX9.)

On November 26, 2012, Petitioner visited Dr. Shah. On examination, Petitioner exhibited full range of motion, with no O'Brien signs or signs of instability or active compression. Dr. Shah opined that Petitioner was not yet at MMI. He instructed Petitioner to begin a program of work hardening/conditioning 5 days a week for 4 weeks. He took Petitioner off work so that he could complete the program successfully. (PX4.)

On December 10, 2012, Petitioner returned to Dr. Shah complaining of pain in the left knee while performing work conditioning. Petitioner informed Dr. Shah that he had had felt something in his knee since the date of accident, and that he was not having issues with his knee prior to the accident. He stated that because he was knocked unconscious and the shoulder was so painful, it was distracting him but that the knee had been bothering him more recently with the lower extremity component to his work conditioning. (PX4.)

Dr. Shah examined Petitioner's left knee, and he noted popping and cracking of the knee with repetitive motion, but negative patellofemoral grind on the anterior aspect of the knee. He noted soreness, but lack of effusion, inflammation, or ligamentous instability. He opined that the issue was superficial in the prepatellar bursa of the kneecap due to palpable thickened bursal tissue. (PX4.)

Dr. Shah diagnosed Petitioner with "Prepatellar bursistis that is indeed related to the work injury." Dr. Shah hoped to treat the issue non-operatively. Dr. Shah gave Petitioner a GenuTrain knee sleeve, prescribed him Flector patches and Meloxicam, and instructed Petitioner to continue with work conditioning, with follow-up to occur in 3 weeks. He kept Petitioner off work. (PX4.)

That same day, Dr. Shah wrote a letter to the Respondent's adjuster. In it, he described Petitioner's knee condition. He stated: "I do believe this is related to the work injury. He likely fell to the ground as he was knocked unconscious, had a concussion and a shoulder dislocation and this is starting to bother him now that he is starting to do some things and work condition with his lower extremities." He stated that Petitioner could likely to return to work in 3 weeks, and that if he still had significant issues with his prepatellar bursitis after 6 weeks, then he would recommend open debridement. (PX4.)

Petitioner next followed up with Dr. Shah on January 2, 2013 complaining of both right shoulder and left knee issues. Dr. Shah stated that Petitioner's right shoulder was improved in terms of range of motion and strength, but not yet where it needed to be in order for him to fulfill his job requirements working full duty. Dr. Shah recommended continued work hardening for the right shoulder. (PX4.)

Dr. Shah noted that Petitioner continued to experience left knee prepatellar bursitis, and that he was experiencing new symptoms indicative of left knee painful plica syndrome. On examination, Dr. Shah noted that Petitioner had soreness and tenderness to palpation over the palpable plica over the medial patellofemoral joint. Dr. Shah administered a cortisone injection for the painful plica. (PX4.)

Petitioner reported that his left knee prepatellar bursitis was plateauing after a period of worsening. Dr. Shah stated that he would like for Petitioner to undergo 4 more weeks of work hardening and then return for a reevaluation. Dr. Shah stated that if Petitioner's knee was still bothering him at that time, then he would recommend an MRI and surgery for the prepatellar bursitis and painful plica syndrome. He kept Petitioner off work. (PX4.)

On January 14, 2013, PMI Diagnostic Imaging took an MRI of Petitioner's left knee. In the intercondylar notch, the radiologist noted abnormal signal intensity and appearance of the anterior cruciate ligament, possibly representative of a partial-thickness intrasubstance tear or chronic full-thickness ACL tear. The radiologist also noted a questionable small tear of the posterior horn of the lateral meniscus near its root attachment, meniscal degeneration, patellar tendinosis, and joint effusion. (PX4.)

Petitioner returned to Dr. Shah on January 17, 2013, complaining of pain over the anterior aspect of his left knee, pain directly with kneeling, and popping on the anterior aspect of the knee.Dr. Shah observed that Petitioner's complaints all seemed to originate from anterior to the patella and just distal to the patella. Dr. Shah reviewed Petitioner's left knee MRI. He stated:

> MRI of the left knee shows findings consistent with pre-patellar bursitis, proximal Insertional patellar tendonitis, possible ACL sprain, partial tear that appears to be chronic and a possible small tear along the lateral meniscus and patellar tendinosis and small joint effusion. MRI findings show a possible chronic injury to his ACL, possible small tear lateral meniscus, patellar tendinosis, joint effusion and pre-patellar bursitis. (PX4.)

Dr. Shah examined Petitioner's shoulder; he observed full range of motion, full strength, and well-healed scars. Dr. Shah examined Petitioner's left knee; he observed thickened bursitis anterior to the kneecap and just distal to the patella, with pain elicited over the patellar tendon and tenderness to palpation over the medial patellofemoral joint and anterior medial joint line. He noted Lachman test results of 0+ and firm, with varus valgus stress testing producing results of 0 to 30 degrees, 1+ and firm, no posterior drawer. (PX4.)

Dr. Shah stated that Petitioner's knee had not improved. He opined that Petitioner had failed conservative treatment. He stated that Petitioner was having pain with squatting and kneeling; he opined that Petitioner's knee condition was aggravated by work conditioning, physical therapy, and kneeling. (PX4.)

Dr. Shah recommended surgery consisting of left knee open pre-patellar bursectomy, patellar tendon debridement, arthroscopy and possible partial meniscectomy. He released Petitioner to work with restrictions of no kneeling. (PX4.)

Petitioner underwent surgery at Orland Park Surgical Center on February 12, 2013. Pre-operatively, Dr. Shah diagnosed Petitioner with left knee prepatellar bursitis, left knee patellar tendinitis, left knee painful Hoffa fat pad syndrome, and left knee painful plica syndrome. Dr. Shah evaluated Petitioner's patellofemoral joint arthroscopically, where he observed mild grade 1 chondromalacia. An open procedure followed. He resected Petitioner's ligamentum mucosum. Dr. Shah then observed that Petitioner had a thickened and scarred Hoffa fat pad, as well as painful medial plica in the patellofemoral joint. Dr. Shah excised both the fat pad and the plica. Next, Dr. Shah observed thickened prepatellar bursa and fibrotic bursa in the patella; Dr. Shah excised these, performing a complete prepatellar bursectomy. Dr. Shah observed grayish discoloration in Petitioner's patellar tendon consistent with patellar tendinitis and patellar tendinosis; he performed patellar debridement until he reached healthy tendon edges, then performed a tendon repair. Post-operatively, Dr. Shah diagnosed Petitioner with left knee prepatellar bursitis, left knee patellar tendinitis, left knee painful Hoffa fat pad syndrome, and left knee painful plica syndrome. (PX4.)

Two days post-surgery, Petitioner presented to Dr. Shah's office for follow-up. Petitioner stated that he was experiencing a significant amount of pain the day prior despite taking Norco 5, but that his pain was controlled much better on Norco 10. Petitioner reported having a lot of swelling and tightness in his knee, with pain anteriorly over the patellar tendon. (PX4.)

On examination, Petitioner's knee exhibited 2+ effusion. Petitioner was unable to fire his quads or do a straight leg raise. Petitioner exhibited a negative Homan sign, with significant tenderness to palpation over the anterior aspect of his knee. (PX4.)

Petitioner received an injection of 1 cc lidocaine and 1 cc Marcaine, with approximately 100 cc of bloody fluid aspirated from the knee using an 18 gauge needle. Petitioner was prescribed physical therapy twice a week for 6 weeks beginning the following week, with instructions to ice and elevate his leg, then return for follow-up in 10 days. Petitioner was taken off work. (PX4.)

On February 27, 2013, Petitioner again returned to Dr. Shah's office. Petitioner reported that his pain had improved to the point that he was only taking one pain pill every 6 to 8 hours. Petitioner reported that he had started physical therapy; he opined that he was making good progress in his home exercises. Petitioner still had a small effusion in his knee, but was significantly improved from the prior visit. Petitioner could perform a straight leg raise, albeit with discomfort and a little extension lag. (PX4.)

Petitioner was instructed to continue with physical therapy as well as to progress in his home exercise program, with particular attention to performing straight leg raises and more quad sets. Petitioner was scheduled to follow up with Dr. Shah in 4 weeks. (PX4.)

Petitioner returned to Dr. Shah for follow-up on March 27, 2013. Petitioner reported improved pain. (PX4.) On examination, Dr. Shah noted that Petitioner's scar was well-healed, with full and excellent range of motion, but not full strength. Dr. Shah prescribed Petitioner 6 weeks of strength and work conditioning, with follow-up thereafter. Dr. Shah informed Petitioner that he was expected to have some soreness at the end of the work conditioning period, and that Dr. Shah expected to return petitioner to work full duty at the conclusion of the program. Dr. Shah kept Petitioner off of work. (PX4.)

Petitioner returned to Dr. Crawford on April 29, 2013. Petitioner reported that he was doing well and spending a lot of time with his son. He stated that he was sleeping well, going to bed for 10 PM and waking up at 6:30 AM. (PX9.) He had a hard night after the Boston Marathon attacks. Petitioner was no longer having nightmares; his appetite had returned, and he was able to be out in crowds. Petitioner was still cautious, but no longer hypervigilant. He stated that he was looking forward to returning to work. Dr. Crawford assessed Petitioner with PTSD; Dr. Crawford stated that Petitioner could return in 3 months. Dr. Crawford prescribed Petitioner Lexapro 20 mg and Trazodone 50 mg. (PX9.)

Petitioner followed up with Dr. Shah on May 13, 2013. On examination, Petitioner had full range of motion of the knee and shoulder with no pain and full strength. Dr. Shah opined that Petitioner had reached maximum medical improvement, and he released Petitioner back to work with no restrictions. (PX4.)

On June 17, 2013, Petitioner had his last visit with Dr. Carillo. He reported anxiety at work related to the adjustment of getting back into his daily tasks. Dr. Carillo opined that Petitioner was managing his anxiety appropriately. Dr. Carillo reviewed coping skills with Petitioner. (PX8.)

Petitioner returned to Dr. Crawford on July 29, 2013. Petitioner reported that he was sleeping well, with good appetite, ability to be out in crowds, and no disturbing dreams. Petitioner stated that he liked his job, but that he felt anxious, sometimes feeling that his job wasn't working out for him. Petitioner was working in a new site with new procedures to follows, and he was trying to adjust to them. Petitioner stated that he did not know

where his feelings were coming from. Dr. Crawford assessed Petitioner with PTSD and anxiety disorder; he prescribed Petitioner Lexapro 20 mg and Trazodone 50 mg. (PX9.)

Petitioner followed up with Dr. Crawford on October 21, 2013. (PX9.) Petitioner reported that he had been unable to sleep for several weeks, and was feeling increased anxiety. (PX9.) Petitioner stated that he had been working and productive, but that he had been reassigned to a location with less-than-ideal conditions and his numbers were bad in August. (PX9.) Petitioner stated that he had been placed under closer supervision, and that he felt he was being punished. (PX9.) Petitioner denied having bad dreams, but reported that he occasionally awoke feeling that someone was standing over him or walking past. (PX9.) His appetite remained good, and he remained able to go out in crowds; he remained cautious but not hypervigilant. (PX9.) Dr. Crawford assessed Petitioner with PTSD and anxiety disorder, with anxiety aggravated by current management practices; he prescribed Petitioner Trazodone 50 mg, Lexapro 20 mg, and Melatonin. (PX9.)

Petitioner followed up with Dr. Crawford on January 6, 2014. Petitioner reported that he had been suspended for 3 days after being hit from behind while at Popeyes at lunch. Petitioner stated that he had not missed any days of work prior to this. Petitioner reported feeling sick; he stated that he had retained an attorney. Petitioner reported no changes in sleep, appetite, tolerance for crowds, or vigilance. He stated that he felt distracted, and that his memory was not as good as before. Dr. Crawford assessed Petitioner with anxiety disorder. (PX9.)

At follow-up with Dr. Crawford on April 10, 2014, Petitioner reported feeling much better. Dr. Crawford opted to taper Petitioner off Trazadone. Petitioner likewise reported feeling much better at follow-up with Dr. Crawford on June 12, 2014. He stated that he felt good, that he was working more and was looking to take advantage of getting overtime work. He reported that he had no more shoulder pain, except when carrying a large ladder. Dr. Crawford began to reduce Petitioner's Lexapro prescription from 20 mg to 10 mg. At Petitioner's next visit with Dr. Crawford on September 14, 2014, Dr. Crawford began to taper Petitioner off Lexapro. (PX9.)

Petitioner's last visit with Dr. Crawford was on December 4, 2014. He had stopped taking Lexapro entirely and was feeling good. Dr. Crawford no longer diagnosed Petitioner with PTSD. (PX9.)

On August 31, 2015, Petitioner underwent a Section 12 examination with Dr. Troy Karlsson, who was instructed by Respondent to provide an Impairment Rating relating to Petitioner's cervical spine, right shoulder, and left knee.

On examination, Dr. Karlsson noted decreased range of motion in Petitioner's right shoulder compared to his left, with 40 degrees less active and passive flexion, and 60 degrees less active and passive abduction. He noted no crepitus, swelling, or difference in shoulder strength. Petitioner's cervical spine exam was "essentially normal." On examination, Dr. Karlsson noted no difference in range of motion or strength between Petitioner's knees. Dr. Karlsson opined that Petitioner had 0% impairment of the cervical spine, 0% impairment of the knee, and 6% loss of use of Petitioner's upper extremity based largely on the loss of range of motion (equivalent to 4% impairment of the whole person).

CONCLUSIONS OF LAW

The sole issue in dispute is the nature and extent of Petitioner's injury.

Pursuant to Section 8.1b (b) of the Act, the Arbitrator considers the following factors in determining the level of permanent partial disability:

(i) Respondent submitted an impairment rating report in which their Section 12 examiner opined that Petitioner was 0% impaired with respect to his left knee and 6% impaired with respect to his right arm; this report did not address any effects from Petitioner's mental injuries.
(ii) Petitioner's current occupation is that of a cable splicer for AT&T.
(iii) Petitioner was 30 years old at the time of his injury.
(iv) Petitioner now works as a lineman full duty; this is a different position from his prior job as a cable splicer. It does however pay the same rate. When he performs his duties, Petitioner notes that he has great difficulty raising his right arm to perform his functions. No other evidence as to Petitioner's future earnings capacity was submitted.
(v) Petitioner offered evidence of disability in the form of testimony at the arbitration hearing, as well as via extensive medical documentation. Petitioner suffered a Bankart tear extending down to the 5 o'clock position, a type 2 posterior-superior SLAP tear, and significant synovitis-bursitis in his right shoulder; left knee prepatellar bursitis, left knee patellar tendinitis, left knee painful Hoffa fat pad syndrome, and left knee painful plica syndrome; and post-traumatic stress disorder as a result of his work accident. In the most recent available records, Petitioner still suffered from recurrent anxiety and caution short of hypervigilance. Respondent's impairment rating report paraphrases statements from Petitioner that he gets stiffness and soreness in his shoulder after heavy work, and that he experiences periods of numbness in 3 of the fingers of his right hand 4 to 5 times per week.

Petitioner credibly testified to all of his ongoing symptoms and was corroborated by the medical records.

Basedupon the foregoing, the Arbitrator finds that Petitioner has sustained a 35% loss of use of the left leg, an additional 18% loss of the person as a whole as a result of his right shoulder injury, and an additional 10% loss of the person as a whole as a result of his psychological trauma.

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.

Milton Black

Signature of Arbitrator

January 8, 2016
Date

JAN 11 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFF FLATT,

Petitioner,

vs.

NO: 13 WC 42474

CATERPILLAR, INC.,

Respondent.

16IWCC0604

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, and prospective medical treatment, and being advised of the facts and applicable law, reverses the Decision of the Arbitrator and finds that Jeff Flatt failed to establish that he sustained a work-related accident arising out of his employment on December 3, 2013. Petitioner's claim for compensation is, therefore, denied.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission makes the following findings:

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1. Per the Application for Adjustment of Claim filed December 18, 2013, Jeff Flatt was a 56 year old, single male with no dependents under the age of 18. Flatt alleged injury to his left leg/knee when he stepped off a platform on December 3, 2013.

2. Flatt began working for Caterpillar on October 31, 1977. He has since retired. T.39. He worked on the liner line during his last 2 years of his employment. *Id.*

3. Flatt was seen by Dr. Stephen Orlevitch of Great Plains Orthopaedics on September 12, 2011. It was noted he injured his left knee on January 29, 2011 when his foot got caught on a hose and twisted his knee. He had some knee pain over the years. At that time, he had to step up on a 2 step platform onto a machine. He had type II borderline diabetes and arthritis. Examination revealed severe crepitation of both patellofemoral joints with active flexion. The x-ray revealed that both knees had some medial compartment narrowing but the tibiofemoral joint was well preserved. Both knees had moderate to severe patellofemoral degenerative changes. Dr. Orlevitch noted that he had some degenerative changes, moderate to severe in the patellofemoral joint, mild in the medial compartment as well as possible torn cartilage. PX.3.

4. Flatt underwent 4 injections and then saw Dr. Orlevitch on January 9, 2012 for continued left knee issues. Petitioner had crepitation in both knees. Dr. Orlevitch advised that the mechanical symptoms would persist likely throughout his life intermittently due to his severe arthritis. He recommended arthroscopic debridement of the patellofemoral joint and examination of the medial and lateral compartments. He advised that there was no guarantee this procedure would eliminate all of his pain, but it could make him better. It would not eliminate the chance of doing injections in the future such as viscosupplementation or corticosteroid. PX.3.

5. Prior to the alleged date of accident, Dr. Orlevitch performed arthroscopic partial medial and lateral meniscectomy with chondroplasty of the medial and lateral compartment, chondroplasty of the patellofemoral joint, microfracture of the trochlear groove, and arthroscopic lateral retinacular release and excision of loose bodies. This procedure was done on February 15, 2012. Per the operative report, Flatt had severe patellofemoral arthritis with kissing osteonecrosis of the lateral facet and apex of the patella with lateral tilt and compression, tricompartment degenerative changes, loose body suprapatellar pouch, grade IV trochlear groove, severe grade III patella apex, and a lateral flap tear of the posterior horn medial meniscus with severe grade III erosions of the medial femoral condyle. PX.3.

6. As of February 24, 2012 Flatt was doing well. He had some mild swelling and some calf tightness but no tenderness or evidence of edema in the lower leg. PX.3.

7. Flatt was given a release to full work as of June 1, 2012 but with restrictions of no kneeling or climbing. He then underwent a series of injections. On July 20, 2012, it was noted that Flatt experienced locking in the left knee. This occurred after sitting for a period of time and his left knee would get stiff and it took some time for him to get up. It was noted this was due to his severe arthritis. His restrictions of no ladders, kneeling or

repetitive squatting were continued. On August 24, 2012, Flatt reported that his left knee was getting worse since having to do two flights of stairs at work as the escalator was not working. Dr. Orlevitch recommended another round of injections. PX.3.

8. Flatt underwent 5 Hyalgan injections. On February 1, 2013, Flatt reported that his left knee was improving. He received his 5th injection and was to follow-up in 12 weeks. PX.3.

9. Flatt testified that he had a follow-up appointment scheduled for April 26, 2013, but forgot about the appointment as his left knee felt better. T.49. He did not see a doctor between February 1, 2013 and December 3, 2013. During this time, he still had some pain and troubles with his left knee, but he could tolerate the pain. T.50. The only restriction he had was to sit as needed and some kneeling restrictions. T.51. He did not have any difficulty performing his job duties between April 2013 and December 2013. *Id.*

10. On December 3, 2013, Flatt was working on the 5008 and 5007 machine. The machine was located on a platform that was 8 inches off the ground. T.40. The other machines did not have the step-up platform. T.41. Flatt grabbed the handle and was stepping down to check a part when his left leg buckled. He experienced instant pain. T.42. He did not notice anything wrong with the step or the floor. T.44. Flatt testified that there was no way to avoid the platform. T.42. He had to step onto and off the platform to change the tool approximately every 15 minutes. T.43.

11. Per the Caterpillar Employee Incident Report dated November 7, 2013, Flatt alleged injury to his left knee after he stepped down off of a platform and felt his left ankle and knee twist. He reported that he previously had left knee surgery. PX.1.

12. On December 3, 2013, Eric Popken sent an e-mail to Jeffrey Nelson regarding Flatt's accident. Per the e-mail, Popken noted that Flatt injured himself while stepping down from the platform. Flatt indicated that he may have stepped wrong and twisted his left ankle, and also felt a twist in his left knee. PX.5.

13. An ambulance was called to the site. Per the ambulance report dated December 3, 2013, Flatt reported that he was stepping off a platform when he felt a twisting sensation in his left knee and ankle. His left knee pain was 8 out of 10 after the accident and now 4 out of 10. There was no edema or deformity on palpation, but pain to the lower portion of the patella on palpation. PX.1.

14. Flatt was taken to Proctor Hospital where examination revealed mild tenderness in the left knee. X-ray of the left knee revealed mild osteoarthritis in the left knee without acute fractures or dislocations. The impression was a left knee sprain. PX.1.

15. Petitioner was seen at the Caterpillar medical department on December 5, 2013 with continued left knee pain. Petitioner reported that he may have twisted or turned when he stepped off the platform. There was no visible swelling. The assessment was left knee

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pain. He was to remain off work. The incident was deemed non-occupational by the facility safety. PX.1.

16. Flatt was seen by Dr. Orlevitch on December 9, 2013. Flatt reported his December 3, 2013 injury and that he had an exacerbation of his anterior knee pain. There was no significant effusion in the knee. Dr. Orlevitch noted that this incident represented an exacerbation of arthritis from his slipping at work. He did not think there was any internal derangement and recommended a series of injections for his arthritic flare. He was to remain off work for the week. PX.3.

17. Per the Caterpillar progress note dated December 12, 2013, Flatt had a possible slight effusion superiorly and possibly medially. There was joint line pain in the anterolateral aspect to palpation. There was some pain in the proximal area above the patella to palpation. The report noted that Dr. Orlevitch returned Flatt to work on December 16, 2013 without restriction. PX.1.

18. Flatt underwent the series of injections. On May 20, 2014, Dr. Orlevitch noted that the injection provided limited relief only. He exhausted conservative care. The only other option was a knee replacement. Flatt's knee was affecting his work and daily activities to a significant degree. He was referred to Dr. Piero Capecci. PX.3.

19. Flatt was seen by Dr. Piero Capecci on June 18, 2014. It was noted Flatt has had pain since his January 29, 2011 work injury. He then sustained a second injury in December 2013. Dr. Capecci noted Flatt was suffering from a severely arthritic knee. The x-rays were not as remarkable as the MRI and arthroscopic findings. Dr. Capecci stated Flatt was a good candidate for a knee replacement. PX.3.

20. Petitioner's attorney obtained a Section 12 opinion from Dr. David Fletcher on June 30, 2014. Dr. Fletcher diagnosed Flatt with osteoarthritis of both knees and the left knee was aggravated by his work injury. It was reasonable for Dr. Capecci to consider a knee replacement. PX.5.

21. Respondent obtained a Section 12 opinion from Dr. Ira Kornblatt on November 17, 2014. He diagnosed Flatt with moderate osteoarthritis aggravated by morbid obesity with an acute episode of buckling dating back to December 3, 2013, from which Flatt appeared to have recovered. He noted that buckling was common with patellofemoral arthritis. He did not recommend a total knee replacement due to the obesity. He recommended weight loss and strengthening. RX.2.

22. Petitioner's attorney obtained a biomechanics study of osteoarthritis as related to Flatt's left knee from Steven McCaw, Ph.D. on April 22, 2015. McCaw opined that the degenerative process in his left knee osteoarthritis was accelerated by the loading from repeatedly stepping up and down the platform at his work station. He noted that the neuromuscular aspect of osteoarthritis, including both sensory and motor responses, contribute to the progress of osteoarthritis when petitioner repetitively stepped up and

down the platform. The neuromuscular changes also made petitioner more susceptible to his knee buckling and falling. PX.6.

23. Flatt testified that he is the chairman of the safety committee. The handle on the machine had been moved 4 to 5 months prior. T.45. He disagreed with Mr. Smith's testimony that there was no handle. T.46.

24. Flatt testified that his condition never returned to its baseline following the accident. T.52. He is now not able to walk any distance and his knee gives out on uneven ground. It hurts to traverse stairs. He is unable to get on his knees. *Id.* His pain is now a 7 whereas after the surgery, and before the injury, it was a 4. T.53. He stated that a total knee replacement had never been recommended, but he was told that he would eventually need one. *Id.* He has diabetes and has to walk as part of his routine. T.54. Petitioner would like to have the surgery as he has pain every day and cannot do things he normally did. His life has changed. T.56.

25. Andrew Schneider is the corporate safety manager. He stated that the 8 inch step up is within OSHA guidelines and this is considered a platform not a step. T.69. On cross-examination, he stated that the standard step is 7 inches. T.73. He stated that this is not an area or common step that the public is exposed to. T.75.

26. Eric Popken is the project facilitator for Reman Components and Work Tool Division. He stated that the machines that Flatt was working on had a step-up platform to access the machines. T.17. He would not dispute that the step up was 8 inches. T.19. He does not recall Flatt stating that he slipped or stepped on anything when he fell. T.20. He noted Flatt mentioned that he had his knee surgically repaired in the past, but was able to work performing the essential functions of his job for the prior 8 months. T.21. He would not dispute that Flatt would have to step down the platform 3 to 4 times per hour. T.23.

27. Kevin Smith is the Group Manager for the Liner Line. He was not present when the accident occurred. He stated that Flatt had to go up and down the platform to access the machines. T.34. Flatt would have to leave the platform at least every 15 minutes to check the parts. T.36.

28. Dr. Piero Capecci was deposed on March 6, 2015. He is board certified and specializes in total joint arthroplasty of the shoulder, hip and knee. He diagnosed Flatt with a severely arthritic knee. He recommended total knee arthroplasty. He discussed with the petitioner the natural history of the condition, the fact that he failed the injections, that he had been on a pain management modality with minimal benefit, that he was having trouble sleeping and walking and, while still working, he would be further impaired without surgery. PX.4. pg.8.

29. Dr. Capecci stated that the patellofemoral articulation is subjected to increased force with stair climbing. PX.4. pg.12. He noted Flatt had osteoarthritis, which can cause a person's knee to buckle. *Id.* He stated that there would be an increased risk of buckling or giving way going down a stair vs. regular walking. PX.4. pg.16.

30. On cross-examination, Dr. Capecci stated that the intake form indicated the petitioner twisted his knee while coming down a step or platform. PX.4. pg.13. He stated that twisting could happen to anyone's knee. PX.4. pg.14.

31. Dr. David Fletcher was deposed November 7, 2014. He specializes in occupational medicine and is board certified, but not in orthopedic medicine. He noted that injections can provide substantial relief sometimes several years or only three to four months of relief. PX.5. pg.9.

32. Dr. Fletcher noted Flatt was doing well and had substantial relief between February 1, 2013 and December 3, 2013. PX.5. pg.10. He was working full duty without restrictions. Flatt was overweight. He weighed 310 pounds and was 73 inches tall. Dr. Fletcher opined that the work injury of December 2013 permanently aggravated his underlying condition and he was in need of a total knee replacement. Fletcher's opinion was based upon the fact that Flatt had resolution of his knee pain and was functioning after the surgery. He had the injections and returned back to his usual job duties. He then had an acute injury that required more treatment and he continues to be symptomatic. PX.5. pg.13. Fletcher noted that Flatt was not a surgical candidate prior to the injury as Flatt was not having any symptoms and his condition was not affecting his quality of life. PX.5 pg.15. The accident was the straw that broke the camel's back and accelerated the necessity for the procedure. *Id.* Had Flatt noticed a gradual onset of symptoms and sought medical treatment after his last injection, then he would say that the injection wore off. *Id.* He could have been a candidate for a total knee replacement in the future absent the injury, however. PX.5. pg.17.

33. On cross-examination, Dr. Fletcher stated that it was possible that his underlying degenerative pathology caused his knee to buckle. PX.5. pg.22.

34. Steven McCaw was deposed on July 10, 2015. He is a biomechanics expert for legal cases. He stated that there is more stress on the knee when ascending and descending the stairs in comparison to walking on flat ground. PX.6. pg.20. Walking on flat ground only requires lifting the foot one to two inches off the ground so one is absorbing less energy. Ascending or descending stairs requires the entire body mass moving and requires additional muscle forces above and beyond walking. PX.6. pg.21. The average force to use a step is two to three times higher. PX.6. pg.22. A person with osteoarthritis is more likely to have buckling and two times more likely to fall. PX.6. pg.23. He stated that if a person is going up and down a platform three to four times per hour, it would accelerate an osteoarthritic condition because of the known effects of loading on cartilage. PX.6. pg.33. He stated that a person is more likely to buckle their knee going down a stair than regular walking. PX.6. pg.65.

35. On cross-examination, he stated that he did not see the step or know if there was a handrail. PX.6. pg.42. He did not examine Flatt or his knee, and has never met Flatt.

36. Dr. Ira Kornblatt was deposed on August 5, 2015. He is a board certified orthopedic surgeon and performed a Section 12 examination on November 17, 2014. Flatt reported that his knee buckled as he was stepping down from his machine. RX.3. pg.8. He diagnosed Flatt with moderate osteoarthritis aggravated by morbid obesity with an acute episode of buckling dating back to December 30, 2013. He has since recovered from that episode. RX.3. pg.13. Petitioner had a totally benign exam. Knee buckling is a common complaint for people with patellofemoral arthritis. He did not recommend a total knee replacement, and thought Flatt would benefit from weight loss and exercise. RX.3. pg.15.

37. On cross-examination, Kornblatt noted that when people go up or down stairs, three times the body weight goes across the patellofemoral joint. RX.3. pg.21-22. Going up and down stairs causes an increase reaction of forces and higher torque forces on the joints of the knee compared to just walking. RX.3. pg.22. The higher the step the greater the force or torque across the knee. *Id.* Kornblatt did not know how often Flatt went up or down the steps. He stated that there is an increase of giving way for a person with tricompartmental arthritis when they go up or down a step. RX.3. pg.23. He stated that it is reasonable for well-qualified physicians to differ on whether Flatt needs a total knee replacement. RX.3. pg.29.

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).

To obtain compensation under the Act, a petitioner bears the burden of showing, by a preponderance of the evidence, that she has suffered a disabling injury which arose out of and in the course of her employment. *Baggett v. Industrial Comm'n*, 201 Ill. 2d 187, 266 Ill. Dec. 836, 775 N.E.2d 908 (2002). "In the course of employment" refers to the time, place and circumstances surrounding the injury. *Lee v. Industrial Comm'n*, 167 Ill. 2d 77, 81, 212 Ill. Dec. 250, 656 N.E.2d 1084 (1995). It is not enough, however, to simply show that an injury occurred during work hours or at the place of employment. The injury must also "arise out of" the employment. *Parro v. Industrial Comm'n*, 167 Ill. 2d 385, 393, 212 Ill. Dec. 537, 657 N.E.2d 882 (1995). The "arising out of" component of establishing entitlement to benefits is primarily concerned with causal connection such that it must be shown that the injury had its origin in some risk connected with, or incidental to, the employment. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003).

The Commission finds that, while Flatt was in the course of his employment at the time of the incident, his testimony failed to demonstrate an accident arising out of his employment. The Commission notes that this case was tried as a specific trauma and not a repetitive trauma injury.

Where the evidence allows for the inference of the nonexistence of a fact to be just as probable as its existence, the conclusion that the fact exists is a matter of speculation, surmise, and conjecture, and the inference cannot reasonably be drawn. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 106, 853 N.E.2d 799, 304 Ill. Dec. 722 (2006).

By petitioner's theory, Flatt was exposed to a greater risk of injury than the general public due to the height of the platform and the frequency at which he had to step onto and off of the platform. The Commission is not persuaded by petitioner's argument.

The Commission finds that the injury did not result from a risk connected to his employment. Flatt testified that:

> I was stepping down to check a part, and in stepping down I grabbed the handle which I always did, and when I went down my leg buckled and instant pain went through it. I hung onto the handle, and I pulled myself up. I never fell but I went down on the... T.42.

Per Flatt's testimony, however, he did not notice anything wrong with the step or floor. In the e-mail dated December 3, 2013, Popken, the project facilitator, noted that Flatt indicated to him that "he stepped off of the platform he may have stepped wrong and twisted his left ankle. He also felt a twist in his left knee." Also, per the ambulance report, it was noted Flatt felt a twisting sensation in his left knee and ankle while stepping off the platform. The Commission finds no evidence that the platform was defective.

Flatt also argues that the step leading to the machine was 8 inches while all the other machines were on the ground level. He argues that this 8 inch step was 1 inch higher than a normal step, which exposed Flatt to a greater risk of injury. The evidence establishes, however, that the step was within OSHA standards. Flatt offered no evidence that he tripped on the step or that his alleged injury was the result of the 8 inch step. Flatt stated that he was required to use this step up to 4 times per hour. The Commission finds that the frequency and height of the platform did not expose Flatt to a greater risk of injury than the general public. Rather, the evidence demonstrates that Flatt's knee buckled at some point while in the process of stepping off of the platform. It is the opinion of the Commission that his knee buckled due to its degenerative condition.

However, and without question, Flatt had a degenerative left knee, is morbidly obese, and had a significant prior left knee history.

Whether a claimant's disability is attributable solely to a degenerative process of the pre-existing condition or to an aggravation or acceleration of a pre-existing condition because of an accident is a factual determination to be decided by the Industrial Commission. *Roberts v. Industrial Comm'n*, 93 Ill. 2d 532, 538, 67 Ill. Dec. 836, 445 N.E.2d 316 (1983); *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36-37.

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The significance of Flatt's prior degenerative left knee condition was well documented in the medical records. In January 2012, Flatt underwent a series of injections due to knee pain. The medical records relative to the injections revealed that Flatt had diabetes, moderate to severe patellofemoral degenerative changes, and mild degenerative changes in the medial compartment. Dr. Orlevitch subsequently performed left knee arthroscopic surgery in February 2012. The operative report revealed severe patellofemoral arthritis with kissing osteonecrosis of the lateral facet and apex of the patella with lateral tilt and compression. He had tricompartment degenerative changes and a loose body suprapatellar pouch. He also had a grade IV trochlear groove, severe grade III patella apex, and a lateral flap tear of the posterior horn of the medial meniscus with severe grade III erosions of the medial femoral condyle. All of these findings preceded his alleged work accident.

Dr. Orlevitch noted that Flatt's mechanical symptoms would persist likely throughout his life intermittently due to his severe arthritis. Dr. Orlevitch also noted that the surgery had no guarantee of eliminating all of his pain and would not eliminate the chance of performing injections in the future.

Following his release to work after the non-work related surgery, Flatt underwent another series of injections due to his severe arthritis. While Flatt testified that he did not have any issue performing his job duties between April 2013 and December 2013, he testified that he still had some pain and troubles with his left knee. The Commission notes that Flatt's testimony relative to his ongoing knee pain between April 2013 and December 2013 was markedly consistent with Dr. Orlevitch's opinion regarding his future pain. The evidence demonstrates that Flatt's knee was continuing to deteriorate due to his arthritic condition.

The Commission finds the opinion of Dr. Fletcher Dr. Capecci and Dr. Kornblatt informative in that respect. All three doctors opined that Flatt had a degenerative condition and that buckling is common for people with degenerative knee conditions. Additionally, McCaw noted that a person with osteoarthritis is 2 to 3 times more likely to have buckling and two times more likely to fall.

The Commission is of the opinion that Flatt's knee gave way due to his degenerative condition and not due to a risk associated with his employment.

Further, the Commission also analyzed this case under the "chain of events" theory, despite this theory not having been advanced by Petitioner. It is well established that "a chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability *may be sufficient* circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *International Harvester v. Industrial Comm'n*, 93 Ill. 2d 59, 63-64, 442 N.E.2d 908, 66 Ill. Dec. 347 (1982). However, such testimony is not always dispositive, particularly where there is persuasive medical opinion testimony or other evidence suggesting that the claimant's injury is not related to the accident. See, *e.g., Sorenson v. Industrial Comm'n*, 281 Ill. App. 3d 373, 382, 666 N.E.2d 713, 217 Ill. Dec. 44 (1996) (affirming Commission's finding that a work-related accident did not cause or aggravate claimant's bone spur based upon medical testimony despite undisputed evidence that claimant's back symptoms began after the accident); *Williams v. Industrial Comm'n*, 216 Ill. App. 3d 536, 539, 576 N.E.2d

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383, 159 Ill. Dec. 714 (1991) (affirming Commission's finding that claimant's injury was unrelated to the alleged accident notwithstanding claimant's testimony that he had no symptoms before the accident where other evidence suggested that the accident would not have caused the injury).

While Flatt was able to perform his job duties prior to the alleged incident, he failed to demonstrate a prior condition of good health or a subsequent injury resulting in disability. The record clearly documented pre-existing arthritis that necessitated multiple rounds of injections and surgery. Despite the surgery, he still had pain that he rated as 4 out of 10. The record reveals that Flatt was experiencing locking, pain and stiffness prior to the alleged incident. Per his testimony, he was advised prior to the alleged accident that he would eventually require a total knee replacement.

Flatt also failed to demonstrate a subsequent injury resulting in disability. Dr. Orlevitch noted that there was no internal derangement following the incident. There was no effusion, no edema, no swelling, no fracture, and no dislocation. Rather, he had pain. His pain was well documented prior to the incident. The Commission notes that Flatt's testimony establishes that his pain intensity did not change as a result of the accident. Flatt testified that his pain prior to the accident was 4 out of 10. Per the ambulance report dated December 3, 2013, his pain was 8 out of 10 after the accident and 4 out of 10 when the ambulance arrived. Furthermore, the x-ray following the incident revealed mild osteoarthritis. The Commission notes that this finding is similar to the x-ray from September 12, 2011, which revealed medial compartment narrowing and moderate to severe patellofemoral degenerative changes. Thus, the Commission finds that Flatt failed to prove a compensable injury under the chain of events theory.

Despite the aforementioned, the Commission notes that there are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill. App. 3d 113, 116 (2007); *Homerding v. Industrial Comm'n*, 327 Ill. App. 3d 1050, 1056 (2002). With respect to the third category, "[i]njuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to the risk to a greater degree than the general public." *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 120219WC. The increased risk may be either qualitative (*i.e.*, when some aspect of the employment contributes to the risk) or quantitative (such as when the employee is exposed to the risk more frequently than members of the general public by virtue of his employment). *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1014 (2011).

Recently, our Appellate Court has examined several claims involving similar issues. The Court has found such matters compensable in light of specific findings of fact that are not present in the case at bar.

In the matter of *Village of Villa Park v. Illinois Workers Compensation Commission*, 2013 IL App (2d) 130038 WC, the Court dealt with a Community Service Police Officer that

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was required to traverse a staircase in the police station numerous times per day. Of specific interest to the Court was the Petitioner's pre-existing injury, which precluded the Petitioner from working at a full duty capacity.

In pertinent part the Court stated:

> The evidence of record supports the Commission's finding that the claimant was "continually forced to use the stairway" both for his personal comfort and "to complete his work related activities." Specifically, the evidence established that the claimant was required to traverse the stairs in the police station a minimum of six times per day. ***This fact, coupled with evidence that the claimant informed his superiors, prior to his fall on April 5, 2007, that he had injured his knee and the testimony of Deputy Chief Budig that he had seen the claimant walk with a limp on numerous occasions prior to April 5, 2007, certainly supports the inference that the Village required the claimant to continuously traverse the stairs in the police station, knowing that he had an injured knee.*** These facts are more than sufficient to support both the conclusion that the claimant's employment placed him in a position of greater risk of falling, satisfying the exception to the general rule of noncompensability for injuries resulting from a personal risk, and that the frequency with which the claimant was required to traverse the stairs constituted an increased risk on a quantitative basis from that to which the general public is exposed. [Emphasis Added]. *Village of Villa Park,* 2013 IL App (2d) 130038WC, ¶ 21, 378 Ill. Dec. 320, 3 N.E.3d 885.

In the case at bar, there is no question that the act of stepping off of the platform was a neutral risk and not a risk peculiar to the Flatt's employment. Though the step off of the platform was 8 inches in height, it was certainly within any height prescribed by OSHA. Petitioner argues that the height of 8 inches is greater than that prescribed by the general building code and postulates that this created an increased risk for this petitioner. We reject this conclusion as it is not borne out by the record.

Here, Flatt testified that he had no trouble ambulating up and down the platform from which he was required to work. Though the height of the step was alleged to be 1 inch higher than an average step, there is nothing of record that demonstrates that the alleged difference created any difficulty for Flatt. Further, there is nothing in the record that demonstrates that this alleged additional inch created a hazard to the person ambulating upon same or a hazard unlike that confronted by the general public on a daily basis.

Unlike the Petitioner in the *Village of Villa Park* case, Flatt was not working under a restriction which affected his ability to perform his regular duties. Flatt had not advised his employer of any difficulty with his knee that precluded him from participating in his full work.

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Flatt had not advised his employer of a condition which created a hazard that was unique to him, when he engaged in his normal duties.

Unlike the Petitioner in the *Village of Villa Park* case, Flatt offered no testimony from a supervisor which demonstrated an observation of an obvious problem with Flatt's leg. Minus such testimony, and or an assertion of a notice from Flatt to his superiors regarding such a condition, the Court's Opinion in *Village of Villa Park* is easily distinguished.

Applying the qualitative analysis i.e. whether some aspect of his employment contributed to the risk, the Commission finds that the mere act of stepping off the platform did not contribute to any risk. The Commission finds that Flatt's knee buckled while coming off the platform. The incident was not caused by a defect in the step or floor. Further, the height of the platform was in compliance with OSHA regulation and no testimony was offered that he tripped on the platform due to it being 8 inches off of the ground.

Nothing about the platform increased the risk of injury to Flatt. There was a handle to hold onto and Flatt testified that he was holding the handle when he apparently stumbled. However, other than preventing a fall, the handle played no apparent role in this incident.

Also, petitioner's expert, Steven McCaw testified that a person with osteoarthritis is likely to have buckling and two times more likely to fall. Flatt had an arthritic knee that buckled. He last underwent an injection 10 months prior and was experiencing pain prior to the incident. The Commission finds that no aspect of his employment contributed to the incident. Thus, Flatt's case fails under the qualitative analysis.

Applying the quantitative analysis i.e., whether petitioner was exposed to the risk more frequently than a member of the general public by virtue of his employment, the Commission finds no evidence of record that demonstrates that Flatt's required ambulation on the single step at a pace of approximately four (4) times per hour quantitatively exposed him to an increased risk of injury greater to that which the general public might be exposed. To conclude otherwise would be to engage in speculation and conjecture that is inappropriate. We do not believe that such falls within the bounds of an appropriate inference. The incident, therefore, fails under the quantitative analysis as well.

The Commission finds that there was no risk of injury distinctly associated with Flatt's employment. The step was within OSHA regulation. No evidence was offered establishing that the step was hazardous or defective in any way. The Commission notes that the incident has some semblance of an idiopathic fall as no evidence was offered that the stair increased Flatt's risk of injury or that Flatt's fall was caused by the step. Rather, the evidence establishes that his knee was degenerative in nature and his knee may have buckled due to his degenerative condition. Since no argument was posited regarding an idiopathic component, the Commission will defer from further consideration of that theory of defense.

It is well settled that if undisputed facts upon any issue permit more than one reasonable inference, the determination of such issues presents a question of fact, and the conclusion of the Commission will not be disturbed on review unless it is contrary to the manifest weight of the

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evidence. *Orsini v. Industrial Comm'n* (1987), 117 Ill. 2d 38, 44; *Sears, Roebuck & Co. v. Industrial Comm'n* (1979), 78 Ill. 2d 231, 233.

The Commission, therefore, finds that Jeff Flatt failed to prove an accident arising out of his employment. His claim for compensation is therefore denied.

Assuming *arguendo* that the Commission found accident, the Commission is of the opinion that Flatt failed to prove causal connection. As stated above, Flatt had an arthritic knee. He was experiencing pain prior to the accident. Per Flatt's testimony, his pain prior to the accident was 4 out of 10. At the time of hearing, his pain was a 7 out of 10. Per the ambulance report dated December 3, 2013, his pain was 8 out of 10 after the accident and 4 out of 10 when the ambulance arrived. Based upon petitioner's testimony, the incident caused a very temporary increase in his pain, which returned to its based line almost immediately following the incident.

There is also no evidence that the incident caused a change in his condition. The x-ray following the incident revealed mild osteoarthritis. This is similar to the x-ray from September 12, 2011, which revealed medial compartment narrowing and moderate to severe patellofemoral degenerative changes. Additionally, the examinations following the incident revealed pain to the lower portion of the patella on palpation, but no edema. When Dr. Orlevitch examined Flatt on December 9, 2013, there was no significant effusion and Dr. Orlevitch did not believe there was any internal derangement. He was subsequently released to work. The Commission finds that Flatt's symptoms and examination findings following the December 3, 2013 incident were similar to his complaints and examination findings prior to the alleged incident. Therefore, had the Commission found accident, the Commission is of the opinion that Flatt failed to prove causal connection.

The Commission also declines to award Flatt a total knee replacement. As stated above, Flatt's knee was severely arthritic in nature. While there was no recommendation for a total knee replacement prior to the incident, the evidence strongly supports that Flatt would have needed a left knee replacement regardless of this incident. Flatt testified that he was told he would eventually need a knee replacement. Also, Dr. Fletcher noted that Flatt could have been a candidate for a knee replacement absent an injury. There is no evidence that Flatt's left knee was in a condition of good health prior to the December 3 2013 incident. He was never pain free prior to the December 3, 2013 incident and was experiencing stiffness and locking. Had the issue of accident and causal connection been resolved in Flatt's favor, the Commission is of the opinion that Flatt failed to establish that the incident played any role in his need for the total knee replacement.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 10, 2015 is hereby reversed. Petitioner's claim for compensation is therefore 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.

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

DATED: SEP 2 2 2016

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
O: 8-8-16
052

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

FLATT, JEFF
Employee/Petitioner

Case# **13WC042474**

CATERPILLAR INC
Employer/Respondent

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On 12/10/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

5035 CATERPILLAR INC
DARCY GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4320

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19 (B)

JEFF FLATT
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # **13** WC **42474**

Consolidated cases:

16IWCC0604

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **D. DOUGLAS McCARTHY**, Arbitrator of the Commission, in the city of **PEORIA**, on **10/23/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **8(a) PROSPECTIVE MEDICAL**

FINDINGS 16IWCC0604

On **12/03/13**, 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 **$53,566.24**; the average weekly wage was **$1,030.12**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

There was no claim for medical expenses or TTD. No monies have been paid by Respondent on this claim.

ORDER

The Respondent is ordered to authorize the total knee arthroplasty as prescribed by Dr. Capecci.

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Respondent shall pay all reasonable necessary medical expenses pursuant to Section 8(a) and 8.2 of the Act for the total knee arthroplasty.

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

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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. Dyer Mc Carty

Signature of Arbitrator

12/01/2015
Date

DEC 10 2015

JEFF FLATT)
)
v.) Case # 13 WC 42474
)
CATERPILLAR, INC.)

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IN SUPPORT OF THE ARBITRATOR'S MEMORANDUM OF DECISION, THE ARBITRATOR MAKES FINDINGS REGARDING THE FOLLOWING ISSUES:

- C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
- F. Is the petitioner's present condition of ill-being causally related to the injury?
- O. Other – 8(a) Prospective Medical

Statement of Facts

Petitioner retired from Respondent on May 1, 2015. Petitioner worked at Caterpillar for 30 years. Petitioner was a lathe and machine operator. On December 3, 2013, Petitioner injured his left knee stepping off an 8" platform in course of his employment for Respondent. (Hereinafter referred to as the "platform incident")

The facts relating to the accident and medical are generally not disputed. There are differing expert opinions on medical questions.

Four witnesses testified in this matter: Jeff Flatt (Petitioner), Eric Popkin (Foreman), Andy Schneider (Safety Manager), and Kevin Smith (Liner Line Superintendent). Petitioner was called to testify by his attorney. Popkin and Smith were called as adverse witnesses by Petitioner and Schneider by Respondent. The testimony of the witnesses was generally consistent with each other and with the documentary evidence.

Petitioner had a pre-existing condition in his left knee. Petitioner underwent left knee arthroscopy and debridement in February 2012. The operative report and intra-operative images revealed significant grade III and IV chondromalacia and osteo-arthritis of knee with the patella-femoral joint being the worst.

Following this surgery, Petitioner continued to experience knee pain. Due to the amount of chondromalacia and residual symptoms, Dr. Orlevitch provided lubricant and cortisone knee injections. Petitioner underwent two series of lubricant injections: June/July 2012 and January/February 2013. Each series of lubricant injection is a total of 5 injections. Petitioner's last lubricant injection prior to the platform incident was February 1, 2013. On that date, Petitioner reported that his knee was improving and he was feeling much better. Petitioner was scheduled to return in April 2013 for follow up. Petitioner missed the appointment and never rescheduled. Petitioner testified that he

responded well to the injections and he did not need to see the doctor because his condition was better. Following his last injection on February 1, 2013,, Petitioner testified that he was doing well. Petitioner testified that he had residual knee pain but it was tolerable and not interfering with his ability to perform activities of daily living or work. Petitioner testified that he was able to perform all the essential functions of his job without complications from his knee condition.

On December 3, 2013, Petitioner was performing his regular job operating a liner line machine identified as machine number 50007. In order to operate said machine, the Petitioner had to stand on a platform which was eight inches above the floor. Every fifteen minutes during his regular work shift, he had to step off the platform to check various parts on his machine. According to Kevin Smith, group manager for the liner line, if something was wrong with a part, the Petitioner would have to climb on and off the platform more often to make repairs. The machine had a railing which the Petitioner could use to step on and off the platform. The work station was depicted in Respondent's Exhibit 4, which the Petitioner said was an accurate depiction as of the accident date.

On said date, Petitioner stepped forward off the platform and experienced an acute buckling/twisting of his left knee. Petitioner stepped down with his left leg first and experienced immediate pain in his left knee and ankle. He was transported by ambulance to Proctor Hospital for treatment. Petitioner followed up on December 9, 2013 with Dr. Orlevitch. The medical records corroborate Petitioner's testimony regarding his accident and the mechanism of injury.

On December 9, 2013, Dr. Orlevitch examined Petitioner. Petitioner reported that he exacerbated his knee in the platform incident. Petitioner told Dr. Orlevitch's nurse that his knee felt like it did before surgery. In addition to increased pain, Petitioner reported popping and instability. Dr. Orlevitch wrote that Petitioner exacerbated his underlying arthritis and recommended more injections.

Petitioner received 3 lubricant injections. On March, 2014, Petitioner returned as instructed for evaluation. Petitioner reported relief from the injections for one week and then return of the pain. Petitioner reported a lot of pain, difficulty with stairs and difficulty sleeping. Unlike previous lubricant injections, these injections did not provide therapeutic relief. Dr. Orlevitch gave Petitioner a cortisone injection.

On May 20, 2014, Petitioner followed up post cortisone injection. He reported one week relief of pain and then a return of symptoms affecting his activities of daily living. Dr. Orlevitch wrote that Petitioner had exhausted conservative care and referred Petitioner for evaluation with his total knee replacement partner. This is the first time Petitioner was ever referred for consideration of a total knee replacement.

Petitioner testified that he never returned to baseline following the platform accident. Petitioner testified that the platform incident increased his pain to 8/10 and that the increase in pain was his affecting activities such as sleep, walking and

negotiating stairs. Petitioner testified that, unlike previous injections, the post platform injections provided only short term temporary relief. Petitioner's testimony is corroborated by the medical records and testimony of the physicians.

On June 18, 2014 Dr. Capecci evaluated Petitioner at the request of Dr. Orlevitch.. Dr. Capecci documented that Petitioner's left knee caused significant pain that was affecting Petitioner's quality of life and his ability to carry out simple activities of daily living. Dr. Capecci examined Petitioner and reviewed x-rays, an MRI, and intra-operative images of Petitioner's knee. Dr. Capecci wrote and testified that the plain x-rays were not as impressive as the MRI and intra-operative images. Dr. Capecci diagnosed severe tri-compartmental arthritis, the most significant being in the patella-femoral joint.. Dr. Capecci offered total knee replacement surgery.

Petitioner last saw Dr. Capecci in October 2014. At that time, Petitioner reported that his quality of life was suffering and he asked for another round of cortisone injections to get some relief while he waits for a decision on approval of his total knee replacement through workers' compensation.

Petitioner testified that he has been trying to lose weight and had lost about 10 pounds at the time trial. Petitioner testified losing weight was difficult due to his knee pain affecting his ability to exercise. Petitioner testified that he wants the knee replacement to eliminate his pain, increase function and get his life back.

Petitioner was also seen at his attorney's request by Dr. Fletcher, an occupational medicine specialist, for an examination. Dr. Fletcher agreed with Dr. Capecci's recommendation for a knee replacement. He also testified on the issue of causation. He said that, based upon his review of the medical records, the Petitioner was functioning reasonably well after his last pre-accident injection in February of 2013. He said that the accident permanently aggravated the Petitioner's underlying arthritis of the left knee. He noted that the Petitioner remained continuously symptomatic since the accident, which he referred to as the straw that broke the camel's back. He said that if the evidence showed a gradual onset of increased symptoms between February and December 3, his opinion might be different. Finally, he said that the Petitioner's underlying arthritis, along with stepping off the platform were the reasons the Petitioner's knee buckled.

Petitioner also presented the testimony of Dr. McCaw, a biomechanical expert. He had reviewed the relevant facts surrounding the accident and treatment, along with the medical records of the pre accident treatment. He said that, from a biomechanical standpoint, an individual descending a stair would put more force on his lead leg and knee than someone just walking normally. He went on to say that a person performing said activity with a similar level of arthritis in the knee as the Petitioner had a two to three greater likelihood of falling than people without arthritis. He said the higher the step, the more force would be generated on the lead leg.

Respondent had the Petitioner examined on November 17, 2014 by Dr.

Kornblatt, an orthopedic specialist. He testified that the Petitioner had preexisting moderate arthritis of the left knee, aggravated by his obesity. He said the buckling accident amounted to a temporary aggravation of that condition, from which the Petitioner had recovered by the time of his examination. He characterized the examination as benign. He also said that the buckling itself could have resulted from the underlying arthritis and obesity. He agreed that going down a step would increased the force across the knee, particularly at the patella-femoral joint. He also agreed that if the Petitioner did not treat for his knee following his final pre-accident injection until the accident, it would be consistent with him having a good result from the injections. He also disagreed with the surgical recommendation, based upon his examination of the Petitioner. He recommended physical therapy instead.

Conclusions of Law

The first issue for consideration is whether the platform incident arose out of Petitioner's employment. "There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with her employment or personal characteristics: (2) personal risks; and (3) neutral risks which no particular employment or personal characteristics." *Young v. IWCC 2014 IL App (4th) 130392WC quoting Springfield Urban League v IWCC 2013 IL App (4th) 120219WC*

The first issue is whether the knee buckling was a pure personal risk, and thus not arising out of the Petitioner's employment. While there is evidence to support the Respondent's argument that the knee buckled solely on its own, the timeline before and after the accident supports the Petitioner. As Dr. Fletcher noted, there was no evidence that the Petitioner had any care for ten months prior to the accident. If he had a knee which was easily susceptible to buckling, it is likely it would have occurred and a record of such occurrence would have been present. There was also no evidence presented that the Petitioner was having any problems performing his regular job during said period of time. The fact that the step was eight inches above the ground also favors the Petitioner. The Arbitrator agrees with Dr. Fletcher's opinion that the accident risk was a combination of the Petitioner's extensive arthritis and his stepping down from the platform. The risk was not purely personal.

The Arbitrator believes the act of stepping down from the platform was a neutral risk, but believes that the evidence shows that the Petitioner was at a greater risk of an accident because of his employment. First of all, the step was eight inches above ground. Mr. Schneider, the Respondent's safety manager, testified that a seven inch riser was normal for an office setting, and that this step was considered safe in a factory setting. Secondly, the unrebutted evidence shows that the Petitioner had to traverse this platform many times during each work shift. Both factors establish that the Petitioner's risk was greater than that encountered by a member of the general public. Accordingly, his accident did arise out of his employment.

The next medical question is if there is a causal connection between the platform incident, current condition of ill-being in Petitioner's left knee and the need for arthroplasty.

The Arbitrator finds by a preponderance of the evidence that the platform incident aggravated Petitioner's left knee condition and that the platform incident is a causative factor in Petitioner's need for the total knee replacement. While Petitioner had significant pre-existing OA in his knee and may have needed the total knee at some time in the future, the platform incident caused an aggravation and at a minimum accelerated the need for the total knee arthroplasty. The Arbitrator bases this conclusion on the following facts:

a. Dr. Kornblatt testified that a person with significant OA is at a greater risk of an acute buckling episode negotiating stairs and that Petitioner did in fact have an acute buckling injury to his knee stepping down from the platform.

b. The medical records are consistent with Petitioner sustaining an acute buckling incident stepping down from the platform. This includes the CAT medical records, Proctor Hospital records, ambulance records, and orthopedic records.

c. Prior to the platform incident, Petitioner had not seen his orthopedic doctor for knee pain in over 10 months.

d. Prior to the platform incident, Petitioner responded favorably to injections. Following the platform incident, Petitioner received minimal short term relief from the injections.

e. The medical records following the platform incident record a significant increase in pain levels and decrease in function.

f. Prior to the platform incident, there is nothing in the medical records discussing a total knee replacement or even a referral to a total knee specialist. It was not until after the platform incident that Dr. Orlevitch referred Petitioner to Dr. Capecci.

g. Petitioner testified that he did have pain in his knee prior to platform incident. Petitioner testified that the platform incident made his knee pain worse and that he never returned to his pre-platform incident baseline. This testimony is corroborated by the medical records.

h. Dr. Orlevitch wrote that the platform incident exacerbated Petitioner's left knee OA. Dr. Fletcher opined that the platform incident caused a permanent aggravation. Dr. Kornblatt opined that the Petitioner recovered from the platform incident based upon his examination on November 17, 2014. The Arbitrator

notes, however, that the Petitioner saw Dr. Capecci on October 31, 2014, complaining that it was getting harder for him to get up out of a chair. The doctor gave him an injection and recommended he be given a lift chair. Prior to that visit, the Petitioner was examined on June 18, 2014, wherein Dr. Capecci noted decreased range of motion, pain with forced flexion and 1+ medial joint pain. On that visit he again recommended a knee replacement.

The above evidence supports the Arbitrator's finding of a causal relationship between the accident and the current condition of ill being.

Finally, the Arbitrator believes the current surgical recommendation is supported by the evidence. On plain X-ray, Petitioner's OA was mild and not as impressive according to Dr. Capecci and Dr. Kornblatt (Respondent section 12 examiner). The MRI and intra-operative arthroscopic images demonstrated severe tri-compartmental OA. Dr. Capecci reviewed the MRI films and operative images personally, whereas Dr. Kornblatt did not. The best evidence of Petitioner's knee arthritis is the operative images, which support that Petitioner has significant left knee OA that would account for Petitioner's symptoms.

The decision for total knee arthroplasty is elective. Petitioner wants the surgery to relieve pain and increase his quality of life. Petitioner's obesity increases the risk of an unfavorable outcome from the surgery. While his pain makes exercise difficult, Petitioner reported that he has lost approximately 10 pounds. Dr. Capecci testified that being obese is not a contraindication to total knee surgery. Dr. Capecci advised Petitioner of the increased risk. Dr. Capecci and Dr. Fletcher (Petitioner Section 12 examiner) both testified that Petitioner was a candidate for total knee arthroplasty and the surgery was reasonable and necessary. Dr. Kornblatt did not recommend surgery because of the x-ray findings and Petitioner's weight. Dr. Kornblatt conceded on cross examination that the surgery is a judgment call and that a reasonably well qualified physician could recommend surgery in this case. Dr. Kornblatt's opinion was equivocal.

Based upon the preponderance of the evidence, the arbitrator finds the recommendation for total knee arthroplasty to be reasonable and necessary for Petitioner Flatt's condition of ill-being in his left knee.

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

Zeno Piechovica,

Petitioner,

16IWCC0572

vs.

NO: 14 WC 1127

EB Commerical, Inc. Brittany Place Condominium Association and American Property Mangagement,

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 4, 2015 is hereby affirmed and adopted.

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

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

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

DATED: SEP - 7 2016
KWL/vf
O-8/30/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0572

PIECHOVICZ, ZENO
Employee/Petitioner

Case# **14WC001127**

E B COMMERICAL INC BPCA CONDOMINIUM ASSOCIATION & AMERICAN PROPERTY MANAGEMENT COMPANY
Employer/Respondent

On 2/4/2015, 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 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0572

Zeno Piechovicz
Employee/Petitioner
v.
E.B. Commercial, Inc., BPCA Condominium Association & American Property Management Company
Employer/Respondent

Case # 14 WC 1127

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on July 31, 2014, September 23, 2014 & November 21, 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 Is there any liability pursuant to Section 1(a)3 of the Act?

16IWCC0572

FINDINGS

On the date of accident, December 24, 2013, Respondent, E.B Commercial Inc. was operating under and subject to the provisions of the Act. There is ongoing litigation in Circuit Court regarding this finding.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent, E.B. Commercial and **possibly,** Respondent American Property Management Company.

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

Timely notice of this alleged accident was given to Respondent, E.B. Commercial.

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

In the year preceding the injury, Petitioner earned **$41,600.00**; the average weekly wage was **$800.00**.

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

Respondent is not liable to pay any charges for any 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 Petitioner has not proven, by a preponderance of the evidence, that he sustained and accident, which arose out of and in the course of his employment, therefore no benefits will be awarded, pursuant to 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.

Findings of Fact

Zeno Piechovicz (the "Petitioner") worked for E.B. as a maintenance man since on or about February 1, 2012. There are three (3) Respondents in this matter. The first is E.B. Commercial Inc., ("E.B. Commercial"), whose disputed issues are 1) did an accident occur during the course of Petitioner's employment; 2) notice; 3) causal connection; 4) medical bills; 5) prospective medical care; 6) temporary total disability; 7) marital status; and 8) the age of Petitioner at the time of the accident. *See*, AX1.

The second Respondent in this matter is American Property Management Company ("APMC"), whose disputed issues are: 1) was there an employer/employee relation; 2) did an accident occur which arose out of and in the course of Petitioner's employment; 3) was timely notice given; 4) earnings; 5) average weekly wage; 6) medical bills; 7) prospective medical care; 8) liability pursuant to Section 1(a)3 of the Act; and 9) temporary total disability. *See*, AX2.

The third Respondent in this matter is Brittany Place Condominium Association ("BPCA"), whose disputed issues are 1) the employer/employee relationship; 2) accident; 3) notice; 4) causal connection; 5) earnings; 6) average weekly wage; 7) medical bills; 8) liability pursuant to Section 1(a)3 of the Act; and 9) temporary total disability benefits. *See*, AX3.

Testimony of Ms. Joanna Wietocha

This witness testified pursuant to subpoena. She is a real estate agent who was showing a unit at BPCA on December 24, 2012, at approximately 3:30 or 4:00 p.m. She happened to run into Petitioner and he was holding his hand. She testified that he told her that he had fallen down stairs, hurting his arm and hand. She offered to drive the petitioner home or to the hospital and he refused her offer saying he thought he was fine and that he could drive. She then went into the lobby of the building of the unit she was showing to wait for her client. Upon cross-examination, she further testified that she called the petitioner a few times to wish him a merry christmas and that the petitioner took her phone number so that his attorney could contact her to schedule her testimony. She denied having a conversation with petitioner regarding this case and denied knowing him other than as the maintenance man at the property.

Testimony of Petitioner

Petitioner testified that began working for E.B. Commercial on February 1, 2012. He saw a job advertisement in the newspaper, spoke to Ms. Eva Ayres about the ad and was hired by E.B. Commercial as a maintenance person to repair certain jobs in the building, check the boilers, clear off the snow and exchange fuses in the boxes for machinery or fans. This process took place at BPCA. Petitioner filled out tax forms and gave them to Eva Ayres at E.B. Commercial. E.B. Commercial paid Petitioner's wages, withheld taxes and had the exclusive right to hire and fire Petitioner. E.B. Commercial set Petitioner's hours and approved his days off. Tr. 7/31/14, pp. 73-77; & Tr. 9/23/14,

pp. 81-82.

Petitioner's last day of work was on Friday, December 24, 2013, on which date he alleges an accident occurred while he was working for E.B. Commercial. He testified that he considered Ms. Ayres to be his boss and that she had called him before 12:00 p.m. and told him that he could leave at 3:00 p.m., that day, if all of his work was finished. He also testified that Mr. Scott Walczak, who worked for BPCA, told him to check the heating elements in all eleven (11) building entryways, before he left for the day and to disburse fliers in the buildings. According to Petitioner, that conversation took place at approximately 12:00 p.m., on December 24, 2012.

Petitioner testified that shortly after 3:00 p.m., on December 24, 2013, while making his rounds to check the entryway heaters in the various buildings, he slipped and fell down icy stairs, injuring his right hand. He testified that there was ice on the stairs and hand railings because the downspout was damaged and had dripped water onto the stairs and railing. He testified that he had brought this condition with the downspouts to the attention of Mr. Walczak. He also testified that when he fell, his work cell phone came apart, which he was holding in his hand, as he had just received a personal call from a friend named Natalia, at 3:43. He testified that he lay on the ground for approximately ten (10) minutes before he was able to get up. He gathered the pieces of the phone, his broken watch and glasses and went into the office. He was there between ten (10) and twenty (20) minutes and noticed swelling and pain in his hand. He further testified that as he was leaving the property, he saw Ms. Wietocha and told her that he had fallen while walking up stairs and hurt his arm and hand "real bad". Tr. 7/23/14, p.104.

At 4:29, Petitioner called Ms. Ayres and left the following voice mail:

> Hi, boss. I have bad news. I fell the fuck down the stairs and almost my entire right hand is swollen. At that time, Natalia was calling me, and she heard this whole incident. My son-in-law drove here. I went; thought that everything will be ok. I left. My entire hand got swollen. Call me because I am by the hospital, and I don't know if I should go to emergency room or not. The whole right hand and this wrist. I am sorry. I am—okay. Call me. Call me on my private number because I cannot answer this one. Okay. See you. Bye-bye. Sorry."

Upon cross-examination, Petitioner testified that he spoke with Ms. Eva Ayres on the telephone, the morning of the alleged accident and she told him that there should be nothing going on; and that he could go home at 3:00 p.m. Petitioner testified that he told Ms. Ayres that Mr. Scott Walczak had given him an assignment to check the heating in all of the buildings before he went home. Petitioner testified that he got the assignment from Scott Walczak on December 24, 2013 to check the heat in the buildings either when Scott was at the property and brought some flyers or when he called, the Petitioner could not recall. Transcript of 7/31/14, pp. 90-91; Transcript of 9/23/14, pp. 33-34, 63.

Petitioner's treatment

Petitioner testified that he initially sought treatment, that day, at Holy Family Hospital in Des Plaines and was informed by a security person that that location was no longer a hospital. He was directed to Lutheran General Hospital and after arrival at approximately 5:00 p.m., he was seen by the emergency room personnel. The hospital record at 5:17 p.m. states, "presents almost 2 hr after fall from 5 steps onto ground floor. Mech fall after slip on ice. Pt had head inj w loc, ? time of unconsciousness. No amnesia..." A note at 6:00 p.m. stated, "slipped and fell backwards down 5 steps this evening striking his head on the ground and he briefly lost consciousness...Occurred at work. Pt. is requesting an alcohol level be drawn for his job to document that he was not drinking on the job." This testing was negative and there was no indication of any alcohol involvement. Petitioner was diagnosed with a displaced distal radius fracture at the right wrist. Rib fractures were suspected but not confirmed by x-ray. A CT scan of the brain revealed no abnormalities.

On January 3, 2014, Petitioner underwent two surgeries at Good Shepherd Hospital, by Dr. Josephine Mo. The first was a closed reduction with percutaneous pinning and placement of an external fixation for the right distal radius fracture. The second was an adjustment of the fixation and a carpal tunnel release. Mr. Piechovicz has followed-up with Dr. Mo and has had extensive physical therapy. As of October 6, 2014, Dr. Mo had not released Mr. Piechovicz to return to work. She recommended a CT scan to evaluate the articular surface of the distal radius. She also suggested a functional capacities evaluation ("FCE"). Neither of these tests has been approved and Petitioner states that he has been unable to move forward with his medical care.

On July 11, 2014, Dr. Michael Vender evaluated Petitioner on behalf of the Respondents. He diagnosed a comminuted inter-articular fracture of the right distal radius with a carpal tunnel release. He felt there was degenerative arthritis with probably diffuse flexor stenosing tenosynovitis, due to the fall. He felt there were significant residuals for the fracture and that the mechanism of the slip and fall on ice was consistent with the injury. He felt Mr. Piechovicz could do one-handed work, avoiding forceful and repetitive lifting. He felt that Mr. Piechovicz might need intrinsic releases of the digits of the right hand as well as additional surgery on the wrist.

Petitioner's further testimony

Petitioner testified that October 6, 2014, was his last appointment with Dr. Mo and that he has an appointment set for January 12, 2015. He has not been released to return to work. He testified that he feels pain and no strength in the hand. He puts his swollen hand under hot water to open his fingers. He uses a ball for massage of the fingers and compensates by using his left hand.

Upon cross-examination by counsel for E.B. Commercial, Petitioner testified to telephone records from his personal cell phone through Verizon, (847)370-9826 (hereinafter "personal cell") and to his business cell phone supplied by E.B. through Sprint, (847)489-0323 (hereinafter "business cell"). Tr. 9/23/14, pp. 14-36; BP1.

It is undisputed that the business cell given to Petitioner, was used only by him. The Arbitrator finds that taken together, the cellular phone records support a finding that the petitioner's injury may not have occurred on the premises of BPCA; and therefore presents a question as to whether or not the accident arose out of and in the course of Petitioner's employment, on December 24, 2013. The following facts support this conclusion. The petitioner lives in Glenview, Illinois and BPCA is in Arlington Heights, Illinois. On the morning of December 24, 2013, the petitioner was supposed to begin working at 8:00 a.m. The personal cell records show that several calls were made by the petitioner, between 8:00 a.m. and 8:10 a.m. that originated in Glenview; and were to his bank in Niles, Illinois, i.e., the PNC Bank. He testified that his bank opens at 8:00 a.m. At 8:13 a.m., the petitioner made another call from his personal cell that originated from Des Plaines, Illinois, which is the route he testified that he takes to BPCA. The petitioner testified that, on his way to work, he would drive from Glenview, through Des Plaines and Mount Prospect to reach Arlington Heights. At 10:40 a.m., the petitioner placed a call on his personal cell that originated in Elk Grove Village, Illinois. The petitioner explained that the call's origination depended on which tower his cell phone would catch. He agreed that BPCA is very close to the border between Elk Grove Village, Illinois and Arlington Heights, Illinois. BP3.

The business cell records show that the petitioner received calls from Ms. Ayres at 9:51 a.m., 11:28 a.m. and 2:03 p.m., on December 24, 2013. Ms. Ayres' business cell phone number is (847)456-5622. BP1. At 11:55 a.m., the petitioner placed personal cell phone calls from Morton Grove, Illinois, which he testified were to his bank in Niles, Illinois. He testified that he ran an errand at lunch, which took him away from BPCA property. At 12:14 and 12:19 p.m., the personal cell phone records indicate that the petitioner was headed back toward BPCA, as those calls originated in Des Plaines. He placed six (6) additional personal cell phone calls originating in Elk Grove Village, near BPCA, between 12:48 p.m. and 1:27 p.m. The petitioner testified that he made those personal calls from BPCA.

Testimony of Mr. Scott Walczak

Contrary to Petitioner's testimony, Mr. Walczak testified that he distinctly recalled working at his desk at APMC's office in Schaumburg, from 8:00 a.m. to 1:00 p.m., because he had come down with the flue and had a terrible sore throat. He was making minimal calls and went home and was in bed on Christmas Eve and Christmas day. Mr. Walczak testified that he did not speak to the petitioner on December 24, 2013 and did not ask the petitioner or E.B. Commercial to check the boilers or the heaters on December 24, 2013. Mr. Walczak's only communication with E.B. Commercial on December 24, 2013, was an e-mail to Ms. Ayres, requesting certain tasks be performed. None of the tasks listed in the e-mail, included checking the boilers or heaters, or distributing flyers. Mr. Walczak also confirmed that based on the Petitioner's cell phone records, he had not spoken to the petitioner on the phone on December 24, 2013. Transcript of 11/21/14, pp. 18-27; APMCX4; BPCAX1.

Mr. Walczak further testified, in a credible manner, that there would have been no reason to check the boilers or the heaters because they were checked the day before. Petitioner admitted that the boilers

were checked twice a week, on Monday and Thursday. Petitioner checked the boilers and the heaters for all eleven buildings on December 23, 2013, the day before the alleged accident, and they were checked again on December 27, 2013 by Ms. Ayres, according to her testimony. The Arbitrator notes that evidence was presented that indicates that Petitioner did not make any notes or log for any check of the boilers and heaters on December 24, 2013, as is the usual custom. Tr. of 9/23/13, pp. 55-64; EBX1; Tr. of 11/21/14, p. 20.

Scott Walczak further testified that he is the manager for BPCA and that his duties include collecting assessment, paying bills, attending to tenant violations and assisting board members. He testified that he does not enter into contracts on behalf of the property and does not exercise control over the petitioner. He further testified that on the date of the alleged accident, he worked in his office until approximately one o'clock, when he went home. He testified that he never spoke to Petitioner or Eva Ayres. He stated that the boilers were checked on Mondays and Thursdays and that he never asked the petitioner to check them that day. He further stated, after being shown an e-mail message from himself to Eva Ayres that this e-mail was a "to do" list for December 24, for workers at BPCA and that the list did not include checking the boilers. Mr. Walczak stated that he did speak to Petitioner on Christmas day calling him to discuss him falling down stairs the night before, but according to Mr. Walczak's testimony, Petitioner did not tell him where the accident happened.

Upon direct-examination by counsel for BPCA, Mr. Walczak testified that the board of directors of BPCA, ("Board") may suggest vendors to be hired and that he verifies the vendors' insurance policies on an annual basis, which he did with E.B. Commercial, in January of 2013. He denied giving flyers to the petitioner for disbursement on December 24, 2013 and again denied telling him to check the boilers on that date and he testified that he stayed in his office and never with onto the property, on December 24, 2013.

Upon cross-examination, Mr. Walczak testified that he was on good terms with the board members and denied being responsible for the upkeep of the property. He further testified that the Board makes the decisions to hire and fire employees and that he only advises the Board as to how the work is being performed and by whom. He again denied being on the property proper, as he was only in his office and denied that the petitioner ever complained to him about ice forming on the gutters, railings and stairs.

Testimony of Eva Ayres

Ms. Ayres testified that she advised the petitioner a day before, i.e. December 23, 2013, that APMC was closing their office at 1:00 p.m. on Christmas Eve; and that he would likely be able to leave early that day. Ms. Ayres testified that she spoke with the petitioner at approximately 2:00 p.m. on December 24, 2013, and advised him that he could go home, as he confirmed nothing was going on at BPCA. The petitioner's business cell phone record shows that Ms. Ayres placed a call to the petitioner

at 2:03 p.m. on December 24, 2013. Ms. Ayres testified that there was no reason for the petitioner to be on the premises of BPCA after 2:00 p.m., on December 24, 2013. BP1.

The personal cell records show that by 2:34 p.m., the petitioner was making calls that originated from an Arlington Heights cell tower, rather than the Elk Grove Village cell tower closer to BPCA. Shortly thereafter, the petitioner made a call at 2:38 p.m., that originated in Mount Prospect, Illinois. Then, at 2:40 p.m., the Petitioner made a call that originated in Des Plaines, Illinois. At 3:11 p.m., the petitioner made a call that originated from Glenview, Illinois. The petitioner testified that it was possible he was driving away from BPCA; at the time those calls were made. BP1.

The Petitioner's personal cell records show he made calls that originated in Morton Grove at 3:43 p.m., in Skokie, Illinois, at 4:10 p.m. and in Morton Grove at 4:16 p.m. The petitioner explained that he had already left for the hospital. However, this is inconsistent with Petitioner's prior testimony that he was injured at BPCA in Arlington Heights between 3:00 and 3:30 p.m. This is also inconsistent with the testimony of Ms. Wietocha, petitioner's witness, Mr. Scott Walczak and with Ms. Ayres. The Arbitrator finds that the petitioner's personal cell phone records indicate that he left the property shortly after 2:00 p.m. on December 24, 2013; and that his injuries did not arise out of or in the course of his employment by E.B. Commercial.

Testimony of George Pawlukowsky

This witness testified that he is president of the board of directors ("Board") at BPCA and described his role as administrative. He further testified that it is a voluntary position; and that the Board employs vendors, i.e., American Property Management Company and that they have employed this company for approximately eight (8) years. Mr. Walczak has been the designated property manager for approximately three (3) years. He further testified that the vendors are required to "have insurance covering whatever job they're going to be doing for both any damage to the property or themselves." He stated that certificates of insurance are verified by the Board, on an annual basis and that he would see copies of these certificates, on occasion. He stated that E.B Commercial had been doing the maintenance and cleaning duties at BPCA for more than ten (10) years. This witness was shown and asked to identify a liability, insurance certificate dated August 21, 2013 through August 21, 2014, on which E.B Commercial and American Properties are listed as certificate holders. He testified that American Property Management required that E.B. Commercial procure this insurance and that each condominium owner contributes to an account managed by APMC, which is then used to pay for any services needed that do not come under the auspices of the condominium owner. Mr. Pawlukowsky testified that the board members do not have direct contact with E.B Commercial, do not pay Petitioner and have not authorized any Christmas bonus or any other monetary gift to him.

Upon cross-examination by counsel for APMC, Mr. Pawlukowsky testified that E.B Commercial was hired prior to APMC, and the Board had a contract with E.B. Commercial and BPCA, in effect on

December 24, 2013. He also testified that APMC collects assessments on behalf of the condominium association and spends them as required. Tr. 9/23/14 pp. 110-132; BPX2.

Conclusions of Law

As to disputed issue "B", was there an employee-employer relationship between the petitioner and any Respondent, the Arbitrator finds the following facts:

Section 1(a)3 of the Act provides that "any one engaging in any business or enterprise referred to in subsections 1 and 2 of Section 3 of this Act who undertakes to do any work enumerated therein, is liable to pay compensation to his own immediate employees in accordance with the provisions of this Act, and in addition thereto if he directly or indirectly engages any contractor whether principal or sub-contractor to do any such work, he is liable to pay compensation to the employees of any such contractor or sub-contractor *unless* such contractor or sub-contractor has insured, in any company or association authorized under the laws of this State to insure the liability to pay compensation under this Act, or guaranteed his liability to pay such compensation."

First, the evidence indicates that Petitioner was a direct employee of E.B. Commercial. Secondly, Respondent, BPCA entered into a contract with Respondent, APMC whereby APMC was to operate and manage the day-to-day affairs of BPCA on behalf of the Board, including collection assessments, procuring checks to pay BPCA's vendors and utilities, fielding homeowner concerns and monitoring vendors hired by the Board. APMCX3; Tr. of 9/23/14, pp. 107, 110; Tr. of 11/21/14, pp. 8-9; Tr. of 9/23/14, pp. 112, 128; APMCX2.

APMC might supply proposals or quotes from a vendor for the Board's review, but APMC does not enter into any contracts for janitorial services, pool maintenance or other vendors' services for BPCA. Petitioner's job was general maintenance, lights, checking boilers, locks and doors and fixing things that did not require the type of specialty, i.e. plumbing or major repairs, for which the Board would call in other vendors. APMC did not provide any materials, tools or equipment to any of the employees of E.B. Commercial for work at BPCA's property and while it did not instruct E.B. Commercial how to perform its maintenance tasks, it did, at times, suggest what tasks the petitioner should do. Tr. of 11/21/14, pp. 10, 16-18, 30; Tr. of 9/23/14, p. 126.

Thirdly, the evidence demonstrates that APMC did directly or indirectly, request that E.B. Commercial's employee do particular maintenance work, i.e., the faxes and input from Mr. Walczak, telling Ms. Ayres what work needed to be done by Petitioner. BPCA contracted with E.B. Commercial to provide maintenance and cleaning services. E.B. Commercial had been providing maintenance service for BPCA for at least ten years and prior to BPCA's hiring of APMC however, APMC would

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occasionally act in a supervisory role with E.B. Commercial, as one of its duties as property manager. There was evidence presented that BPCA has a paging service for homeowners to call after hours, if there is an emergency; and the paging service contacts E.B. Commercial directly. E.B. Commercial's contract with BPCA allows a set dollar amount for overtime, and if there is a request for overtime, those requests are given to the Board for approval, on a monthly basis. Tr. of 9/23/14, pp. 112, 128; APMCX2; Tr. of 11/21/14, pp. 11-12; 34-40.

APMC is the managing agent of the Board and on occasion, issues work orders to E.B. Commercial for tasks that needed to be done under BPCA's contract with E.B. Commercial; or to address homeowner concerns. If APMC is dissatisfied with the employees of E.B. Commercial or any other contractor, APMC could recommend replacement of vendors. APMC would advise BPCA's Board what issues arose, and it is up to the Board to make a decision to take action. Tr. of 11/21/14, pp. 9-10; 17-18; 40.

Pursuant to section 1(a)3 of the Act, APMC could be liable as a statutory employer if the contractor is not insured for the liability, or has not guaranteed his liability to pay such compensation. Here, it is not clear that E.B. Commercial guaranteed its liability to pay such compensation. George Pawlukowksy, Board President and Scott Walczak of APMC testified that they both checked the certificates of insurance for E.B. Commercial, to ensure everyone was covered. Mr. Pawlukowksy testified that BPCA verified E.B. Commercial's insurance prior to engagement and thereafter on an annual basis. E.B. Commercial produced the certificate of insurance, which shows effective dates from August 21, 2013 to August 21, 2014, which covers the date of the accident on December 24, 2013. The Certificate of Insurance specifically states, "This is to certify that the policies of insurance listed below have been issued to the insured named above for policy period indicated." However, there is currently as issue with the insurance company that has denies coverage for this period. The matter is in litigation, in Circuit Court. BPCAX2.

Misters Pawlukowsky and Walczak testified that the parties reasonably relied on the certificate of insurance; and believed there was a policy of insurance in effect on December 24, 2013; otherwise, there would have been a problem. The Arbitrator finds that while the petitioner is definitely an employee of the Respondent, E.B. Commercial, depending on whether this company had worker's compensation insurance, on the date of accident; Petitioner may also have been a statutory employee of APMC on December 24, 2013, the date alleged on the Application for Adjustment of Claim 14 WC 1127, filed on January 14, 2014.

The Arbitrator finds that Respondents' reliance on the certificate of insurance provided by E.B. Commercial was reasonable. Further, the Arbitrator finds that E.B. Commercial's proffer of the certificate of insurance to APMC and BPCA was effectively a guarantee of its liability to pay such compensation.

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As to disputed issue "C", did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following.

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).
The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also, *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

The Arbitrator finds and concludes that the petitioner has failed to prove, by a preponderance of the evidence, that he sustained an accidental injury that arose out of and in the course of his employment by Respondent E.B. Commercial, on December 24, 2013. In support of this finding, the Arbitrator finds the following facts.

Petitioner was supposed to arrive at work on December 24, 2013 at 8:00 a.m. Petitioner's cell phone records show that Petitioner made calls at 8:02 a.m. and 8:08 a.m. that originated in Glenview and at 8:13 a.m. that originated in Des Plaines, Illinois. Petitioner's home address on December 24, 2013 was 4260 Central Road, Glenview, Illinois. BPCA was located near Algonquin Road and Goebbert Road, Arlington Heights, Illinois. Petitioner testified that he goes through Des Plaines on his route to work, and he passes through Mount Prospect and then to Arlington Heights. Petitioner also made a call at 10:40 a.m. that originated in Elk Grove Village, which he admitted is very close to BPCA. Petitioner said it was possible he was late for work and making calls from his car.

Petitioner made a call at 11:55 a.m. on December 24, 2013, originating from Morton Grove near his bank. Petitioner testified that he ran an errand at lunchtime and was back near Elk Grove Village by 12:48 p.m. Petitioner's cell phone records reflect calls made from Des Plaines at 12:14 and 12:19 p.m. and then from Elk Grove Village at 12:48 p.m.. Petitioner testified that he was at BPCA between 12:48 p.m. and 1:27 p.m., when he made six calls originating from a cell tower in Elk Grove Village.

Petitioner made two calls at 2:34 and 2:37 p.m. from Arlington Heights, which is near Brittany Place. After 2:37 p.m., however, Petitioner's cell phone records reflect calls at 2:38 from Mount Prospect, 2:40 from Des Plaines; and 3:11, from Glenview. Petitioner admitted that it was possible he was driving east, away from BPCA and further agreed that he had calls at 3:43 from Morton Grove, 4:10 from Skokie and 4:16 from Morton Grove.

According to Petitioner's cell phone records, Petitioner was at or near Mount Prospect at 2:38 p.m. and was not near Elk Grove Village or Arlington Heights at any time after 2:37 p.m. on December 24, 2013. Petitioner testified that he fell between 3:00 p.m. and 3:30 p.m. on December 24, 2013. The Arbitrator finds that Petitioner was not at Brittany Place, his assigned work location, and was no longer in the course of his employment with E.B. Commercial at the time of the accident, as claimed by Petitioner.

Ms. Eva Ayres testified that she called the Petitioner at about 2:00 p.m. on December 24, 2013 and advised him that he could go home because the Petitioner advised that nothing was going on and APMC's office was closed at 1:00 p.m. In fact, Ms. Ayres advised Petitioner a few days before that APMC was closing at 1:00 p.m. and he would be able to leave early. Petitioner's business phone records show that Ms. Ayres called him at 2:03 p.m. on December 24, 2013. Ms. Ayres testified that there was no reason for the petitioner to be on the property after 2:00 p.m. Tr. of 11/21/14, pp. 72-75. & BPCAX1.

Mr. Walczak's testimony corroborated Ms. Ayres testimony that there was no reason for Petitioner to be at Brittany Place after 2:00 p.m. Mr. Walczak confirmed that he worked from 8:00 a.m. until 1:00 p.m. Mr. Walczak further testified that the only communication he had with Ms. Ayres on December 24, 2013 was an e-mail at about 10:54 a.m. advising that if the petitioner had a half-hour, he could complete the tasks indicated, otherwise the work order for those tasks could wait until Thursday. None of the tasks listed in the e-mail were urgent.

The Arbitrator notes that the Petitioner's testimony is inconsistent, offers multiple versions of events concerning this accident and lacks credibility. Petitioner testified that he fell between 3:00 p.m. and 3:30 p.m. on December 24, 2013 while going up the stairs from the maintenance office. He testified that he had put light bulbs for the exit lights in his pocket and taken out a small stepladder that he left at the bottom of the stairs because he did not know if he would need it. He testified that at the time of the fall, his business phone rang; he pulled out the phone, went to grab the handrail, and lost his balance. Petitioner testified that when he lost his balance, the battery fell apart from the phone and he broke his wristwatch and glasses. When Eva Ayres went to Brittany Place on December 26, 2013, she did not find a stepladder at the bottom of the stairs or any debris from a broken watch or glasses or other evidence that the Petitioner's accident had occurred.

Petitioner also testified that he tried to put his phone back together but he could not do it because his hand was swollen; and didn't think he was able to make any calls with his business phone after it fell apart. However, he later agreed that he did make calls to his wife and Ms. Ayres, from the business phone when shown his cell phone records and testified that that he did put the battery back in while in the office and it took about ten minutes. Petitioner further testified that he called Ms. Eva from the landline or his private phone after the accident, but admitted later that there was no landline in the maintenance office at Brittany Place.

At 4:28 p.m., Petitioner left a message for his boss, Ms. Eva Ayres, advising her that he had fallen down the stairs, and that Natalia was calling him and heard the whole incident. Petitioner's cell phone records show that he received a call on his personal phone from Natalia, a Ukraine number, at 3:43 p.m., while presumably, in Morton Grove. Petitioner claimed that he was in the maintenance office after the accident when he received the call from Natalia. Petitioner later claimed he was going to the hospital or at the hospital when Natalia called at 3:43 p.m.

Petitioner testified that he drove himself to the hospital near Golf and Des Plaines River Road but there was no hospital there anymore so he drove to Lutheran General Hospital. Petitioner admitted that Golf and River Road was between his house and Lutheran General Hospital. Petitioner's cell phone records are consistent that he was near his home rather than at Brittany Place around 3:00 p.m. when the accident allegedly occurred according to the Petitioner.

When asked about making calls from Glenview at 3:00 p.m., Petitioner testified that he was already in the hospital at that time, yet he testified earlier that the accident occurred around 3:00 p.m. The emergency room records reflect that Petitioner was in Lutheran General Hospital at approximately 5:09 p.m. Petitioner claimed that he did not know how it was that his cell phone records showed he was nowhere near Arlington Heights after 2:30 p.m., and that he was at work. Yet, he did agree that all cell phone calls after December 26, 2013, were from Glenview where he lives. Petitioner further agreed that he had calls at 3:43 from Morton Grove, 4:10 from Skokie and 4:16 from Morton Grove. Petitioner testified that he had already left for the hospital by 3:43 p.m. At the same time, Petitioner also testified that he did not leave Brittany Place until approximately 4:00 p.m., which is inconsistent with his cell phone records and prior testimony.

Petitioner testified that as far as the U.S. government was concerned, he retired in 2013, prior to the accident. Petitioner applied for and collected social security retirement benefits as of June 2013, yet Petitioner continued to work full-time for E.B. Commercial, while receiving social security benefits.

The Arbitrator finds that there is no credible evidence that the Petitioner was involved in an accident between 3:00 p.m. and 3:30 p.m., while working at Brittany Place, on December 24, 2013. The Arbitrator further finds that Petitioner failed to prove, by a preponderance of the evidence, that he sustained an injury that arose out of and in the course of his employment with E.B. Commercial or any other Respondent.

The Arbitrator further finds that the testimony of Petitioner's witness, Joanna Wietocha, lacks credibility. Ms. Joanna Wietocha, a realtor, testified that she became acquainted with Petitioner when she was a former tenant in one of the units at Brittany Place. Petitioner gave her a mail key and did some work in her unit; and she knew she "could count on him as a handyman." Petitioner denied having called Ms. Wietocha on December 24, 2013, but then said it was possible, when his business phone records showed he called her number at 1:10 p.m. He testified that he left a message with greetings for the holidays.

Ms. Wietocha testified she called Petitioner after December 24, 2013, at what she thought was his business number, or the line everyone used that was on a board downstairs [at Brittany Place] if you have any problems with maintenance. Ms. Wietocha testified she still had Petitioner's business card and called him after Christmas. Petitioner called Ms. Wietocha and asked her for help in this case and told her that the woman he was working for did not have insurance; that he has no money right now; and the doctors had to be paid from his own pocket.

Joanna Wietocha testified that on the day of the alleged accident, she parked her car at Brittany Place at 3:30 p.m. on December 24, 2013, to show a unit to a client at 4:00 p.m. She testified that while walking to the building, she saw Petitioner walking toward the parking lot at 3:35 p.m. or 3:40 p.m. Ms. Wietocha testified that the Petitioner told her that he fell walking up the stairs, but she did not see

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him fall and he did not tell her what time he fell. Petitioner testified that he "saw the lady from the realty office around 3:00, 3:30, 4:00 p.m.". Ms. Wietocha stated she offered Petitioner a ride home or to the hospital, but Petitioner said he was going to be fine, so she did not insist because she had her client coming in for the showing. Ms. Wietocha testified that she met her client at 3:50 p.m.

Ms. Wietocha's testimony, however, is inconsistent with the Petitioner's cell phone records, which indicates that Petitioner was not at Brittany Place after 2:37 p.m. As such, Ms. Wietocha's testimony lacks credibility and does not confirm that the Petitioner's accident occurred at the time and place alleged by Petitioner.

As the Arbitrator has found that the petitioner has not proven, by a preponderance of the evidence, that an accident occurred, which arose out of and in the course of his employment, all other disputed issues are moot and will not be addressed.

Zeno Piechovicz
14 WC 1127

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC1127
SIGNATURE PAGE

L Thompson Smith
Signature of Arbitrator

February 3, 2015
Date of Decision

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FEB 4 – 2015

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY ROBERTS,

Petitioner,

16IWCC0575

vs.

NO: 14 WC 01199

CONTECH CONSTRUCTION PRODUCTS,

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 accident, medical expenses, and temporary disablity 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 only with respect to the temporary partial disability benefits awarded. The parties stipulated that Petitioner's average weekly wage when he worked for Respondent was $754.08. The Decision of the Arbitrator properly used that figure to begin calculating Petitioner's temporary partial disability benefits. The Commission finds the Decision of the Arbitrator erred in using Petitioner's as-testified-to current earnings rather than his earnings as reflected in his 2014 W-2.

Petitioner testified that he currently earns $10.00 an hour as a department store Store Protection Specialist and testified to currently working about thirty hours a week. He provided no paystub or similar document that would have provided a true record of the hours he worked. His qualified testimony, combined with the lack of documentation as to the number of hours he

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works on a weekly basis, prevents the Commission from properly ascertaining Petitioner's current average weekly wage.

Petitioner's 2014 W-2, combined with Petitioner's testimony that he has worked at the department store since 2013, allows the Commission to determine Petitioner's most recent ascertainable average weekly wage. He earned, per the 2014 W-2, $12,228.44 in 2014. He worked at the department store, as inferred from Petitioner's 2015 testimony of working at the department store since 2013, for the entirety of 2014. Dividing $12,228.44 by 52 weeks leads to a finding that Petitioner's pretax average weekly wage is $235.16.

Employing the formula as set forth in Section 8(a) of the Act, the Commission finds Petitioner to be entitled to a temporary partial disability award of $345.60 per week. This figure is equal to the two-thirds difference between Petitioner's preinjury average weekly wage and his current average weekly wage.

The Decision of the Arbitrator is, therefore, modified to reflect that Petitioner's temporary partial disability benefits are to be paid at an amount of $345.60 per week.

The Commission leaves undisturbed all other issues addressed in the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $345.60 per week for a period of 92-3/7 weeks, that being the period of temporary partial disability incapacity under §8(a), 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 $3,412.55 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay the reasonable and necessary charges associated with the left carpal tunnel release and left cubital tunnel release prescribed for Petitioner by Dr. Blair Rhode, as provided in Section 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.

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP - 7 2016
KWL/mav
O: 07/11/16
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Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0575

ROBERTS, JEFFREY
Employee/Petitioner

Case# **14WC001199**

CONTECH CONSTRUCTION PRODUCTS
Employer/Respondent

On 10/21/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
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PEORIA, IL 61603

2461 NYHAN BAMBRICK KINZIE & LOWRY
JAMES P TOOMEY
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0575

Jeffrey Roberts
Employee/Petitioner
v.
Contech Construction Products
Employer/Respondent

Case # 14 WC 1199

An *Application for Adjustment 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 **Peoria**, on **August 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. ☒ 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, **September 17, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,212.16**; the average weekly wage was **$754.08**.

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

Respondent shall pay Petitioner temporary partial disability benefits of **$302.72**/week for **92 3/7** weeks, commencing **November 11, 2013** through **August 19, 2015**, as provided in Section 8(a) of the Act

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of **$3,412.55**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary charges associated with the left carpal tunnel release and the left cubital tunnel release prescribed for the Petitioner by Dr. Rhode, 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.

Arbitrator Anthony C. Erbacci

October 16, 2015
Date

OCT 21 2015

FACTS:

On October 15, 2013 the Petitioner was employed by the Respondent as a rivet machine operator and that he started his employment with the Respondent in 2007. The Petitioner testified that his job was to build steel culverts by riveting two-foot sections of pipe together, and that that culverts would be from 8 feet to 50 feet long. He testified that the diameter of the culverts would be from 12 inches to 120 inches in diameter, and 16-gauge to 8-gauge steel thickness. The Petitioner testified that he would use a rivet machine that punched holes into steel and hammered rivets into the culvert, and that he also used hand tools, such as an air binder, a hand binder, a hammer, and a chisel.

The Petitioner described that he used the rivet machine to punch holes in the culvert pipe, and he would then put the rivets into the holes by hand. He would then put the culvert pipe back into the machine, which hammered the rivets. He testified that the process did not always go smoothly, and that the punch could stick in the material and he would need to rock the pipe off or use a small hammer or sledgehammer. The Petitioner testified that he would occasionally have to use a sledgehammer to make sure there was no slack in the sections of pipe when they got attached to the next piece of pipe and that he also had to use a hand spud to pry the cans open.

A CD Rom containing video of the rivet machine being used was viewed during the hearing and the Petitioner testified that what was depicted in the video was essentially the same type of machine that he used in his job and that the operation of the machine depicted was essentially accurate when the operation is going smoothly.

The Petitioner testified that he would perform his rivet machine work eight to ten hours per shift and that he worked from forty-five to fifty-five hours per week. The Petitioner testified that there were no breaks, and that his hands and shoulders were sore at the end of each day. The Petitioner testified that he started to notice numbness and tingling in his hands which was not simply being "worn out." He testified that the symptoms were the same as when he had carpal tunnel syndrome four years earlier and that he told the plant foreman, Bryan Dorsey, about the symptoms in his hands.

The Petitioner testified that he had previously been diagnosed with carpal tunnel syndrome for which he underwent surgery by Dr. Rhode in 2009. The Petitioner testified that he recovered from that surgery and returned to his regular full-duty work on the rivet machines after the surgeries. The Petitioner testified that he spoke with Bryan Dorsey on two or three occasions to let him know his hand condition was getting worse and that both hands were numb and tingling all the time. The Petitioner testified that by October to November, the condition was "really bad." The Petitioner testified that on the day he was laid off, he told Brian Crader that he had already spoken with Bryan Dorsey about his hands and that he was going to get his hands "looked at" during the lay off because they felt the same as the previous time.

On November 11, 2013, the Petitioner presented to Dr. Daniel Hoffman and provided a history of prior bilateral carpal tunnel surgery, repetitive work operating a rivet machine, and pain and numbness in both hands radiating up the elbow since September. Dr. Hoffman noted a positive Tinel's sign at the wrist with normal reflexes and he diagnosed the Petitioner with repetitive carpal tunnel syndrome.

On December 24, 2013, the Petitioner presented to Dr. Edward Trudeau, reporting that he has noticed a repeat of his right upper extremity symptoms in October and notified his employer in November 2013. Dr. Trudeau indicated that he previously performed a bilateral upper extremity EMG on the Petitioner on November 10, 2009 and Dr. Trudeau performed another EMG/NCV of the Petitioner's upper extremities. Dr. Trudeau noted bilateral prolongations and slowing of nerve conduction velocity across the elbow in either ulnar motor distribution, but indicated that other nerve conduction studies were normal. Dr. Trudeau concluded that needle electroneuromyographic examination of the upper extremities was normal. He interpreted bilateral median neuropathies at the wrists that were mild and neurapraxic and he also interpreted bilateral ulnar neuropathies at the elbows, mild to moderately severe on either side, right greater than left.

On January 9, 2014, the Petitioner returned to Dr. Hoffman, complaining of pain and numbness in his hands and elbows. Dr. Hoffman diagnosed carpal tunnel syndrome and cubital tunnel syndrome, and referred the Petitioner to an orthopedic surgeon.

On January 15, 2014, the Petitioner presented to Dr. Blair Rhode complaining of work-related bilateral elbow and wrist pain that began in October 2013. He told Dr. Rhode that he has performed the same job for three years, and that the job is highly manual and repetitive. He reported that his last date of work was November 19, 2013. On examination, Dr. Rhode noted bilateral pain over the palms, bilateral Phalen's tests and cubital tunnel signs at the wrists, and bilateral Tinel's signs. He also noted a positive Tinel's at the right elbow and a positive tennis elbow test on the right, and a positive tennis elbow sign and positive cubital tunnel sign on the left elbow. Dr. Rhode administered a right lateral epicondyle injection and provided the Petitioner with oral anti-inflammatories and bilateral wrist splints, in addition to an elbow splint.

Petitioner returned to Dr. Rhode on January 29, 2014, reporting lateral elbow pain improvement, but continued numbness. Dr. Rhode discussed treatment options, and the Petitioner indicated that he wished to proceed with a repeat left carpal tunnel release and cubital tunnel release.

The Arbitrator notes that the Petitioner continued to see Dr. Rhode on a biweekly basis after January 29, 2014. Dr. Rhode performed identical examinations on each occasion, with the same test results and diagnoses, and he continued to prescribe Norco 7.5/325mg and Mobic 7.5mg.

At the request of the Respondent, the Petitioner was examined by Dr. Michael Vender on May 22, 2014. Dr. Vender ordered an electromyogram and nerve conduction study that was performed by Dr. Scott L. Heller of Lakeshore Neurology, Ltd. on the same date. Dr. Heller found mild residual bilateral median neuropathies at the wrist without active denervation within the right distal median innervated muscles following bilateral carpal tunnel releases. Dr. Heller reported that he found no electrodiagnostic evidence of bilateral ulnar neuropathies across the elbows or the wrists.

The December 1, 2014 evidence deposition testimony of Dr. Vender was admitted into the record as Respondent's Exhibit1. Dr. Vender testified that the Petitioner reported his previous bilateral carpal tunnel releases and indicated that he subsequently was doing well until 2013. Dr. Vender testified as to his examination findings and the findings from the new EMG on May 22, 2014 which he indicated were normal with regard to the elbows and showed mild residuals from the previous carpal tunnel syndrome. Dr. Vender testified that the Petitioner's subjective presentation did

not match the objective findings, and indicated that, in addition to nonphysiologic findings, the distribution of numbness that the Petitioner complained of did not match the findings on electrodiagnostic testing. Dr. Vender testified that he did not believe a causal relationship existed between the Petitioner's complaints and the alleged repetitive trauma to the wrists, as the video demonstrated nonrepetitve and non-forceful hand use. He testified that he did not believe there was any real pathology to the elbows and that there was no significant forceful use of the elbows to be contributory to the elbow condition. Dr. Vender opined that the Petitioner was at maximum medical improvement and was capable of full duty work as of May 22, 2014.

The March 12, 2015 evidence deposition testimony of Dr. Rhode was admitted into the record as Petitioner's Exhibit 7. Dr. Rhode testified that with regard to the alleged October 15, 2013 occurrence, the Petitioner demonstrated positive compressive neuropathies of the wrist and elbow with a positive Tinel's and Phalen's at the wrist and a positive Tinel's at the elbow, along with lateral epicondylar findings. Dr. Rhode testified that he performed a lateral epicondyle injection because the Petitioner demonstrated symptomatology consistent with lateral epicondylitis. Dr. Rhode testified that the EMG findings he reviewed were positive, and that he recommended bilateral wrist and elbow splints, with use of anti-inflammatories and a home exercise program. Dr. Rhode testified that on January 29, 2014, the Petitioner told him he was unwilling to live with his symptoms and wished to undergo a revision left carpal tunnel release and a cubital tunnel release.

Dr. Rhode testified that after a carpal tunnel release, the tissues reform, and a return to the same activities can cause symptom recurrence. He also testified that the Petitioner's pathology could be so advanced that he did not return to the pre-injury baseline. Dr. Rhode testified that he has seen Petitioner as recently as February 23, 2015 and that he sought to obtain a second opinion from Dr. Fernandez. Dr. Rhode testified that he recommended proceeding with a carpal and cubital tunnel release on the most significant side. Dr. Rhode testified that the Petitioner's job exposure as described and the previous incidence of carpal tunnel syndrome met his level for causation on carpal and cubital tunnel syndrome.

Brian Crader, the Respondent's plant manager testified that the Petitioner was under his direct supervision, and that the Petitioner primarily operated the two-man rivet machine. Mr. Crader testified that the Petitioner never told him about work-related injuries to his wrists, elbows or arms between October 2013 and the layoff on November 11, 2013. He testified that that Mr. Dorsey not anyone else at the Respondent ever made him aware of the Petitioner's complaints and that the first time he became aware of the Petitioner's hand and wrist complaints was when he received a letter from the Petitioner's attorney in January or February 2014. Mr. Crader testified that Mr. Dorsey was a more direct point of contact for employees and he denied that the Petitioner came to him before the layoff and reported that he was going to go to his doctor to have his hands checked out.

The Petitioner testified that he currently continues to experience numbness and tingling in his hands with activity as well as some loss of strength. He also testified that he has difficulty sleeping and has symptoms in his forearms. The Petitioner testified that he currently works as a security guard at Ross Stores Incorporated on a part-time basis and that he obtained that part-time job in anticipation of the seasonal layoff which occurred in the winter of 2013. The Petitioner testified that he is paid $10.00 per hour in his current employment and that he now works about thirty hours per week. The Petitioner testified that he wants to undergo the bilateral carpal and cubital tunnel releases

recommended by Dr. Rhode, but that he has no way to obtain the surgery without authorization from the Respondent's insurance carrier.

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:

The Arbitrator notes that Petitioner's testimony at the hearing was persuasive as to the repetitive and forceful nature of his work. The video demonstration of the job activities confirmed that the riveter position required repetitive forceful grasping and repetitive exposure to vibration, especially when the rivets were being hammered in by the rivet machine. The Arbitrator also notes that the Petitioner had previously been diagnosed with carpal tunnel syndrome as a result of his performance of the same job activities for the Respondent. The Petitioner underwent bilateral carpal tunnel releases for that condition and he then returned to the same job duties without restrictions or limitations. After a period of time performing those job activities, the Petitioner again became symptomatic and was diagnosed with carpal tunnel syndrome and cubital tunnel syndrome.

Dr. Rhode, the Petitioner's treating physician, has opined that the Petitioner's condition is causally related to his work activities for the Respondent and that the Petitioner is in need of surgery to address that condition. Dr. Vender, the Respondent's examining physician, opined that no causal relationship existed between the Petitioner's complaints and his job activities, as the video demonstrated nonrepetitve and non-forceful hand use. He testified that he did not believe there was any real pathology to the elbows and that there was no significant forceful use of the elbows to be contributory to the elbow condition. Dr. Vender opined that the Petitioner was at maximum medical improvement and was capable of full duty work as of May 22, 2014.

While the Arbitrator notes the testimony and opinions of Dr. Vender, the Arbitrator finds that the work activities depicted in the video and the description of the work activities provided by the Petitioner demonstrate that, contrary to Dr. Vender's assertion, the Petitioner's work activities clearly required repetitive and forceful hand use. Thus, the Arbitrator finds the opinions of Dr. Vender to be less persuasive than the opinions of Dr. Rhode in the instant matter.

Based upon the foregoing, and having considered the totality of the persuasive credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's work activities did result in accidental injuries which arose out of and in the course of the employment. The Arbitrator further finds that the testimony and opinions of Dr. Rhode are sufficiently reliable and persuasive to satisfy the Petitioner's burden of proving that a causal relationship exists between the Petitioner's work activities and his current condition of ill-being.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that he had previously been diagnosed with carpal tunnel syndrome for which he underwent surgery by Dr. Rhode in 2009. The Petitioner testified that he recovered from that surgery and returned to his regular full-duty work on the rivet machines after the surgeries. The Petitioner testified that after his symptoms returned, he spoke with Bryan Dorsey on two or three occasions to let him know his hand condition was getting worse and that both hands were numb and tingling all the time. The Petitioner testified that on the day he was laid off, he told Brian Crader that he had already spoken with Bryan Dorsey about his hands and that he was going to get his hands "looked at" during the lay off because they felt the same as the previous time. Brian Crader denied that the Petitioner came to him before the layoff and reported that he was going to go to his doctor to have his hands checked out. But he acknowledged that Mr. Dorsey was a more direct point of contact for the Respondent's employees. Mr. Dorsey did not testify.

Again, the Arbitrator notes that Petitioner's testimony at the hearing was persuasive as to the repetitive and forceful nature of his work. The video demonstration of the job activities confirmed that the riveter position required repetitive forceful grasping and repetitive exposure to vibration, especially when the rivets were being hammered in by the rivet machine. The Petitioner had previously been diagnosed with carpal tunnel syndrome as a result of his performance of the same job activities for the Respondent and the Respondent was aware of that previous diagnosis and treatment. It is not difficult to conclude that after a period of time performing the same job activities, the Petitioner again became symptomatic and notified his supervisor of the return of those symptoms.

The Arbitrator notes that the Petitioner's testimony that he told his supervisor, Bryan Dorsey, about his hand complaints was not contradicted or rebutted and the Arbitrator finds the Petitioner's testimony in that regard to be credible and persuasive.

Based upon the foregoing, and having considered the totality of the persuasive credible evidence adduced at hearing, the Arbitrator finds that timely notice of the injury was provided to the Respondent.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

After reviewing the testimony of the Petitioner, Dr. Rhode, Dr. Vender, and Mr. Crader, and reviewing all of the evidence in question, the Arbitrator finds that the medical treatment provided by Dr. Hoffman and Dr. Trudeau was reasonable and necessary, but the medical treatment provided by Dr. Blair Rhode was neither reasonable nor necessary. In reviewing PX 9, the Arbitrator notes that Dr. Rhode is alleging outstanding charges totaling $41,516.69 from January 15, 2014 through June 18, 2014. In reviewing the medical records and the bills, it appears that Dr. Rhode has merely performed examinations on a biweekly basis since January 15, 2014 with one epicondyle injection,

the biweekly dispensing of medication, and the preparation of a hand written work status report. The Arbitrator notes that Dr. Rhode charges $100.00 for the preparation of a work status report, as referenced in his evidence deposition under CPT code 99199, which likely takes less than one minute to complete. The Arbitrator also notes that while Dr. Rhode indicated that the Petitioner insisted on coming in for the biweekly short appointments, the Petitioner testified that Dr. Rhode's office told him to come in every two weeks. These periodic appointments served no purpose other than to "run up" a medical bill on a claim that was disputed by Respondent. As a consequence, the Arbitrator finds the charges of Dr. Rhode to be unreasonable and awards only the following amounts to the Petitioner:

Dr. Daniel Hoffman:	$330.95 (8.2 allowable amount for $400.00 in charges)
Dr. Edward Trudeau:	$1,999.99 (8.2 allowable amount for $2,822.00 in charges)
Orland Park Orthopedics:	$1,081.61 (8.2 allowable for 1/15/14 and 1/29/14 less the 99199 charges for the work statuses)
Total:	**$3,412.55**

Additionally, the Arbitrator orders that the Respondent pay the appropriate fee schedule for the prescription drugs for the J8499 charges on January 15, 2014 and January 29, 2014. No charges other than the foregoing are reasonable and necessary.

In Support of the Arbitrator's Decision relating to (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Having found for the Petitioner on the issues of accident and causation, the Arbitrator finds that the left carpal tunnel release and left cubital tunnel release prescribed for him by Dr. Rhode are reasonable and causally related medical treatment to which the Petitioner is entitled pursuant to Section 8(a) of the Act.

In Support of the Arbitrator's Decision relating to (L.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Petitioner testified that his last day of work for the Respondent was November 8, 2013 and the evidence indicates that he was laid off on or about November 11, 2013. The Petitioner began his course of treatment on November 11, 2013 when he saw Dr. Hoffman. The Petitioner testified that subsequent to his layoff by the Respondent, the Respondent called him back to work but could not accommodate his then current restrictions. There was no testimony as to when that call back occurred. There was also no testimony as to what those restrictions were or when they commenced. The Petitioner testified that, in anticipation of the layoff, he had obtained part time employment as a security guard and that he maintained that employment through the present time. The Petitioner testified that he earns $10.00 per hour in his current employment and that he works about thirty hours per week.

As the Arbitrator has found for the Petitioner on the issues of accident and causation, the Arbitrator finds that the Petitioner is entitled to Temporary Partial Disability benefits commencing on November 11, 2013 and continuing through the date of hearing. The Petitioner's average weekly wage was stipulated to be $754.08 and the Petitioner is currently earning $300.00 per week, resulting in a diminution of earnings in the amount of $454.08. Thus, the Petitioner is entitled to Temporary Partial Disability benefits of $302.72 per week ($454.08 x .666 = $302.72) from November 11, 2013 through August 19, 2015, a period of 92 3/7 weeks.

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 UP	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON B. GARRETT,

Petitioner,

16IWCC0587

vs.

NO: 14 WC 3167 & 15 WC 18366

LIBERTY MUTUAL GROUP, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) of the Act having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, permanent partial disability, medical expenses both current and prospective, and the Arbitrator's denial of Petitioner's Motion to Consolidate Petitioner's claims 14 WC 3167 and 15 WC 18366, and being advised of the facts and law, supplements 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.

Initially, the Commission notes that the Arbitrator provided a very detailed summary of the issues presented. As noted above, her decision is attached to and made part of this decision. In addition, the Commission is not changing the ultimate outcome of her decision. Therefore, an extremely detailed account of the issues of Petitioner's current condition of ill-being is not required in this decision. Finally, in this decision, the Commission only addresses the issues of accident/causation and the denial of the consolidation of claims. Accordingly, the Commission will analyze Petitioner's medical treatment only as it relates to the issues of accident and causation.

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Findings of fact and Conclusions of Law

1. Petitioner called Lisa Raydant who testified she worked for Respondent for 20 years and that she "quit" on July 31, 2012. From 1998 to 2006 she was Service Manager in the Springfield area, from 2006 to 2008 she was Assistant Regional Service Manager, and she was Branch Manager from 2008 to 2012. Ergonomic assessments were made for new employees, transferred employees, and were performed periodically thereafter. As manager she performed these assessments. She was given a form to follow but otherwise had "pretty much" no training.

2. Ms. Raydant knows Petitioner, eventually became his immediate sales manager, and supervised him. Petitioner told her that he was having issues with his back. She did not remember exactly when he first mentioned it, but she visited him in his home office in 2009; "his knees were up around his ears." "He is a very tall guy and it didn't look like he was set up correctly as far as that goes. His monitor was too low for him so [she] did get monitor risers for him." The form she used indicated the monitor should be at eye level and Petitioner's was not. He was "twisted" and leaning forward when she was there. The desk was not adjustable. Petitioner was the only sales representative working from home because Respondent closed its Springfield office.

3. "Lead days" are days a sales representative is assigned to follow-up on leads from the internet on an as soon as possible basis. Not responding to leads on a timely basis caused problems. Each representative would get one lead day per week on a rotating basis. The representative would start at 8 am and was pretty much tied to their desks to get the leads and respond to them. If a representative did not respond quickly he/she would eventually be removed from the program and it generated a lot of commissions.

4. On cross examination, Ms. Raydant testified she never worked for Respondent as a sales representative; however, she did often accompany them on appointments and watch them work in the office. She did not have free access to Petitioner's home. She talked to Petitioner about his knees being around his ears and the way his head was looking at the low monitor, but did not recall talking to him about being twisted. On lead days, Petitioner would have been able to stand or sit as desired. She was only at Petitioner's home twice, once in 2009 and once in 2011.

5. On redirect examination, Ms. Raydant testified the 2 times she was at Petitioner's home she was there about three hours each. She never did an ergonomic assessment on Petitioner. She assumed he had been so assessed when he moved into the home office.

6. Petitioner called Alysha Davis-Barth. Ms. Davis-Barth testified she is a physical therapist. She has an M.A. and Ph.D. in physical therapy. She has performed about 25 to 30 ergonomic assessments. To the best of her knowledge no particular licensing is needed to be able to perform an ergonomic assessment.

7. Ms. Davis-Barth was provided a packet including photos of Petitioner's work space, an ergonomic assessment performed by an occupational therapist, and depositions of that therapist as well as those of Dr. Payne and Dr. VanFleet. She noted that the photos showed that Petitioner had to rotate to the left in order to use the keyboard and see the monitor; there was no leg space to the left to allow his chair to turn, there was not sufficient clearance for his legs to go underneath the desk so he had to push his chair back requiring him to lean forward to reach the keyboard, and Petitioner's shoulders were angled left and his hips and knees were pointed straight forward resulting in torsion or twisting of the trunk while working at the station.

8. Ms. Davis-Barth explained that "forward flexion and torsion causes an increased pressure on the discs and a breakdown of the static protective tissues around the spine and discs." If the protection of the spinal structures fails the disc can herniate. Numerous studies have found that flexion and rotating both increase inter discal pressure and "the combination of those compounds the increase in pressure." It also opens the facet joints reducing their protection and leaving discs more vulnerable to herniation. Sitting causes significantly greater pressure on the disc than standing. She characterized the ergonomic of the work station as "poor" on a scale commonly used in occupational therapy that includes rating of poor minus, poor, and poor plus. Repeated exposure to a poor ergonomic work place accumulates over time.

9. On cross examination, Ms. Davis-Barth testified she did not perform an ergonomic assessment of, and did not see, Petitioner's workplace. She did not go to his home and did not observe other chairs that were there. Petitioner approached her and hired her to perform an ergonomic evaluation. She talked with Petitioner about his job activities for about 20 minutes. She knew that Petitioner was diagnosed with a herniated disc and that what she observed of his work station could have led to a disc herniation. It appears from the photos that Petitioner could have moved his computer to the right on his desk. Ms. Davis-Barth was not aware of any studies that have evaluated body habitus and the onset of disc herniation. Greater height and weight would probably put more pressure on discs; however, skinny people may be susceptible because of lack of muscle structure. Strengthening the muscles can help prevent disc injuries.

10. On redirect, Ms. Davis-Barth testified she understood that the onset of the herniation occurred when he started to get up from his chair after working in that chair for seven years. She would not trust an ergonomic assessment performed over the telephone. She opined that "prolonged sitting in the flexed and rotated position" caused the disc herniation. Somebody in such an awkward position for extended periods of time for a number of years "is much more likely to herniate a disc than somebody who has not been in poor posturing and just stood up from a chair."

11. Petitioner testified he worked for Respondent since September 27, 1997. He started as personal sales representative and was promoted to resident sales representative in 2005.

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12. In late 2006 he was asked whether he wanted to continue to work for Respondent from a home office. He dedicated a room in his home as an office and had to send pictures of the set up to Respondent. He bought the house in 2006 and the desk was already there. The docking station and chairs were sent to him by Respondent. Nobody from Respondent helped him set up the office.

13. Petitioner also testified his job was "quite diverse." He went out to solicit clients, petition existing clients, and service existing clients. Mainly he was responsible to acquire new business for Respondent. Lead days were important for all sales representatives. After they closed the Springfield office Respondent instituted lead days in which all leads generated in a certain day were sent to a single agent. He started working leads exceptionally early because leads could be generated the night before. August 29th, the date of the alleged accident, was his lead day.

14. On that day he started probably between 7:30 and 8 a.m. He worked until he was injured between 3:30 p.m. and 4:30p.m. It was a busy day and he was at his desk the entire day prior to his injury. He got up to use the restroom once. His wife brought him lunch because he was on the phone. While he was on the phone he would be imputing data at the same time. He had to twist his body to the left to access the computer and lean forward to talk to the client. He was "always twisted" the entire day. He could not move the monitor because there was no room due to the extensive paperwork. He was not aware of the risk he was in. Petitioner began to have back pain early in the day, but it progressively got worse. At one point he needed to get some paper and could not get up because of intense pain in his back and left leg. His wife had to help him get up.

15. The accident was on a Thursday. He stayed in bed all day Friday. On Saturday he was traveling with his wife to Marion. He was lying flat in the passenger seat. When they arrived, Petitioner went to bed but could not get any sleep or rest because of the pain. He drove to an ER at about 1 a.m. It was only about three miles. They administered injections and Petitioner's wife had to come and pick him up.

16. Petitioner followed up with Dr. Payne, who performed surgery. The surgery helped him stand straighter and walk better. After he was weaned off pain medication, he noticed a lot of pain down the left leg; it was weak and would give out nearly daily. He still has that issue. He was going up stairs and his left leg gave out. He twisted to grab the handrail and injured his back again. He had a second surgery.

17. Petitioner further testified he began to have problems with his back related to the chair shortly after he started working from home. He had no such problems when he was working in the office. He informed Respondent that the chair was hurting his back by e-mail dated August 7, 2007. They sent a technician to replace the hydraulic ram on the chair. That repair did not alleviate his pain.

18. By e-mail dated November 14, 2006, he had asked to have the chair he used in the office sent to his home. That chair had been specifically ordered for him after an ergonomic assessment. Respondent performed two ergonomic assessments; one at the Springfield office and one at his home after the injury. He asked Lisa Raydant for an in-person assessment in late 2010 because his back was hurting and that he thought it was related to his desk and chair.

19. Petitioner believed he began to treat for his back in 2011, he thought with his principle care physician. He later treated with Dr. Western, who administered ESIs at L5-S1. He felt better after the injections, but he "took it easy" nevertheless. He was later diagnosed with a herniated disc at L2-3 for which he had a discectomy.

20. The Sunday before his injury, Petitioner gave a eulogy in Marion, which was probably a 2 hour 45 minute drive each way. The drive and standing to give the eulogy did not cause problems with his back.

21. Petitioner last worked on September 27, 2013, which was the date of the first surgery. He had scheduled it for that day so he could finish up his work for the quarter. He cannot perform his previous job because sitting, standing, and walking are all painful.

22. On cross examination, Petitioner agreed that he began to have back problems in 2007 and saw a chiropractor prior to seeing Dr. Payne. He did not remember whether he previously discussed with doctors the cause of his back complaints. He agreed that on November 2, 2011, he reported to Dr. Payne that on June 1, 2011 he injured his back golfing. There was an MRI taken shortly after that visit. Dr. Payne was the doctor who referred him to Dr. Western.

23. Petitioner denied that when he moved to his home office he was either offered a desk or had the opportunity to request a desk from Respondent. He set up his home office. He agreed that he sent an e-mail to a representative of Respondent indicating that he had a desk he could use. He was responding to a query whether he had a desk. He did not recall sending an e-mail asking for a new desk. He also did not send any e-mails about his chair after 2007.

24. Petitioner testified he himself performed two ergonomic assessments while office operations manager in 2005, but he is "not even close" to being familiar with the process of those assessments. He requested an ergonomic assessment from Ms. Raydant, but did not get one. He requested the assessment by phone and not e-mail. He had a telephone conversation with Rachel Weygandt regarding an ergonomic assessment.

25. On redirect, Petitioner testified he complained about his chairs on dates other than those memorializes by e-mails. He had no training in performing ergonomic assessments and he would simply fill in information on a form.

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26. After he attended the doctors' depositions he referred to the treatment notes and found them "incomplete or there was an assumption made by the doctor and that's what he reported as fact."

27. On re-cross examination, Petitioner testified that although he attended the deposition of Dr. Payne he did not attempt to correct the medical records because he "wouldn't know the first thing about doing that."

28. On re-redirect examination, Petitioner testified that Dr. VanFleet was incorrect when he reported that Petitioner said he was injured while working at his desk in 2011; at that time he was injured swinging a golf club. He told Dr. VanFleet that he was working in his office since 2011. Dr. Payne was incorrect in stating he hurt his back getting up; it hurt throughout the day.

29. Monica Garrett, Petitioner's wife of 24 years, testified Petitioner did not have problems with his back before they moved into their current residence in 2006. Petitioner looked uncomfortable at the desk; he could not get his legs underneath the desk so he had to reach across the desk and to go back and forth to his computer continuously. Petitioner had back problems prior to "the 29th" but "he was fine. He had some kind of a back shot and it seemed to help a lot."

30. "On the 29th" she was working and Petitioner told her he was very busy and to try not to disturb him. She went up there to ask if he wanted lunch; she made him grilled cheese. She delivered it and returned downstairs to continue working. Later, "he hollered down for" her. He was sitting at his desk and said he could not get up. She helped him get into bed and he stayed there through the next day. When they returned to Marion, she did not want Petitioner to stay alone due to his medications. He sat flat on the passenger side. When they arrived at Marion he laid down on her mother's bed.

31. Rachel Weygandt was subpoenaed by Respondent for which she worked from October 2012 to April 2015; she currently worked for another insurance company. She was administrative assistant for Brittany Brickmann, who was Petitioner's supervisor, and who trained the witness how to perform safety assessments. Ms. Weygandt also took some tele-courses with Respondent's ergonomics expert. She was "deemed a safety specialist for the office." She conducted safety assessments per Respondent's policy.

32. Ms. Weygandt conducted a work station assessment regarding Petitioner on April 25, 2013. In such an assessment she was to go over the proper procedures to maintain the desk and the way things should be situated to have a safe environment. On the form, employees are informed that if they notice anything unsafe they should report it to their managers or the witness. Her assessment of Petitioner's station was unique because it was done over the phone. She cleared that procedure with her boss.

33. Ms. Weygand believed Petitioner was provided a form to follow. She filled out the form completely based on Petitioner's responses to the questions in the form. It is similar to the procedure when she is with an employee in person. She sent Petitioner a copy of the form as completed.

34. Ms. Weygandt remembered this particular assessment because of the uniqueness of the circumstances. She specifically remembered reiterating the last element noted in the form that if there was anything noteworthy concerning his work station he should bring it to their attention. She did this to be sure he fully understood because she did not have much interaction with Petitioner. He did not mention any such thing then or at any time before she left Respondent's employment. During the process Petitioner did not mention any back/leg pain, or problems with his chair/desk/monitor. She did not believe any more formal evaluation was necessary because Petitioner "was always very forthcoming with anything that he needed" and if he needed something he would have mentioned it. If he had expressed any problems she would have worked to correct them.

35. On cross examination, Ms. Weygandt testified she did not ask Petitioner any questions that were not on the form because she did not believe they were necessary based on his responses. She did not see the workstation or take any measurements of it.

36. Brittany Brickmann was called by Respondent for which she works as senior territory manager. Before May 2015, she was senior branch manager managing the Geneva and Peoria offices. She was Petitioner's supervisor when she managed those offices from July 2012 to May 25, 2015. The Springfield office was closed by then. She took over that position from Lisa Raydant.

37. Besides her training, Ms. Brickmann had numerous ergonomic assessments because she moved to many different locations. She also assigned her assistant, Ms. Weygandt, to perform ergonomic assessments. Petitioner reported that he was receiving back treatments in 2013, but he did not report any work injury, indicate his condition was related to his office equipment, or ask for an ergonomic assessment at that time. Later he told her he thought it was related to his work station but he did not want to file a claim; he simply wanted to get his condition taken care of. She referred him to human recourses. Ms. Brickmann also testified that Petitioner could "absolutely" have come to her with any ergonomic problem. There were discussions via conference calls about the means of reporting ergonomic problems.

38. Petitioner never asked for a new chair or desk. He did ask for an ergonomic assessment to see if he needed a new chair after the alleged date of accident. Part of Ms. Brickmann's work duties included providing office equipment. If there were a request for new furniture, it would be something she could help with. Ms. Brickmann identified an e-mail she sent on August 31st. In it she mentioned that Petitioner reported his back was uncomfortable, but there was no indication that he reported a work injury.

Vacuum

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39. On cross examination, Ms. Brickmann agreed that in her training by Respondent she was taught that ergonomic assessments were important. A reason they are important is to set up an ergonomic environment to prevent injuries. When Petitioner reported his back hurt on August 30th he indicated he thought it was because of the setup of his workstation.

40. Petitioner testified in rebuttal that the telephone ergonomic assessment performed by Ms. Weygandt took no more than two-three minutes and he clearly told her that he had to twist his body to the left to access the computer. His home workstation had always been set up that way. He did not sign or even see the assessment performed by Ms. Weygandt. The only one he saw and signed was the one done when he worked in the Springfield office. In her assessment she indicated that the requirement that the keyboard and monitor be centered with the employee's body so that the employee did not have to move from side to side, were met.

41. On cross examination, Petitioner testified that he was not aware that his monitor was badly positioned because he knew nothing about ergonomics; his job was to sell insurance and service customers. He sent pictures to Respondent and heard nothing back. He became aware the monitor should be moved only after a 3rd party assessment.

42. Ms. Weygandt testified in surrebuttal that her telephone ergonomic assessment took about 15 minutes; "you can't go through that any less than that." During that assessment, Petitioner never told her he had to bend and twist in the chair. On cross examination, Ms. Weygandt testified that she sent Petitioner a copy of the completed form. However, none of the workplace assessments have to be signed either by her or the employee.

43. The medical records reveal that on November 4, 2011, Petitioner presented to Dr. Payne, who knew Petitioner for a long time trap shooting across Southern Illinois. Petitioner was 6'6" and 365 lbs. He reported left sciatica for about four months. He remembered a golf swing in which he felt immediate pain and he gradually felt the onset of the sciatica. He was able to take Ibuprofen and referee high school varsity soccer games. He had been to a chiropractor which was somewhat helpful.

44. Dr. Payne noted positive SLR and ordered an MRI and ESI. X-rays showed moderate to severe diffuse degenerative changes most prominent at L4-5 and L5-S1. The MRI showed multilevel degenerative disc disease, superimposed on multilevel congenitally short pedicles, resulting in severe left neuroforaminal stenosis at L4-5 secondary to disc extrusion. In December 2011, Dr. Western administered an ESI at L5-S1 after evaluation.

45. Petitioner returned to Dr. Western on May 6, 2013. He had done quite well after the injection in December 2011. He reported the return of pain, which Dr. Western thought was similar to what he had in 2011. He reported a high pain level. SLR was positive of the left and negative on the right. Dr. Western ordered another ESI at L5-S1, which was performed on May 9th.

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46. Petitioner returned to Dr. Western on May 13th and reported no benefit from the latest injection. Petitioner reported no new issues or injuries. Dr. Western prescribed Gabapentin, prednisone, Flexeril, and a new MRI.

47. The new MRI showed mild endplate osteophyte and small left lateral disc protrusion causing moderate neural foraminal stenosis at L4-5. However, the principle pathology noted was a large left post-lateral disc extrusion at L2-3 compressing the L3 nerve root

48. Petitioner's condition continued to worsen. On September 3, 2013, Petitioner reported a sudden worsening of his pain over the weekend. "He was just sitting at his desk on Friday doing a lot of work on the computer when he stood up, sudden pain worsening, left lower extremity radicular pain." He could not stand straight or find a position that relieves the pain. He was on the verge of being admitted for pain control. Dr. Payne ordered a "STAT MRI" and would schedule surgery ASAP. The MRI showed interval worsening of L3 nerve compression and additional chronic degenerative changes. Dr. Western administered another ESI at L3-4.

49. On September 12, 2013, Dr. Payne noted that Petitioner's L2-3 herniation was much larger with inferior migration of his fragment, which means he would have to take off a fair amount of L3. Petitioner's symptoms were still severe. Dr. Payne performed L2-3 laminectomy/microdiscectomy for herniated disc and spinal stenosis on September 30, 2013.

50. On October 17, 2013 – Petitioner was doing "really good" two weeks postop. Petitioner "was concerned about going to work because he has to sit for long periods of time and that seems to be what aggravated it before so he would like to be off work until the next visit." This notation appears to be the first mention in the medical records of Petitioner complaining that sitting at work aggravated his condition.

51. About a month later, Petitioner reported continued dull thigh pain and a lot of axial back pain, worse while sitting. He "can only sit in the chair for five minutes." Dr. Payne ordered physical therapy and a new MRI to check for residual/recurrent disc. The MRI showed only postop changes and thoracolumbar degenerative changes.

52. On December 26, 2013, Petitioner still had axial and left radicular pain. Petitioner talked "more about his radicular pain, how it started after at the end of the day he had been at his desk for seven or eight hours leaning forward, working at a computer, *etc.* When he got up to leave he could not stand straight." Dr. Payne noted that leaning forward in a chair is a position that puts some of the greatest pressure on discs. He then opined "obviously he has had herniation there before and problems with his back, but those have resolved without surgical intervention. Clearly, before we did surgery, he had a very significant change in disc herniation in the lumbar spine, so [he thought] there is a link there between the seating position at work and his back problems."

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53. On January 16, 2014, Petitioner presented to Dr. Payne because he had to go into work for a while to set up his office. "They were getting him a new chair and a new desk. He was sitting there for a couple of hours, and all of the pain came rushing back. He has pain in the left leg again." Petitioner thought his symptoms were bad enough to warrant a new MRI, which Dr. Payne ordered.

54. On February 6, 2014, Petitioner reported that when he got out of his car the previous week he felt a severe/sharp pain that "almost knocked him to the ground. "He went in to his job to set up his new chair and desk and had severe back pain after one hour work." Dr. Payne diagnosed worsening left leg radicular pain and again noted they needed a new MRI. The MRI appeared to show no change at L2-3, stable foraminal protrusion at L4-5, and mild degenerative stenosis secondary to bulging protrusion at T12-L1.

55. Petitioner continued to treat with Dr. Payne but showed little improvement. On September 11, 2014, Petitioner returned to Dr. Payne reporting a new problem. He was going up stairs two days ago when his left leg gave out. He twisted to grab the railing and "kind of fell down the stairs." He had very bad axial back pain which was worse than he ever had before. His leg was "a little worse." Dr. Payne ordered a new MRI. The MRI showed multilevel degenerative changes most notably at L2-3 with a large central disc protrusion with subarticular extension causing severe central canal stenosis. There was also multilevel moderate to severe neural foraminal encroachment and mild central canal stenosis at T12-L1.

56. Petitioner did not improve with conservative treatment for the recurrent herniated disc. On December 22, 2014, Dr. Payne performed laminectomy at L2, transforaminal interbody fusion L2-3, posterior fusion L2-3, with instrumentality and bone graft for recurrent disc herniation at L2-3 and spinal stenosis.

57. Dr. VanFleet testified by deposition on June 25, 2014. He examined Petitioner on March 12, 2014, reviewed medical records, and issued a report. Subsequently, he was provided additional MRI films and issued an addendum report. Dr. VanFleet recited the history Petitioner reported. He had low back pain in 2011 after sitting for a long time. He was treated with injections and Ibuprofen and it resolved. He had a recurrence in August 2013. He was sitting in his chair by his desk for a long period of time and as he stood up he had significant pain across the back and down into his left leg. Petitioner eventually had surgery at L2-3 and had minimal improvement of back pain, but still had pain down the left leg. He required Gabapentin and Flexeril and was still not able to work.

58. On examination Petitioner was 6'6" and 380 lbs, and with a BMI of 46.3; he would be considered morbidly obese. He had difficulty with both flexion and extension. Reflexes, strength, and sensation were normal; he had no neurological deficit. He viewed an MRI from February 18, 2014 which noted postsurgical changes, degenerative disc disease at L2-3, and no focal neurological compression at L4-5 or L5-S1.

59. Subsequently he viewed MRI films from May 21, 2013 and November 27, 2013. The May MRI showed the very large left-sided extrusion at L2-3, but the previously noted disc extrusion at L4-5 was not evident. The diagnostic studies showed that Petitioner had long-standing lumbar degenerative disc disease prior to the instant injury. Morbid obesity is a contributing factor in degenerative disc disease. It has a significant impact in terms of degeneration and rate of degeneration as gravity puts greater pressure on the discs because of the additional mass. There could also be a genetic factor.

60. Dr. VanFleet opined that the incident of August 29, 2013 as Petitioner described did not contribute in any way to Petitioner's preexisting degenerative disc disease. "The fact that somebody is sitting or standing during the course of the day, it doesn't matter where they are, if you happen to have it at work." The preexisting condition was "the most important determinant in developing this condition." The simple act of sitting in a chair without motion would not cause a disc prolapse.

61. It was Dr. VanFleet's understanding that the onset of back pain occurred as Petitioner got out of a chair. That "certainly could" change the pressure on the spine. The movement would cause a change in intradiscal pressures, and which disc is involved could be dependent on how the person bends. The mechanism of getting out of that chair should be no different from that of getting out of a dinner table chair. Dr. VanFleet did not recall Petitioner indicating there was any defect in the chair.

62. On cross examination, Dr. VanFleet testified he did not remember whether he reviewed an ergonomic assessment. In all likelihood if he reviewed one he would have mentioned such in his report. He did not see any photographs of the workstation. He had no information about any complaints of his sitting position or workstation. Dr. VanFleet did not denote any dishonesty on Petitioner's part, and if he had he would have mentioned it.

63. Dr. VanFleet conceded that if Petitioner were leaning forward while seated such a position could lead increased intradiscal pressure because of gravity and body mass. Petitioner's obesity would also be detrimental in that respect. Workstations would have more detrimental effects on the cervical spine as opposed to the lumbar spine. Manual workers tend to have more lumbar rather than cervical conditions.

64. Dr. VanFleet was aware of the study of Alf Nachemson, who did a classical study on intrathecal disc space pressures. If he remembered correctly there were four positions which ranged from least to greatest disc pressure: (1) supine; (2) standing upright; (3) sitting; and (4) sitting and leaned forward holding weights.

65. Erin Steinacher testified by deposition on September 16, 2014. She had been an occupational therapist for three years and has an M.A. in occupational therapy and an M.A. in body ergonomics. She was asked to perform an ergonomic assessment at Petitioner's home.

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66. Ms. Steinacher noted that she thought the desk was too low for Petitioner to fully fit underneath the desk because he was 6'6". In addition, there was "a cabinet built into the desk where it went all the way in. He could not put his feet properly all the way underneath the desk without having to be out a little bit so his legs fit under there."

67. Petitioner's knees were above 90 degrees which puts more pressure on the hips, and he did not have a keyboard area so he had to put his arms up and over the desk and have his wrist extended. Because of the position of the computer, he had forward flexion of his neck, low back, and upper back.

68. The positions she observed are not recommended ergonomically; they can cause strain on the neck, back, and spine if experienced for prolonged periods. His shoulders should be over his hips. There was a small lumbar support in the chair, but she did not believe it was sufficient to have him sit straight with the proper lumbar curvature.

69. Ms. Steinacher recommended risers to lift the height of the desk or a new desk, a higher chair because his hips would still be too low, and another lumbar support. On questioning about twisting and turning, Ms. Steinacher indicated the twisting/turning was not a problem; it was the body position itself which causes problems.

70. When Petitioner sat at the station he "looked crunched," and "definitely more flexed in every direction." 12 of the 14 positions she checked were not optimal. She rated the workstation as "fair minus." She thought the most egregious aspect was the inability of Petitioner to get his legs completely underneath the desk to be able to move closer to the desk.

71. On cross examination, Ms. Steinacher testified that she was under the impression that Petitioner "had a back surgery that was due to stress over time." She did not need any medical background to perform an ergonomic assessment. She did not review medical records. She had no idea who set up the work station or who was responsible for its maintenance.

72. The desk was standard and did not appear to be in any state of disrepair. She did not believe the chair was defective. Petitioner could get up and stretch, but he may have had difficulty when he was on the phone because of the cord. He made it sound like he was on the phone 2/3 of the time. There is no rating below poor, such as a poor minus.

73. Dr. Payne testified by deposition on February 19, 2015. He had known Petitioner socially for a long time trap shooting together and as a patient for about five years for treatment of his back. Petitioner sold insurance and spent long hours working on a computer and had been working at home for seven years.

74. Dr. Payne saw pictures of the home office and they discussed his sitting position and how he spent "a lot of time at his desk turned to the side in a flexed position." That can exert detrimental "pressures in the low back and stuff." Twisting causes some fibers in the annulus to become tense and others to become lax, "and it's thought that that predisposes to herniation." There are anatomical studies about orientation of fibers and where they are stressed; the greatest pressure was caused sitting flexed forward at the waist. However, Dr. Payne did not "know of any study that describes a certain position where people have more disc herniations."

75. When he saw Petitioner in June 2013, Petitioner was being treated for a L2-3 herniation, with anti-inflammatories and ESIs were considered. He did not want to have surgery at that time. When he saw Petitioner on September 3, 2013, "he was significantly worse;" so much worse that he was "basically teetering on the edge of needing to be admitted to the hospital for pain control." The aggravation of symptoms began while sitting at his desk. His pain progressively worsened during the long day working at his desk.

76. In looking at a new MRI, Dr. Payne "thought his disc was a lot bigger," and was the cause of Petitioner's increased pain. Dr. Payne performed laminectomy/discectomy surgery in September 2013 because of "the bigger disc." After that surgery, Petitioner continued to have leg pain. A new MRI showed a recurrent disc herniation at L2-3, so he performed a second surgery, a fusion, in 2014.

77. Dr. Payne indicated that the initial herniation caused a weak point in the annulus which made the new herniation more likely. Dr. Payne agreed that it was fair to say that "the injury he sustained sitting at his desk was a factor in the fusion." Dr. Payne opined that the way Petitioner was sitting in his chair was a "bad ergonomic position." L2-3 is in the upper lumbar spine and upper spine surgeries comprise less than 5% of the discectomies he performs. However, he did not think that Petitioner's sitting position had anything to do with the fact that the herniation was in the upper rather than lower spine.

78. On cross examination, Dr. Payne testified there are various causes of herniations including simply normal degenerative processes. He thought that when he saw him in 2011, Petitioner related his back pain to golf. Such activity can cause a disc herniation. He ordered an MRI at that time. It showed a mild diffuse disc bulge with mild central canal stenosis but no significant neuroforaminal stenosis at L2-3. "A disc bulge is kind of a normal middle-age finding." He really did not consider that finding abnormal for a 40 year old. Dr. Payne agreed that it did show that there was "something going on there."

79. Dr. Payne also testified he reviewed previous medical records. He agreed that on May 1, 2013 Petitioner complained of radiating radiating into the left leg to his principle care provider, who referred Petitioner to Dr. Western. Dr. Western's May 6, 2013 note did not indicate a mechanism of injury. He ordered an MRI which showed the large disc herniation at L2-3. Dr. Payne thought that condition caused Petitioner's radiculopathy.

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80. The disc had worsened from 2011 to 2013 from a disc looking middle-aged to one with a large herniation. Dr. Payne had no documentation that Petitioner reported a mechanism of injury when he saw him on June 4, 2013, but he reported he gave up his refereeing of soccer, an activity which could cause of aggravate a herniation.

81. When Dr. Payne saw Petitioner on September 3, 2013 he reported a sudden worsening of his symptoms after moving from a sitting to standing position. Such an action may or may not place greater stress on discs. The act of getting up from a chair could be the same as getting up from a toilet or dining room chair. The act of rising from a seated position would be the same. He and Petitioner talked about Petitioner's work station on several occasions but Dr. Payne could not remember the exact dates.

82. On redirect examination, Dr. Payne testified he thought Petitioner's work station was terrible; the forward flex with a twist is the worst position for the back. He thought Petitioner herniated his disc while sitting and it got more painful when he put traction on the nerves.

83. On re-cross examination, Dr. Payne testified that people who sit in a terrible position sitting at a desk leaning forward do not automatically develop a herniated disc. One can herniate a disc while standing up. According to his notes Petitioner noticed the aggravated pain when he stood up.

84. Petitioner also submitted into evidence published articles. The article *Low Back Pain Development Response to Sustained Trunk Axial Twisting* in the 2013 European Spine, investigated the issue whether sustained axial truck twisting has an effect on the development of low back pain. The results appear to support such an association.

85. The finding in this 2013 study appeared to be mostly muscular in nature. However, it was also written: "It is not clear which of the viscoelastic tissues were active and underwent creep in their investigation. The facet capsule may be one of the major tissues, since facet joint is thought to be served as a critical component to resist the torsion during axial truck twisting. Each of the other tissues, such as dorsolumbar fascia, posterior ligaments, supraspinatus and intraspinatus ligaments, is probably one of the active tissues in the FRP (flexion relaxation phenomenon) response and probably is subjected to creep as well. Another important issue is the IVD (intervetebral disc). The sheer stresses and movement created by spinal twisting within discs might elicit a shrinkage on spine by making the nucleus pulposus loose (*sic*) some fluid like twisting a cloth full of water. Moreover, spinal shrinkage itself could indeed elicit change in FRP response according to our recent investigation."

86. Petitioner also submitted the Article *Low Back Pain Development Response to Sustained Trunk Axial Twisting* in a 1980 Journal of the American Physical Therapy Association, which appears to be a primer for physical therapists to identify low back conditions and provide appropriate physical therapy.

87. The most relevant portion of this 1980 article refers to intradiscal pressure. On the issue of bending and torsion, the authors indicate that the combination of movements such as twisting, bending, and bending with rotation increases stresses and strains on discs which alone can account for a disc injury. The stresses are magnified in a degenerated disc. The authors cite a study that indicates sitting causes 1/3 greater disc pressure than standing and leaning forward 20 degrees increases the pressure by 30%. The article also includes the Alf Nachemson chart cited by Dr. VanFleet and elsewhere in the record; with the most relevant aspect being that sitting upright exerts a force of "140" and sitting leaning forward exerts a force of "185."

88. In analyzing work activities, the authors concentrated on lifting and pushing/pulling. However, they also note that exposure to truck rotation is an important consideration. Rotation of three degrees can disrupt annulus fibers at their weakest point and at 15 degrees a total breakdown of the annulus. Discs and facets each receive 50% of the torsion. Flexion, opening the facet joints, followed by rotation is dangerous because the discs are not protected by the facets. The authors also discuss the importance of proper lumbar support in chairs and the height of the chair should allow adequate thigh support as well as comfortable placement of the feet. Frequent change of position is important to vary the compressive load on a degenerated disc.

The Arbitrator found that Petitioner failed to prove accident basically because he did not provide any evidence of his precise work activities that could lead to his alleged repetitive trauma injury of his lumbar spine. Rather, he concentrated on the set up of his workstation and the theory that sitting in his chair resulted in the breakdown of the protective structure of his back resulting in the disc herniation. The Arbitrator also noted that Petitioner had similar symptoms in 2011 from golfing and found that the condition never completely resolved. She also noted that Petitioner did not initially relate his condition to his work activities. Finally, she seemed to discount the testimony of both doctors because they did not have a sufficient understanding of Petitioner's job activities. Petitioner argues the evidence that there was accident and causation was overwhelming, and stresses that three out of four "medical professionals" opinions supported causation.

The Commission agrees with the determination of the Arbitrator and affirms her decision. The Arbitrator was correct that Petitioner did not present evidence regarding his specific work activities that could have caused or aggravated his lumbar spine position. However, Petitioner's claim for compensability is based on his theory that working at an ergonomically improper workstation all day, every day, for seven years caused his disc herniation. Assuming that theory of compensability his specifying his work activities, such as how much of the time he was on the telephone or imputing data, may not have been entirely dispositive of the issues of accident/causation. Therefore, the Commission will address the argument that Petitioner's evidence sustained his burden of proving that the ergonomic condition of his workstation itself caused or aggravated his condition of ill-being.

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Petitioner presented evidence that his work station may not have been optimal. He also presented evidence that a poor ergonomic work station may be a contributing factor in aggravating a preexisting degenerative disc condition. Nevertheless, the Commission finds that Petitioner did not sustain his burden of proving that his allegedly ergonomically improper work station actually aggravated **his** preexisting degenerative disc disease thereby causing **his** herniation.

The Commission does not consider proof of a bad ergonomic condition and a particular condition of ill-being is sufficient prove a compensable accident. Because there was no evidence directly relating Petitioner's work station to his herniation, a finding that Petitioner's work station was the cause of his herniation necessarily would be based on conjecture or speculation, in which the Commission is not permitted to engage. Therefore, the Commission affirms the Decision of the Arbitrator that Petitioner failed to sustain his burden of proving a repetitive trauma accident resulting in a condition of ill-being of his lumbar spine.

Petitioner filed two Applications for Adjustment of Claim. 14 WC 6167 was filed on January 14, 2014 and alleged injuries to the lumbar spine from repetitive trauma with a manifestation date of August 29, 2013. 15 WC 18366 was filed on June 4, 2015 and alleged injuries to the lumbar spine from a discrete traumatic event also with an accident date of August 29, 2013. The mainframe indicates that Petitioner filed a motion to consolidate the claims on June 30, 2015 and that that motion was denied on July 24, 2015. Petitioner filed a Petition for Review on both claims; therefore the Commission currently has jurisdiction over both. The Commission notes that the claims involve the same claimant, the same employer, and the same allegedly injured body part. The only difference between the claims is the theory of compensability, with 14 WC 6167 alleging repetitive trauma and 14 WC 18366 alleging discrete trauma. The Commission agrees that these claims should be consolidated.

The record clearly delineates Petitioner's alleged discrete traumatic event; his arising, or attempting to arise, from his chair on August 29, 2013. Petitioner testified that he needed to get some paper and could not get up because of intense pain in his back and left leg. Dr. VanFleet testified Petitioner indicated that he was sitting in his chair by his desk for a long period of time and as he stood up he had significant pain across the back and down into his left leg. Dr. Payne testified that when he saw Petitioner on September 3, 2013 he reported a sudden worsening of his symptoms after moving from a sitting to standing position. Getting up from a seated position is clearly an activity members of the general public engage in numerous times on a daily basis. Dr. Payne and Dr. VanFleet both testified the mechanism of getting out of that work chair should be no different from that of getting out of any other chair.

Petitioner has not sustained his burden of proving that his work activities placed him at any greater risk of injuring himself by arising from a seated position than that of any member of the public in general. The act of arising out of a chair itself is not an "accident" compensable under the Act. Therefore, Petitioner has not met his burden of proving he suffered a compensable work-related discrete traumatic accident on August 29, 2013 causing injury to his lumbar spine.

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In conclusion, Petitioner has not sustained his burden of proving either a discrete traumatic accident on August 29, 2013 or a repetitive traumatic accident causing a condition of ill-being of his lumbar spine manifesting itself on August 29, 2013. Therefore, compensation is denied on both claims.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claims, 14 WC 6168 and 15 WC 18366, are consolidated on review.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner has not sustained his burden of proving a repetitive traumatic accident causing a condition of ill-being of his lumbar spine manifesting itself on August 29, 2013 and compensation in 14 WC 6168 is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner not sustained his burden of proving either a discrete traumatic accident on August 29, 2013 causing a condition of ill-being of his lumbar spine and compensation in 15 WC 18366 is denied.

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

DATED: SEP 13 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-8/16/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

16IWCC0587

GARRETT, JASON B
Employee/Petitioner

Case# **14WC003167**

LIBERTY MUTUAL INSURANCE
Employer/Respondent

On 9/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

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

JASON B. GARRETT,
Employee/Petitioner

v.

LIBERTY MUTUAL INSURANCE,
Employer/Respondent

Case # 14 WC 3167

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **7/24/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **8/29/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$80,471.04** ; the average weekly wage was **$1,547.52**.

On the date of accident, Petitioner was **42** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$33,126.92** for other benefits, for a total credit of **$33,126.92**.

Respondent is entitled to a credit under Section 8(j) of the Act for any bills paid.

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his lumbar spine due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 8/29/13. Petitioner's claim for compensation 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

8/28/15
Date

ICArbDec19(b)

SEP 8 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 42 year insurance agent, alleges he sustained an accidental injury to his low back due to repetitive work activities, that arose out of and in the course of his employment and manifested itself on 8/29/13.

Petitioner began working for respondent on 9/28/97. He started as a personal sales representative. In 2005 petitioner became a resident sales representative. His duties included helping new hires, trainees, and overseeing office operations. He was responsible for monthly safety checks, monthly meetings, and fire extinguishers. In October of 2006, petitioner moved his office to his home. He dedicated one of the rooms in his home to his office. Petitioner took pictures of his home office in December of 2006 at the request of Administrative Assistant, and emailed them to the Administrative Assistant. Petitioner also took pictures of his desk on or about his alleged injury date (PX38-42). Petitioner testified that the desk he used was in his house when he purchased the house in 2006. He testified that respondent sent him the docking station and all the chairs. He stated that no one helped him set up the office.

Petitioner described his job description as a salesman as being quite diverse. He testified that he would go out and solicit clients and service existing clients. He was also responsible for new customers. He would gather business through marketing groups. Petitioner testified that if a person was closing on a house he would sit on the phone for hours reviewing stuff in the house and value of the home and evaluating risk.

On 12/9/07 petitioner signed and completed an ergonomic assessment. The evaluator recommended a slight movement of the monitor to stay center of the body.

Lisa Raydant worked for respondent for 20 years. On 7/13/12 Raydant resigned her employment with respondent. From 1988-2006 Raydant was a service manager. From 2006-2008 she was assistant regional service manager in Springfield. From 2008-2012 she was a branch manager. Raydant was the manager of ergonomic studies. She was not trained to do ergonomic studies. She just followed the form. Raydant performed ergonomic assessments on new employees, transfer employees, and random studies. Raydant was immediate sales manager over petitioner. She was aware of petitioner's low back issues.

In November 2006 petitioner moved from respondent's sale office to his home office. In an email dated 11/14/06 to Cheryl Popielarz, petitioner reported that he had measured his home office and had roughly 266 ft. of space, which he indicated was very large for his needs. With respect to his desk, he reported that he had one that he could use. He indicated that he did not have a chair similar to the one

from the office. He wrote that about two years ago respondent had special ordered him an office chair that was more suited to his height and weight. He questioned whether he could take that one to the house. Petitioner claims he had trouble with the chair only at his home office, and conveyed that via email to respondent. Respondent sent a technician out who fixed the chair. No further emails regarding this issue were offered into evidence as part of RX4.

Petitioner testified that he started having problems with his back in mid 2007.

In April of 2009 Raydant visited petitioner's home. Petitioner told her that he was uncomfortable and his desk was low. She noted that petitioner is very tall. She stated that the form she followed indicated that the monitor had to be at eye level and it was not. She also stated that petitioner was twisted and leaning forward, and the desk was unadjustable. As a result, she got petitioner risers for his desk and corrected his monitor level. Raydant testified that she was in petitioner's home another time in 2011 but did not do an ergonomic assessment of petitioner.

Raydant described Lead Days. She testified that representatives are assigned a day of the week to work leads and call the contacts within approximately 15-30 minutes. She testified that when reps are working Lead Days they are essentially tied to the office, but not their desk, so they could respond quickly. She testified that they can go to lunch and have appointments as long as they handled the leads in a timely manner. If a rep did not respond timely to the leads they might be removed from the program.

On 11/4/11 petitioner presented to Dr. Payne with a five-month history of back pain, following an injury to his back while playing golf on 5/1/11. Dr. Payne noted that he has known petitioner for a long time, and that they used to travel to trap shoots together all over southern Illinois. Petitioner complained of significant pain for the past four months. He reported that his pain started gradually and he underwent chiropractic care that did not result in any lasting improvement. He also complained of pain in his left leg. An x-ray of the lumbar spine that day revealed moderate to severe diffuse degenerative changes most prominent at the L4 – L5 and L5 – S1 levels. Petitioner told Dr. Payne that he gets sharp pain, numbness, and tingling that starts in the buttocks on the left side, and shoots down the back of the leg over the hamstrings down to the gastrocnemius. He stated that it has radiated to his foot a couple times. Petitioner gave a history of swinging the golf club and experiencing immediate pain in his back, that has persisted. He also reported that over the past 48 hours he started getting radiating pain into his left lower extremity. Dr. Payne assessed lower back pain and lumber radiculopathy. He ordered an MRI of the lumbar spine and an epidural steroid injection for petitioner. An MRI of the lumbar spine performed 11/15/11 revealed multilevel degenerative changes superimposed on multilevel congenitally short

particles. Also noted was resulting severe left neuroforaminal stenosis at L4 – L5, secondary to a left neural foramina disc extrusion.

On 11/21/12 petitioner presented to Dr. Western complaining of pain in the left leg following an injury on 5/1/11 when he twisted his back playing golf. He reported that simply walking hurts his back. He stated that he was working "somewhat". On 12/8/11 petitioner underwent an L5 – S1 transforaminal epidural steroid injection on the left.

Rachael Weygant, a marketing assistant for respondent, was called as a witness on behalf of petitioner. Weygant was Administrative Assistant for Brinkman from October of 2012 through April of 2015. Weygant was trained in safety assessments. She also did telecourses with Ergonomics Team. Upon completion of her training she became a Safety Specialist, and did work station assessments per company policy. Weygant did a workstation assessment over the phone with petitioner on 4/25/13 that lasted 15 minutes. She read over each question with petitioner and she noted his responses on the form. She relied solely on petitioner's responses to complete the form. She testified that had petitioner reported some problems with his workstation setup she could have made adjustments because she had tools and aids at her disposal. Weygant testified that all conditions of the workstation assessment were met based on petitioner's responses. She testified that petitioner brought no problems to her attention. Weygant testified that the completed form was sent to petitioner, and his signature is not required on the form. She testified that petitioner reported no back or leg pain and no problems with his chair, desk or monitor. She stated that petitioner was always forthcoming with what he needed and stated that he did not need anything, and if he had she could have corrected it. Petitioner testified that Weygant's ergonomic assessment lasted only 2-3 minutes and he told her he had to twist to the left to access the computer. He testified that he was not in pain on the day of the ergonomic assessment. Petitioner denied he got a copy of the ergonomic assessment. Petitioner testified that he did not know his monitor was in a bad position.

Petitioner next followed up with Dr. Western on 5/6/13 for evaluation of his back and left leg pain. Dr. Western noted that petitioner had L4 – L5 lateral recess stenosis and L4 – L5 foraminal stenosis secondary to disc bulging, some congenitally shortened pedacles, and degenerative arthritis. Petitioner reported no new injuries or issues. He reported pain in the lateral leg to his knees, that was achy, and occasionally sharp. He also complained of buttocks pain and occasionally getting some numbness all the way down into his foot. He stated that bending, walking, and sitting aggravate him. Petitioner reported that he has a mostly sit down job. Dr. Western examined petitioner and assessed a high level of pain. He took petitioner off work for at least three days before a repeat injection. He prescribed Vicodin. On

5/9/13 petitioner underwent a L5 – S1 transforaminal epidural steroid injection on the left. On 5/13/13 petitioner stated that he got no relief from the epidural injection. He complained of pain in the left lower extremity in the L5 distribution from his knee to his ankle, and burning on the bottom of his foot. On physical examination petitioner was more comfortable in a slightly forward flexed posture. Petitioner had some decreased sensation in his lateral lower leg, L5 – S1, more S1 distribution possibly. His straight leg raise was positive. A repeat MRI was ordered. Dr. Western started him on gabapentin, prednisone, and Flexeril.

On 5/21/13 petitioner underwent a repeat MRI of his lumbar spine. The impression was largely left posterolateral disc extrusion with inferior migration at L2 – L3, compressing the left L3 nerve root. On 5/22/13 petitioner returned to Dr. Western who noted that he had a large L2 – L3 left paracentral disc herniation causing lateral recess stenosis. He further noted that the disc material migrates behind the L3 vertebral body. Petitioner reported that when he is more active the leg does feel weaker, and he has a hard time with bowel movements and increased pain with Valsalva maneuvers. Petitioner stated that he was taking 2 hydrocodone every 6 to 8 hours and it was only helping minimally. He reported that he took himself off the prednisone because it elevated his blood sugars, and was not sure if the flexeril was working. Following an examination Dr. Western's impression was that petitioner had a large L2 – L3 disc herniation on the left side causing the lateral recess stenosis and that his L3 symptoms appeared to be affecting some of the lower nerve roots as well. Dr. Western talked about surgery versus a second epidural injection. Petitioner decided to go ahead and undergo a repeat injection. Dr. Western noted that if it was unsuccessful in relieving a significant amount of petitioner's pain, that he would send petitioner to a spine surgeon for a surgical evaluation. On 5/23/13 petitioner underwent the left L3 – L4 transforaminal epidural steroid injection. Dr. Weston's postoperative diagnosis was left lower extremity radiculopathy secondary to left L2 – L3 disc herniation with left lateral recess stenosis.

On 6/4/13 petitioner returned to Dr. Payne regarding his left side disc herniation at L2 – L3. He complained of weakness in his quadriceps, a lot of pain down the left leg, and numbness and tingling below the knee. He also complained of real sharp pain that shoots up in the groin, into the trochanter and buttocks on the left side only. Petitioner stated that he had been using Aleve 660 mg, and 2 hydrocodone in the morning, and another 2 at night. Petitioner stated that he gave up referring soccer, and took himself off the call schedule for the fall. Dr. Payne reviewed the MRI that showed a large disc herniation of the left side at L2 – L3. Petitioner stated that he wanted to try anti-inflammatories and pain medications for another month, and wanted to avoid back surgery. Dr. Payne talked to petitioner about a discectomy at

L2 – L3. Since he was prediabetic, and the oral steroids had been raising his blood sugars, Dr. Payne decided to continue conservative treatment.

Prior to 8/29/13, despite all his treatment for his lumbar spine to this date, including the discussion of surgery, petitioner never reported to any healthcare provider that he had any problems with his back while working.

On 8/29/13 petitioner was assigned Lead Day. He stated that some leads might come in overnight and the faster he contacted them the better chance of getting the business. Petitioner testified that he started between 7:30-8:00 am that day. He testified that he worked all day at his desk and may have gotten up once to go to the bathroom. He claims he was twisted at his desk all day long. He claimed that he did not have room on his desk to move his computer. Petitioner stated he started having pain in his back early that day, and that it got progressively worse throughout the day. He testified that he could not stand up by 3:00 pm when he went to fetch some paper. He stated that his left leg and low back were so sore he could not get up on his own and had to call his wife to help him up.

Petitioner did not report his alleged injury to respondent on 8/29/13. Petitioner did not mention it until his daily call to Brittaney, at the end of his workday on 8/30/13. At the end of the call he stated that he told her that he hurt his back at his desk the day before. She asked if he wanted to report the injury and he said yes. Petitioner testified that he stayed in bed all day Friday and went to the emergency room on Saturday in Marion, Il, where he was because he went with his wife to go through her grandma's belongings. He stated that she drove him there while he laid in the passenger seat. When he could not sleep that night he testified that he drove himself three miles to the emergency room.

At the emergency room at Heartland Regional Medical Center in Marion, Illinois 9/2/13, petitioner had complaints of lower back pain, and a history of the same. He reported his onset of symptoms as two days ago, and stated that the symptoms came on gradually. He reported that his symptoms had increased from their onset, and were located in his left lower back. He described his symptoms as dull and aching, and moderate intensity. Petitioner was given medication and discharged from care in a stable, satisfactory, and improved condition. He made no mention that these complaints were related to his work activities.

On 9/3/13 petitioner returned to Dr. Payne with respect to his back pain. He also had complaints of left leg weakness. Petitioner reported a sudden, severe worsening of his pain over the weekend. He stated that his left anterior thigh was worse than it had ever been before. He stated that he was just sitting

at his desk on Friday doing a lot of work on the computer and when he stood up, he experienced sudden severe worsening in the left lower extremity radicular pain. Dr. Payne noted that petitioner's pain was in the same dermatomes that it had been in the past when he had his disc herniation at L2 – L3. Petitioner stated that this pain was actually worse and he was having constipation. He stated that he could not stand up straight, and could not find any position that relieved his pain. He reported that he had a couple shots of Dilaudid and then switched over to some oxycodone tablets, and his previous hydrocodone. Dr. Payne gave him a prescription for Percocet, Flexeril and Colace. He also told petitioner to continue his Medrol Dosepak, that he had. Dr. Payne ordered a repeat MRI.

On 9/10/13 petitioner underwent a repeat MRI of the lumbar spine. The impression was interval worsening of L3 nerve root compression from a large left lateral L2 – L3 disc extrusion. Additional chronic degenerative changes were noted. That same day petitioner underwent a left L3 – L4 transforaminal epidural steroid injection. Dr. Western's postoperative diagnosis was large left L2 – L3 disc herniation with fusion done on the L3 vertebral body causing a left lateral recess stenosis and a left lower extremity radiculopathy.

On 9/12/13 petitioner wrote an email to Britney Brinkman stating that "I delayed my trip down south in order to attend to the some issues here at home. If you have time later this morning we can do the measurements for ergonomic assessment. I am moving my operation around a little bit because just to sit and type this note only serves to aggravate my condition. I will discuss that with you and we talk later. If you have time between 930 and one that would be great."

On 9/12/13 petitioner returned to Dr. Payne. Dr. Payne noted that petitioner's disc herniation at L2 – L3 was much larger than it had been in the past, and his symptoms were still severe. Dr. Payne scheduled petitioner for an L2 – L3 microdiscectomy. Dr. Payne noted that petitioner was diabetic and heavyset so there would be a 5 to 10% chance of an infection.

On 9/26/13 Erin Steinacher, an occupational therapist, completed an ergonomic assessment of the petitioner's work place at the request of the respondent. She found several issues with the petitioner's workplace and opined that it was "fair minus", and noted that these issues could lead to back problems and increased spinal pressure. Steinbach did not review any of petitioner's medical records. She testified that anyone can adjust a computer monitor. She did not notice any defects in the operation of the desk or chair. She also testified that there was nothing in petitioner's workplace to preclude him from getting up or stretching as needed.

On 9/30/13 petitioner underwent a laminectomy at L2 – L3 and microdiscectomy at L2 – L3 performed by Dr. Payne. Petitioner's preoperative diagnosis was herniated nucleus pulposus at L2 – L3, and spinal stenosis at L2 – L3. Petitioner followed up postoperatively with Dr. Payne. This treatment included physical therapy. On 11/14/13 Dr. Payne noted that petitioner was still getting anterior thigh symptoms that was a kind of dull pain. He also reported a lot of axial back pain, worse with sitting. He stated that he could only sit in a chair for about five minutes. Dr. Payne ordered physical therapy.

On 12/26/13 petitioner returned to Dr. Payne. He stated that he was still getting axial back pain as well as his left lower extremity radicular pain. He reported that he was going to physical therapy three times a week. Dr. Payne talked to petitioner about trying to get back to work part-time. However petitioner stated that his job is a sales job, and if he does not make his quotas, he really does not get paid. So petitioner stated that he was really not able to go back part-time. Petitioner reported to Dr. Payne how his radicular pain started at the end of the day. He reported that he had been at his desk for seven or eight hours leaning forward, working at a computer, etc. When he got up to leave, he stated that he was unable to stand straight and experienced severe pain down the left leg. Petitioner reported that after that he had a work space expert come in and help him with positioning at his desk. Dr. Payne noted that sitting in a chair, and leaning forward in a chair puts some of the highest pressure on discs as far as positions go. He was of the opinion that prolonged sitting could be a link to petitioner's disc herniation of the lumbar spine. He noted however that petitioner had herniations there before and problems with his back, but believed that those had resolved without surgical intervention.

On 1/16/14 petitioner went into work for a while after receiving a new chair and a new desk. He stated that after sitting for a couple hours, all the pain just came rushing back.

On 1/31/14 petitioner filed his Application For Adjustment Of Claim with respect to an alleged date of accident of 8/23/13, claiming a repetitive trauma injury to his back. Petitioner signed the application for adjustment of claim on 1/10/14.

On 2/6/14 petitioner returned to Dr. Payne complaining of worsening pain down the left lower extremity. He reported that it was down the anterior thigh into the medial calf. He stated that it does not always go to the foot, but sometimes does. He stated that when he got out of his car last week he had such severe sharp pain as he exited his vehicle that it almost knocked him to the ground.

Dr. Payne had petitioner undergo a repeat MRI of the lumbar spine. He was of the opinion that petitioner had epidural fibrosis with no evidence of recurrent disc herniation. He referred petitioner to Dr. Narla for pain management. Dr. Payne continued petitioner off work.

On 3/7/14 petitioner presented to Dr. Narla for pain management. Petitioner gave a history of lumbar back pain for two years. He stated that he ended up with a severe pain radiating into the left leg in August 2013 and underwent surgery in September 2013. He reported a 50% improvement postoperatively. Dr. Narla noted that an MRI from May 2013 showed a left-sided significant disc herniation at L2 – L3, and a disc bulge at T12 – L1. Dr. Narla noted that petitioner's pain was mostly the same as prior to the operation. Dr. Narla began petitioner on gabapentin.

On 3/12/14 petitioner underwent a Section 12 examination performed by Dr. Timothy Van Fleet, at the request of respondent. Petitioner provided a history, and Dr. Van Fleet performed a physical examination and reviewed notes from Dr. Payne, Dr. Western, and from Memorial Physician Services Office. He also reviewed an MRI film dated 2/18/14, and other MRI reports. Petitioner gave a history of being an insurance producer for respondent. He stated that his pain began in 2011. Petitioner complained of pain, which he reported was due to sitting for a long period of time in his chair at work. In 2011 petitioner was seen by Dr. Western and underwent some injections. He stated that he was also treated with ibuprofen and his symptoms improved. Petitioner reported a recurrence of his back pain in August 2013. He reported that on 8/29/13 he was sitting in his chair at his desk for a long period of time and when he went to stand up, he had significant pain across the back and down into his left lower extremity. He noted that the pain was quite substantial. Petitioner was ultimately seen and treated by Dr. Payne, who performed a left L2 – L3 discectomy on 9/30/13. Petitioner reported minimal improvement in his pain following surgery. He also continued to report difficulties with pain radiating down into the left lower extremity. Petitioner stated that he currently takes gabapentin and Flexeril for relief of his symptoms. He stated that he was unable to work because he did not feel as though he could sit.

Dr. Van Fleet noted that petitioner was morbidly obese. He also noted that petitioner's surgical history was consistent with a previous meniscectomy and a lumbar microdiscectomy. He noted that petitioner is a diabetic, but does not smoke or drink. Dr. Van Fleet noted that petitioner is 6'4" and weighs 380 pounds, and his BMI was 46.3. On examination he noted some difficulty with both flexion and extension. All other tests were normal. Dr. Van Fleet reviewed the MRI of petitioner's lumbar spine dated 2/18/14 which showed no evidence of any focal neurologic compression, and degenerative disc signal intensity at the L2 – L3 level. Dr. Van Fleet's diagnosis was that petitioner was morbidly obese

and was post lumbar discectomy. Dr. Van Fleet was of the opinion that petitioner's refereeing of high school soccer games did not have any impact on his back condition. He was of the opinion that petitioner's weight had every bit to do with his underlying condition, and had led to his difficulties both at work, as well as away from the workplace. He was of the opinion that petitioner's weight creates a significant hazard for his lumbar disc spaces, especially with sitting, as this loads his disc spaces more considerably than either standing or lying down. He was of the opinion that if petitioner was closer to an ideal body that he would likely not have the difficulties that he currently reports. Dr. Van Fleet saw no changes between the 11/15/11, 5/21/13, and 11/27/13 MRIs. Dr. Van Fleet noted that the petitioner had postsurgical changes which he estimated to be related to the 8/29/13 incidents. He believed that petitioner's need for surgery was related to his morbid obesity and significant loading of his disc spaces. He could not determine if the petitioner sustained a lumbar disc prolapse as a result of sitting in his chair at work. Dr. Van Fleet was of the opinion that his current diagnosis and petitioner's reported pain for the lumbar spine was a result of the 8/29/13 incident. However, he was of the opinion that petitioner had long-standing difficulties with his back, that are not entirely related to his workplace, but related more towards his home environment and his morbid obesity. Dr. Van Fleet opined that petitioner is at a greater likelihood of sustaining an injury to the disc space while attempting to referee a soccer game than sitting at work. Dr. Van Fleet was of the opinion that since petitioner is a very large individual, that getting out of any chair certainly can create a situation that is hazardous to his disc space, but not necessarily mutually exclusive to his workplace. He was of the opinion that petitioner is at risk in a car, out of the car, sitting around the dinner table, as well as sitting down at night and relaxing. Dr. Van Fleet was of the opinion that petitioner had reached maximum medical improvement with respect to his low back, and could return to full duty work with no restrictions.

On 4/1/14 Dr. Van Fleet drafted an addendum report, specifically addressing the differences between the MRIs on 11/15/11, 5/21/13, and 11/27/13. Dr. Van Fleet was of the opinion that the 11/15/11 MRI showed evidence of disc degeneration at the L4 – L5 level with evidence of lateral recess stenosis at the L3 – L4 level. He further noted that the L4 – L5 level showed a far lateral disc extrusion involving the neural foramina on the left hand side. Dr. Van Fleet was of the opinion that the MRI film dated 5/21/13 of the lumbar spine showed evidence of disc degeneration at the L4 – L5 level, and the far lateral disc was no longer evident. He was further of the opinion that petitioner's MRI of 11/27/13 showed a very large left-sided L2 – L3 disc extrusion that was not evident on his previous films. The L2 – L3 disc was protruded posterior to the body of L3 on the 11/27/13 MRI study. Dr. Van Fleet was further of the opinion that the study demonstrated postsurgical changes on the left side at the L2 – L3

level without evidence of any kind of focal neurologic compression. He was of the opinion that the interval surgery was successful in decompressing the lateral recess in the central canal of the L2 – L3 disc.

On 4/24/14 petitioner underwent a Functional Capacity Evaluation. Petitioner demonstrated the ability to work in the mid range of the medium physical demand level for all lifts and carries. The therapist noted that the position of a Sales Representative at Liberty Mutual is a sedentary position. It was noted that while petitioner met the standing and walking requirements required for the position, deficits in his sitting ability may limit his ability to return to work in this capacity. It was recommended that petitioner may benefit from a modified station, including ability to stand as needed, a higher desk chair, and/or standing workstation. Prognosis for petitioner's returning to work was guarded, unless modifications could be made.

On 4/29/14 Dr. Payne gave petitioner permanent restrictions and released him on an as needed basis. He increased petitioner's gabapentin and continued petitioner on hydrocodone and Flexeril. He suggested a stationary bicycle exercise program. Dr. Payne was of the opinion that petitioner is in the mid range of medium physical demand level for all lifts and carries, 21 to 50 pounds. He also was of the opinion that petitioner meets the light physical demand level with material handling tasks, limited seating, kneeling, overhead work, and walking. He was of the opinion that petitioner may benefit from modified work. Dr. Payne released petitioner on an as needed basis. Petitioner continued to treat with Dr. Narla.

On 6/19/14 petitioner returned to Dr. Payne stating that his back had been bothering him more lately. He stated that he was able to sit for around 30 to 45 minutes and then has to get up and change positions and stretch out his back. He reported persistent radicular pain. Following an examination Dr. Payne was of the opinion that petitioner was as good as he was going to get. Dr. Payne talked with petitioner about working part-time, maybe four hours a day. Dr. Payne believed that petitioner had reached maximum medical improvement, and that they should see if petitioner could get his job back with some restrictions.

On 6/25/14 the evidence deposition of Dr. Van Fleet, an orthopedic spine surgeon, was taken on behalf of respondent. Dr. Van Fleet reported that petitioner told him that he had some back pain beginning as far back as 2011. He further testified that petitioner told him that he was habitually sitting for long periods of time in his chair at work. Dr. Van Fleet noted that petitioner gave him a history that on 8/29/13 he was sitting in his chair at his desk for a long period of time, and when he went to stand up

he had significant pain across the back and down the left lower extremity. Dr. Van Fleet noted that petitioner had done extensive rehab of physical therapy and core strengthening, but continued to have quite a bit of pain on a fairly regular basis. Dr. Van Fleet testified that petitioner gave him a history that he had prior back problems dating back to 2011, and that these complaints were due to sitting for long periods of time. Dr. Van Fleet noted that after reviewing petitioner's MRIs that petitioner had evidence of restricted range of motion about the lumbar spine which one may anticipate with a multilevel degenerative process that may be symptomatic. Dr. Van Fleet found no significant reflex changes or any neurologic deficits.

Dr. Van Fleet opined that the treatment petitioner had was reasonable and necessary. He further opined that morbid obesity and a predisposing genetic condition are contributing factors to lumbar degenerative disc disease. Dr. Van Fleet opined that the alleged accident on 8/29/13 did not contribute in any fashion to the petitioner's underlying degenerative disc disease. He was of the opinion that that was an entirely pre-existing condition. He was of the opinion that everybody sits or stands during the course of the day, no matter who they are, and if you happen to have it at work, that is not a contributing factor because you have to be standing or sitting at some location. Dr. Van Fleet was of the opinion that petitioner's getting out of his chair at work was the same as anybody getting up from any seated position to a standing position. Dr. Van Fleet opined that petitioner's act of getting out of his work chair is substantially similar to an activity that a member of the general public would do. Dr. Van Fleet opined that petitioner does not have any real structural issue, but rather only subjective pain. Dr. Van Fleet opined that for anybody with multilevel degenerative disc disease, altering positions between sitting and standing is fine. Dr. Van Fleet opined that the simple act of sitting in a chair does not cause a lumbar disc prolapse. He opined that anything can cause a lumbar disc prolapse, and that sitting in a chair would not cause a lumbar disc prolapse unless there was an impending disc prolapse already in evolution.

On cross-examination Dr. Van Fleet testified that he performs 95% of his Section 12 examinations for respondent. Dr. Van Fleet opined that he had no issues with any of the opinions of Dr. Payne in the reports that he read. Dr. Van Fleet testified that he did not base his opinion on an ergonomic assessment. He also testified that he had no knowledge regarding petitioner's workstation or his seated position, and did not see any functional capacity evaluation. Dr. Van Fleet was of the opinion that if petitioner was in a seated position leaning forward that could potentially lead to increased intradiscal pressure that is seen with people in the upper right or in the seated position, because of gravity and body mass. Dr. Van Fleet was of the opinion that workstations tend to be more difficult on individuals necks than on their lumbar

spines. He opined that people that have more sedentary type work are more prone to cervical disorders, and people who have more laborious type of jobs tend to have more lumbar related conditions. Dr. Van Fleet noted that Alf Nachemson's classic study on intrathecal disc space pressures states that laying down has the least intradiscal pressure, standing up has an intermediate intradiscal pressure, and sitting and leaning forward with or without weights in the hands provides the most at risk position for the disc space. Dr. Van Fleet was of the opinion that prior to 8/29/13 petitioner did not seek out any surgical opinion regarding L2 – L3.

On 6/27/14 Dr. Narla was of the opinion that a stimulator would not be of any use in petitioner. He was of the opinion that petitioner might be at maximum medical improvement as far as medications are concerned. Dr. Narla gave petitioner a home exercise program.

On 7/16/14 petitioner filed an amended Application For Adjustment Of Claim with respect to this case. Petitioner amended the date of accident from 8/23/13 to 8/29/13. Petitioner signed this Application on 6/24/14.

On 9/8/14 petitioner fell while going up the stairs. On 9/11/14 he returned to Dr. Payne. He reported that while he was going up the stairs his left leg gave out, he twisted and tried to grab the stair railing and kind of fell down the stairs. He experienced immediate back pain, very bad. He stated it was worse than previously.

An MRI performed 10/3/14 showed multilevel degenerative changes, most severe at L2 – L3 with a large central disc protrusion with subarticular extension causing severe central canal stenosis. Also noted was multilevel moderate to severe neural foramina encroachment, and mild central canal stenosis at T12 – L1. On 10/7/14 Dr. Payne ordered another course of physical therapy. On 10/21/14 Dr. Narla performed a L3 – L4 foraminal epidural injection with contrast. Petitioner did not receive any relief. On 11/18/14 Dr. Payne discussed operative treatment alternatives as well as continued observation and treatment with pain medications. Petitioner stated that he wanted to proceed with surgical intervention. Dr. Payne recommended a transforaminal lumbar and her body fusion at L2 – L3.

On 12/22/14 petitioner underwent a laminectomy at L2, transforaminal lumbar interbody fusion with cage at L2 – L3, posterior fusion at L2 – L3, segmental instrumentation at L2 – L3, allograft bone, local autograft bone, and iliac crest aspirate on the left. This procedure was performed by Dr. Payne. Petitioner's postoperative diagnoses were spinal stenosis at L2 – L3, and recurrent herniated nucleus pulposus at L2 – L3. Petitioner followed up postoperatively with Dr. Payne. On 1/6/15 Dr. Payne noted

that petitioner was back to his baseline level of radicular pain. On 2/3/15 petitioner noted that he had increased his activity and was walking up to 2 miles a day. He stated that it takes him about 40 minutes to walk 2 miles. Petitioner stated that he could sit for about 30 minutes before he has to get up and stretch his back and walk around. On 3/30/15 Dr. Payne wrote a Health Status Form indicating that petitioner needed to change positions from sitting to standing every 15 minutes. He stated that petitioner could only work two hours per day.

On 5/12/15 Sarah Boyle, Senior Disability Case Manager II with respondent, drafted a letter to petitioner's attorney Matthew Rokusek, informing him that petitioner had been paid a total of $33,126.92 in short-term disability payments, from 10/7/13 through 3/30/14.

On 7/15/15 petitioner underwent a second functional capacity evaluation at the request of Dr. Payne. It was determined that petitioner met the light physical demand level for above shoulder lifts and carries, and the sedentary physical demand level for below the waist lifts. It was noted that petitioner's true limitations in sitting and standing work, and walking abilities may limit his ability to fully meet these physical demand levels fully. Petitioner's prognosis for improving his current abilities, postural deficits, returning to work full duty, and prior level of functioning were identified as guarded.

Petitioner offered into evidence two photos of his desk and office at home (P17 and PX18). He testified that these pictures were taken in 2006, but his desk, chair and office were the same in 2013. The pictures indicate that petitioner's chair is in the middle of the desk, with his monitor and keyboard to the left of his chair on the desk.

Alysha Davis Barth, a 13 year physical therapist, was called as a witness on behalf of petitioner. Barth works for Advanced Physical Therapy as a physical therapist and has done 25-30 ergonomic assessments, none for petitioner. She testified that one does not need to be certified to perform ergonomic assessments. She testified that to be a certified ergonomic assessment specialist she had to be a medical professional and take courses. Barth testified that she reviewed photos of petitioner's workstation (PX17, PX18). She assessed that based on these photos that petitioner's computer workstation was set up on an angle and he would have to rotate left to use the keyboard and terminal. She noted that there appeared to be no leg room under the desk to turn the chair to the left. She believed petitioner would need to rotate at his trunk. She also testified that petitioner's chair was away from the desk because he could not get his knees under the desk, and as a result he leaned forward to reach the keyboard. Barth was of the opinion that by sitting in this position when petitioner turned it caused stress in his discs, breaking down the protective structures of the discs. She was of the opinion that if one sits

in an awkward position and the protective structures of the discs break down the discs can herniate. She was of the opinion that this could happen with as little as 20-30 degrees of flexion.

Barth testified that she did not do an ergonomic assessment of petitioner's workstation, and only met petitioner when he came in her workplace and hired her to do an evaluation. She stated that her report was only based on a review of the photos and depositions, and not any medical reports. Barth only talked to petitioner for about 20 minutes about his job duties. Barth testified that petitioner told her that he sustained a disk herniation a year ago while playing golf. Barth agreed that many things can cause a disk herniation including genetics, repetitive trauma, and age. She also testified that any sitting can cause the breakdown of protective structures in flexed and rotated positions. Barth testified that petitioner could have moved his computer so that he was not rotated and in a better position.

Currently, petitioner testified that he has difficulty sitting in any position, standing for more than a few minutes, and any walking. Petitioner testified that he does everything with difficulty. He testified that sitting, standing, and walking is painful, and he cannot do his job. Petitioner testified that prior to his alleged accident date he treated with a chiropractor .

Petitioner testified that he never requested a new desk from respondent. He testified that respondent does not control his house or have access to it without permission. Petitioner testified that he set up his own home office and was in charge of ergonomic assessements, and had done some himself. He testified that he only filled out the form and recorded information. He made no recommendations. Petitioner claimed he asked Lisa to have an ergonomic assessment done, but it never was.

Petitioner's wife, Monica Garrett, was called as a witness on behalf of petitioner. She denied that petitioner had any back problems before 2006. She testified that petitioner looked uncomfortable at his home workstation and could not get his legs under the desk. She testified that he reached over to the desk and rotated. She admitted that petitioner had back problems before the alleged injury.

Brittany Brinkmann, Senior Territory Manager, was called as a witness on behalf of respondent. Before 5/25/15 petitioner was Brinkmann's direct report from July of 2012-5/25/15 while she was a Senior Branch Manager. Brinkmann testified that she was the one who directed Weygant to perform petitioner's ergonomic assessment. Brinkmann testified that from July of 2012 to 8/29/13 petitioner told her he was getting injections for his back and he would have to get off work for surgery. She testified that during this period petitioner never reported any work injury. She testified that the first she learned of petitioner's alleged injury was when she came to trial. She testified that petitioner never asked her for a

new desk. She stated that he did not ask for an ergonomic assessment until after the alleged date of injury. She testified that at that point Human Resources hand an external vendor, Cascade, take care of it. She testified that if petitioner had requested a new desk she could have helped him with that request.

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

Petitioner is alleging injuries to his lumbar spine due to repetitive work activities that arose out of and in the course of her employment by respondent and manifested itself on 8/29/13.

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers' Compensation Act is best serviced by allowing compensation in a case … where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming injuries to his lumbar spine, in Illinois, recovery under the Workers' Compensation Act is allowed, even though the injury is not traceable to a specific traumatic event, where the performance of the employee's work involves constant or repetitive activity that *gradually* causes deterioration of or injury to a body part, assuming it can be medically established that the origin of the injury was the repetitive stressful activity. In any particular case, there could be more than one date on which the injury "manifested itself". These dates could be based on one or more of the following, depending on the facts of the case:

1. The date the petitioner first seeks medical attention for the condition;
2. The date the petitioner is first informed by a physician that the condition is work related;
3. The date the petitioner is first unable to work as a result of the condition;
4. The date when the symptoms became more acute at work;
5. The date that the petitioner first noticed the symptoms of the condition.

Petitioner claims 8/29/13 was the date on which his symptoms became more acute a work when he could not get up out of his chair at 3:00 pm when he went to fetch some paper. Petitioner testified that he sat at his desk all day, except when he went to use the bathroom.

The Supreme Court held that compensation can be found in a case where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction. However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

In the case at bar the arbitrator finds the petitioner has failed to place into evidence any specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc. Most of petitioner's testimony and evidence focused on whether or not sitting in a chair and twisting could cause the breakdown of the protective structures of the spine over time, thus resulting in a disc herniation. Petitioner also spent a lot of time talking about his workstation setup, but did not spend much time providing evidence concerning his work activities, such as the frequency, duration and manner in which he performed his job.

Petitioner, weighing 380 pounds, 6'4" tall, and having a BMI index of 46.3, was a found to be morbidly obese. Petitioner worked for respondent since 1997. In October of 2006 he moved his office to his home. At that time respondent indicated that he wanted the chair he had in the office, but declined a new desk, stating that there was one that came with the house that he was going to use. At one point petitioner reported that he was having trouble with his chair and a technician came out and fixed it.

A lot of evidence was offered with respect to the ergonomic assessment of petitioner's home office. In April of 2009 petitioner reported that he was uncomfortable and his desk was low. As a result, Raydant went to petitioner's home, completed an ergonomic assessment, and got raisers for petitioner's desk, and corrected his monitor level. On 4/25/13 Weygant performed an ergonomic assessment of petitioner's workstation set up with him over the phone. She testified that it took about 15 minutes, and she read petitioner each question, and noted his responses on the form. Having had petitioner respond that each condition was met, she took no further action with respect to his workstation. She indicated that had petitioner indicated that any condition was not met she had the tools to correct any issues that existed. All further ergonomic assessments did not occur until after the alleged injury.

Petitioner testified that his work duties were diverse, but spent no time detailing his specific work duties. As far as his daily work duties were concerned, the only duties he discussed were Lead Days. On lead days, one agent is assigned to handle all the leads that come in that day. The agent is expected to follow-up on the leads within 15-30 minutes. If the agent did not follow-up in timely manner they risked being removed from the rotation of Lead Days. Raydant testified that there was no requirement that the agent handling Lead Day remain at their desk all day, or even remain in their office, as long as they respond to the leads in a timely manner.

Petitioner testified that 8/29/13 was his Lead Day. He stated that he sat down at his desk between 7:30-8:00 am, and did not get up until 3:00 pm, other than to go to the bathroom. Petitioner testified that when he tried to get up at 3:00 pm to fetch some paper, he could not get up and his wife had to help him up. Petitioner provided no details as to how many leads he had to follow-up on that day or any other day. He also provided no details as to what he actually was doing that day while he was at his desk. The actual amount of work he processed that day is unknown. It is also unknown how often he was working on his computer or just sitting at his desk, or was talking on the phone. Petitioner also did not testify as to the time he went to the bathroom, but offered no credible evidence to sustain a finding that he had any trouble getting up out of his chair to go to the bathroom that day. As such, it is unknown how long petitioner was actually sitting at desk before he was unable to get up.

In addition to the failing to provide any credible evidence as to his diverse duties on 8/29/13, petitioner failed to offer into evidence any credible evidence as to his diverse duties on any given day. The petitioner failed to offer into evidence with respect to how often he worked at home; how often he was in the field visiting existing or potential clients; how many clients he had; how often he was on the computer each day; how often he did paperwork each day; how long he was on the phone each day; how long he sat at his desk each day; etc. Bottom line is petitioner provided no specific and detailed information concerning his work activities, including the frequency, duration, or manner in which he performed them. Instead petitioner spent most of the time focusing on the fact that he could not get out of his chair on 8/29/13 after working Lead Day, without any specific and detailed information of what he did on that day or any other day.

The Supreme Court has also held that it is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities. In the case at bar, when petitioner first sought treatment for his injuries at the emergency room of Heartland Regional Medical Center in Marion, IL on 9/2/13, he reported complaints of lower back pain, and a history of the same. He reported

the onset of his symptoms as two days ago, with a gradual onset. He made no mention of an alleged injury at work on 8/29/13.

Petitioner told Dr. Payne on 9/3/13 that he was just sitting at his desk on Friday doing a lot of work on the computer, and when he stood up he experienced sudden severe worsening in his preexisting left lower extremity radicular pain. Dr. Payne was of the opinion that petitioner's pain was in the same dermatones that it had been in the past when he had his disc herniation at L2-L3.

The arbitrator finds the credible record shows that neither Dr. Payne, Dr. Western, or Dr. Van Fleet had a detailed and accurate understanding of petitioner's work activities. At most, the arbitrator finds the petitioner gave a history of sitting at his desk for many hours on 8/29/13 and then had difficulty getting up from his chair. Petitioner provided no specifics regarding his work duties on a daily basis.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his lumbar spine due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 8/29/13. The arbitrator also finds it significant that petitioner had sustained a disc herniation while playing golf on 5/1/11 that never resolved prior to the alleged injury on 8/27/13. In fact, the credible medical records show that within just 2-3 months of the alleged injury the petitioner had diagnostic evidence of a large left posterolateral disc extrusion with inferior migration at L2-L3, compressing the left L3 nerve root; weakness in his quadriceps; a lot of pain down his left leg; numbness and tingling below the knee; real sharp pain shooting up in the groin into the trochanter and buttocks on the left side; difficulty with bowel movements; increased pain with Valsalva maneuvers; a pattern of taking 2 hydrocodone every 6-8 hours that only worked minimally; inability to referee soccer games; as well as failed conservative treatment and 2 recommendations for possible surgery, that were only being delayed because of complications that might arise due to his preexisting diabetes. The arbitrator also finds it significant that when petitioner got up to go the bathroom at some time during the day on 8/29/13 he had no problems getting up and doing so. Therefore, the arbitrator finds that the petitioner, contrary to what he claimed, was not sitting at his desk for 7 1/2 to 8 hours on 8/29/13 before being unable to get up out of his chair when he tried at 3:00 pm.

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 TEMPORARY BENEFITS ARE IN DISPUTE?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained an accidental injury to his lumbar spine due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 8/29/13, the arbitrator finds these remaining issues moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Moises Cervantes,
Petitioner,

vs. NO: 14 WC 09817

Five Star Decorating, Inc.,
Respondent.

16IWCC0602

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2015 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 19 2016

Joshua D. Luskin

Charles J. DeVriendt

o-09/13/16
jdl/wj
68

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CERVANTES, MOISES
Employee/Petitioner

Case# **14WC009817**

16IWCC0602

FIVE STAR DECORATING INC
Employer/Respondent

On 7/1/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0210 GANAN & SHAPIRO PC
JULIA A MURPHY
210 W ILLINOIS ST
CHICAGO, IL 60654

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

Moises Cervantes
Employee/Petitioner

v.

Five Star Decorating, Inc.
Employer/Respondent

Case # **14WC 09817** _____

Consolidated cases: _____

16IWCC0602

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **February 23, 2015 & 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 **12/5/2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 **$53,232.92**; the average weekly wage was **$1,023.71**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$1,000.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$1,000.00**.

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

ORDER

Petitioner failed to prove by a preponderance of the credible evidence that an accident occurred on December 5, 2013, which arose out of and in the course of his 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.

#01 George J. Lucas
Signature of Arbitrator

June 29, 2015
Date

JUL 1 - 2015

16IWCC0602

Findings of Fact 14 WC 09817

Moises Cervantes, ("Petitioner") testified he worked as a taper for 5 Star Decorating ("Respondent"). (T. 7 - 9). Petitioner was working on a remodeling job at the Great Lakes Naval Base. (T.). Respondent was hired as a subcontractor on the project by the general contractor, Old Veterans. (T.). This project included working on some buildings which were to be barracks. (T. 57). Petitioner was working with two other employees on that job, Jason Howell ("Howell") the foreman and Michael Burne ("Burne").

Petitioner testified he had surgery on his left shoulder approximately 20 years earlier. (T. 8). On cross-examination, Petitioner confirmed he had left shoulder surgery in 2003. (T. 42).

Petitioner confirmed that as an employee, he was aware of the accident reporting policy. (T. 32-33.)

On December 5, 2013, Petitioner testified he was working on a four foot scaffolding. (T. 12). He testified the scaffolding broke and he fell back landing on his left side. (T. 12-13). He testified his left arm was underneath his body and he felt pain in the left shoulder. (T. 13-14).

Petitioner testified he looked for Howell, told him that the scaffolding broke and he landed on his left side. (T. 15). Petitioner confirmed he did not report any pain to Howell and continued working. (T. 15). Petitioner confirmed he did not fill out any forms and did not report the accident to either the Navy or to Old Veterans ("OVC"). (T. 35 - 36). Petitioner further testified he did not ask to seek any medical treatment. (T. 35).

Petitioner testified Howell told him to buy a new scaffolding. (T. 16.). Petitioner testified he did so and turned in the expense to Respondent for which he was reimbursed. (T. 16, Pet.Ex. 1).

Petitioner continued working through the end of the year for Respondent doing his regular job. (T. 20). Payroll records confirm Petitioner worked through January 10, 2014. (Resp.Ex. 3). During this time, he affirmed he did not seek medical care. (T. 35 - 38).

Howell testified on behalf of the Respondent. He testified he works for Respondent and had been there about three years. (T. 54). Howell testified he is a foreman, which requires him to manage the job and employees. (T. 55). As the foreman, he testified he also knows Respondent's accident reporting policy. (T. 56). He asserted that if a person is injured on the job they must notify him or someone in charge, possibly the general contractor, immediately. (T. 56). Howell stated he would then have to notify Respondent of the accident. (*Id.*).

Howell confirmed Petitioner worked for Respondent as a taper. (T. 55). He testified they worked together on a job at the Great Lakes Naval Base. (T. 57). In addition to reporting accidents to the Respondent, Howell stated that if an accident occurred on the Naval Base, they were required to report the accident to the general contractor, OVC. (T. 59). He stated there were always people from the Navy and OVC at the site. (*Id.*). He further testified that if an accident had occurred including equipment, he would have to report that to OVC and the Navy. (T. 62-63).

Howell testified that during the Navy job there were no accidents reported by Respondent to the Navy. (T. 60 - 61). He testified there were no accidents reported to him on December 5, 2013 by anyone, including Petitioner. (T. 61). He stated that Petitioner did not report any accidents to

him after December 5, 2013. (T. 62). Howell confirmed that nether the Navy nor OVC questioned him about an incident involving Petitioner. (T. 64).

Howell testified he did not direct Petitioner to buy a new scaffolding. (T. 63).

Petitioner initially sought medical treatment with his personal physician, Dr. Marius, on March 3, 2014, three months after the incident. (T. 22, Pet.Ex. 2). On March 13, 2014, Dr. Marius ordered an MRI of the left shoulder. (Pet.Ex. 2).

The MRI was performed on March 14, 2014. It was positive for severe hypertrophic degenerative changes in the AC joint, osteoarthritis, severe tendinosis and a tear in the supraspinatus tendon with retraction. (Pet.Ex. 2).

Petitioner was referred to Dr. Chhadia, an orthopedic physician, who he initially saw on April 4, 2014. (Pet.Ex. 3). Petitioner testified that he filled out forms to provide a history of his prior surgeries. He testified he was honest with the answers provided. Under the section for prior surgeries, the only one listed is a right shoulder surgery in 1999. (Pet.Ex. 3). The records from April 4, 2014, also indicate Petitioner provided a history of the accident and that he denied previous shoulder problems. Petitioner testified he did not tell Dr. Chhadia about his previous shoulder surgery. (T. 39). Diagnosis was left shoulder rotator cuff tear and AC joint osteoarthritis. Dr. Chhadia recommended surgery. (Pet.Ex. 3).

Petitioner was evaluated by Dr. Atluri pursuant to Section 12 on September 11, 2014. (Resp.Ex. 1, p. 1). Petitioner provided a consistent history of accident. (*Id.*). He advised Dr. Atluri he did not report the accident to Respondent until about three months later, when the symptoms did not improve. (*Id.*). Dr. Atluri advised Petitioner denied any prior left shoulder problems, stating that his only prior surgery was in 1992 for his right shoulder rotator cuff (*Id.*, p. 2). Dr. Atluri stated that after questioning Petitioner about scarring on his left wrist and left shoulder, he admitted to having a left shoulder surgery 20 years prior and that he had left wrist surgery thereafter. (*Id.*, p. 2). Petitioner asserted that when Dr. Atluri asked him about prior surgery, he did provide a history of the right shoulder surgery. (T. 44). When questioned about any prior left shoulder surgery, Petitioner testified he did not know whether he responded to the question because Dr. Atluri was going to examine him and find the details. (*Id.*).

Dr. Atluri reviewed the medical records, including those of Dr. Chhadia and the MRI report. He noted that Petitioner also did not report any prior left shoulder symptoms to Dr. Chhadia. (Resp.Ex. 1, p. 4). In addition, Dr. Atluri notes Petitioner told Dr. Chhadia he immediately reported the incident, which was inconsistent with when Petitioner claimed to have reported it during Atluri's evaluation. (*Id.*). As for the MRI report, Dr. Atluri noted the findings were consistent with a chronic condition. (*Id.*). He opined that while surgery was reasonable, it was not related to the alleged work incident. (*Id.*). Dr. Atluri felt Petitioner's ability to continue working his regular job and wait until he sought treatment was consistent with an ongoing degenerative process, and not an acute rotator cuff tear. (Resp.Ex. 1).

On November 13, 2014, Petitioner underwent left shoulder surgery, which included a left shoulder arthroscopic rotator cuff repair, arthroscopic subacromial decompression and arthroscopic biceps tenotomy. The operative report notes there was a previous repair noted in the supraspinatus tendon where the sutures had ripped out of the tendon. (Pet.Ex. 3).

Petitioner underwent therapy postoperatively at Advocate Good Shepherd Hospital. (Pet.Ex. 8). He testified he continued to follow up with Dr. Chhadia, and was released to return to work light duty on February 27, 2015. On April 6, 2015, he returned to Dr. Chhadia and was released to return to work in a full duty capacity. (Pet.Ex. 3).

Petitioner last saw Dr. Chhadia on May 16, 2015. No additional treatment or medications were provided and Petitioner was advised he could work full duty. (Pet.Ex. 3). Petitioner testified his left arm is improved but it hurts when he lifts more than ten pounds. He stated he does not take any prescription medications. Petitioner testified he has not returned to work, but he has placed his name on the work list with the Painters' Union.

Michael Burne ("Burne") testified for Respondent by way of evidence deposition. (Resp.Ex. 4). He testified he works for Respondent as a painter. (Resp.Ex. 4, p. 5). He further testified about the accident reporting policy. He confirmed that if someone is injured at work, they must report it to the foreman of the job, and the general contractor. (*Id.*).

Burne confirmed that in addition to this policy, there were additional safety training policies and procedures in place for the Navy job. (Resp.Ex. 4, p. 6 - 7). He stated they were required to go through safety training/ In addition, any accidents were to be reported to the foreman and to OVC, the general contractor. (*Id.*, p. 7). People from OVC and the Navy were present at the job daily. (*Id.*).

Burne stated he worked with Petitioner at the Navy Base in 2013. (Resp.Ex. 4, p. 7). He testified he worked as a painter, and Petitioner worked as a taper. (*Id.*, p. 6). Burne confirmed he saw Petitioner every morning, at break and when they left to go home. (*Id.*).

Burne testified he saw Mr. Cervantes on December 5, 2013, and Petitioner never mentioned anything about a scaffolding breaking. (Resp.Ex. 4, p. 8). He further confirmed he worked with Petitioner through Christmas, and during that time Petitioner never said anything about a scaffolding breaking. (*Id.*). He further testified he was never questioned by the Navy or OVC about the alleged December 5, 2013 incident. (*Id.*, p. 9). Mr. Burne confirmed he was not aware of Petitioner's alleged work accident until months after, when he was called by Howell and questioned if he knew about any accident involving Petitioner. (*Id.*, p. 19).

Conclusions of Law

In support of the Arbitrator's findings relating to (C) did an accident occur that arose out of and in the course of the petitioner's employment by the respondent, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove an accident occurred on December 5, 2013, which arose out of and in the course of his employment with Respondent. The Arbitrator concludes Petitioner's testimony was not credible. In the instant case, the Arbitrator finds that the preponderance of the credible evidence does not support Petitioner's allegations. Petitioner testified he fell between 4 and 4.5 feet on top of his left shoulder, and immediately had pain. (T. 12-13). He claimed he immediately reported the incident to Howell, but did not tell Howell he was experiencing any pain. (T. 15). In fact, Petitioner testified he was able to complete his tasks that day, and he continued to work full duty through the beginning of January 2014. (T. 35 - 36, Resp.Ex. 3).

Petitioner admitted he did not ask to seek any medical care on December 5, 2013. (T. 35). Further, he did not seek any treatment until March 3, 2014. (T. 22).

The Arbitrator finds that the preponderance of the credible evidence does not support that an incident occurred on December 5, 2013 to be deemed an accident which arose out of and in the course of Petitioner's employment with Respondent. The ladder receipt is not determinative nor is it a tipping point in favor of the Petitioner at bar.

In support of the Arbitrator's findings relating to (E) was timely notice of the accident given to Respondent, the Arbitrator finds the following facts:

The Arbitrator finds Petitioner failed to prove timely notice of the accident was provided to Respondent. In support thereof, the Arbitrator relies on the testimony of Howell and Burne and the medical records. The Arbitrator infers the Respondent as a contractor for the United States Military has no basis to effectively "bury" and accident against all rules and jeopardize the business relationship with the United States Navy with full knowledge they are insured.

Petitioner and Respondent's witnesses confirmed the accident reporting procedure of Respondent required that an incident be immediately reported to the foreman. Howell confirmed that as the foreman on the job, he would notify the Respondent's shop and the general contractor, OVC. Howell and Burne confirmed there were safety people available from OVC and the Navy everyday on the base. (T. 59, Resp.Ex. 4, p. 7-8).

The Arbitrator concludes Petitioner's testimony that he immediately reported the incident to Respondent is not credible. The records of Dr. Chhadia indicate Petitioner immediately reported the accident to his employer. (Pet.Ex. 2). Yet, Dr. Atluri's report indicates Petitioner told him he did not immediately report the incident to his employer, and instead waited three months. (Resp.Ex. 1). The Arbitrator finds it is more likely that Petitioner waited the three months to say something to his employer, as this is when he initially sought treatment. (Pet.Ex. 2).

16IWCC0602

Both Howell and Burne testified they were not aware Petitioner alleged he injured himself on December 5, 2013. (T. 60 - 62, Resp.Ex. 4, p. 8). Both confirmed Petitioner did not report the incident on that date, or thereafter. (*Id.*). Both Howell and Burne testified they were not questioned by either the OVC or the Navy about an incident involving Petitioner. (T. 63, Resp.Ex. 4, p. 9). Petitioner also admitted he did not report the incident to either the OVC or the Navy. (T. 36).

The medical records confirm Petitioner did not seek treatment until March 3, 2014, 88 days after the accident. By that time, Petitioner had not worked for Respondent for approximately 60 days. (Pet.Ex. 2, Res.Ex. 3).

The Arbitrator finds Petitioner failed to provide timely notice of the accident to Respondent.

In support of the Arbitrator's findings relating to (F) is the present condition of ill-being causally related to the injury, the Arbitrator finds the following facts:

The Arbitrator concludes Petitioner failed to prove his current condition of ill-being is causally related to the December 5, 2013 incident. First, Petitioner failed to prove that an accident occurred which arose out of and in the course of his employment with Respondent.

In addition, the Arbitrator finds Petitioner's testimony is not credible. On direct exam, Petitioner testified he had surgery on his left shoulder approximately twenty years before the alleged incident. (T. 8). On cross-examination, he confirmed that his left shoulder surgery was actually in 2003. (T. 42). Petitioner admitted he did not mention his prior left shoulder treatment to his treating orthopedic physician, Dr. Chhadia. (T. 41). Petitioner confirmed when he initially saw Dr. Chhadia he was given a set of forms to fill out. (T. 39). Petitioner testified he was assisted by some women who worked in the office. (*Id.*). They asked him the questions, and he provided the answers to the best of his ability. (*Id.*). The intake form confirms the only surgery Petitioner reported to Dr. Chhadia was one involving the right shoulder, which occurred in 1992. (Pet.Ex. 3). In fact, the report from Dr. Chhadia's initial evaluation on April 4, 2014 states Petitioner "denies previous shoulder problems." (Pet.Ex. 3).

Petitioner also did not provide Dr. Atluri a history of his prior left shoulder care. Dr. Atluri advised Petitioner denied any prior left shoulder problems, stating that his only prior surgery was in 1992 for his right shoulder rotator cuff (*Id.*, p. 2). Dr. Atluri stated that after questioning Petitioner about scarring on his left wrist and left shoulder, he admitted to having a left shoulder surgery 20 years prior and that he had left wrist surgery thereafter. (*Id.*, p. 2). Petitioner asserted that when Dr. Atluri asked him about prior surgery, he did provide a history of the right shoulder surgery. (T. 44). When questioned about any prior left shoulder surgery, Petitioner testified he did not know whether he responded to the question because Dr. Atluri was going to examine him and find the details. (*Id.*).

The medical records substantiate the opinions of Dr. Atluri, Respondent's Section 12 physician, that Petitioner was suffering from an ongoing degenerative process in the left shoulder. (Resp.Ex. 1). Dr. Atluri stated that while surgery was appropriate, Petitioner's ability to continue working his regular job and wait until he sought treatment was consistent with an ongoing degenerative process, and not an acute rotator cuff tear. (Resp.Ex. 1). The MRI was positive for severe hypertrophic degenerative changes in the AC joint, osteoarthritis, severe tendinosis and a tear in the supraspinatus tendon with retraction. (Pet.Ex. 2). The operative report notes there was a previous repair noted in the supraspinatus tendon where the sutures had ripped out of the tendon. (Pet.Ex. 3).

Therefore, the Arbitrator concludes Petitioner failed to prove his current condition of ill-being is causally related to the alleged work accident by a preponderance of the credible evidence.

In support of the Arbitrator's findings relating to (J) were the medical services that were provided reasonable and necessary, & has the Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following facts:

Petitioner failed to prove he suffered a work related incident on December 5, 2013. Therefore, the Arbitrator finds Petitioner failed to prove the medical bills submitted were reasonable, necessary and causally related to the injury.

In support of the Arbitrator's findings relating to (K) what amount of compensation is due for temporary total disability, the Arbitrator finds the following facts:

Petitioner failed to prove he sustained injuries that arose out of and in the course of his employment with Respondent on December 5, 2013. Therefore, the Arbitrator concludes Petitioner failed to prove entitlement to temporary total disability benefits.

In support of the Arbitrator's findings relating to (L) what is the nature and extent of the injury, the Arbitrator finds the following facts:

Petitioner failed to prove he sustained injuries that arose out of and in the course of his employment with Respondent on December 5, 2013. Therefore, the Arbitrator concludes Petitioner failed to prove the alleged injury caused any permanency.

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

MICHAEL KRISFALUZY,

Petitioner,

16IWCC0626

vs.

NO: 14 WC 10337

PERRY COUNTY HOUSING 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 issue of nature and extent and being advised of the facts and law, corrects 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.

Contained within the Decision of the Arbitrator are multiple scrivener's errors. There are inconsistencies in the references to Petitioner's average weekly wage rate and the corresponding temporary total disability benefits Respondent shall pay Petitioner listed in the Memorandum of Decision of Arbitrator, Conclusions of Law relating to issues (K) and (N) and in the Order regarding Respondent's temporary total disability overpayment. The parties stipulated that Petitioner's earnings in the year preceding the injury are $48,667.44; the average weekly wage was $935.91. Based upon the average weekly wage of $935.91, Petitioner's entitlement to temporary total disability benefits is $623.94. The Findings on page 2 of the Arbitrator's Decision regarding Respondent's credit for TTD, $51,608.73 is consistent with 82-5/7 weeks of TTD paid at the correct rate $623.94.

Also, contained within the Memorandum of Decision of Arbitrator, Conclusions of Law, specifically the last paragraph on page 6, and in the Order addressing §8(e) specific loss, the Arbitrator refers to the Petitioner's right leg. Both the Conclusions of Law and the Order should reflect that Petitioner sustained 40% loss of use of his left leg.

16IWCC0626

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $623.94 per week for a period of 82 weeks from November 12, 2013 through July 7, 2015, the date he was released to return to work full duty, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall be given credit for amounts paid, including the overpayment of 5/7 week, $445.49, for the period of July 8, 2015 through July 12, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $561.55 per week for a period of 86 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 40% loss of use of the left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services related to Petitioner's left knee as reflected in Petitioner's Exhibit 4 that remain unpaid, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for amounts paid, as agreed by the parties.

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

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

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

DATED: SEP 30 2016
KLW/bd
O: 8/8/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0626

KRISFALUZY, MICHAEL
Employee/Petitioner

Case# **14WC010337**

PERRY COUNTY HOUSING AUTHORITY
Employer/Respondent

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
#3 EXECUTIVE WOOD CT SUITE 100
BELLEVILLE, IL 62226

0000 RUSIN & MACIOROWSKI LTD
SARAH K TRIPP
231 W MAIN ST SUITE 2E
CARBONDALE, IL 62901

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

16IWCC0626

MIKE KRISFALUZY
Employee/Petitioner

v.

PERRY COUNTY HOUSING AUTHORITY
Employer/Respondent

Case # **14** WC **10337**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **January 13, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ 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 14, 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 with regard to his left knee. Petitioner's bout of pneumonia following surgery ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$48,667.44**; the average weekly wage was **$935.91**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** paid ***or will pay*** all appropriate charges for all reasonable and necessary medical services ***related to Petitioner's left knee***.

Respondent shall be given a credit of **$51,608.73** for TTD, **N/A** for TPD, **N/A** for maintenance, and **N/A** for other benefits, for a total credit of **$51,608.73**.

Respondent is entitled to a credit of ***any and all payments made*** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that his bout of pneumonia was causally related to his accident of August 14, 2013. All benefits relating to the pneumonia are denied.

Respondent shall pay reasonable and necessary medical services related to Petitioner's left knee as reflected in Petitioner's Exhibit 4 that remain unpaid, pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for amounts paid, as agreed by the parties.

Respondent shall pay Petitioner temporary total disability benefits of $623.54/week from November 12, 2013, through July 7, 2015, the date he was released to return to work full duty. Respondent shall be given credit for amounts paid, including the overpayment of 5/7 week, $445.39, for the period of July 8, 2015, through July 12, 2015.

Respondent shall pay Petitioner the sum of $561.55/week for a period of 86 weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused a **40% loss of use of the right leg.**

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

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

Signature of Arbitrator

March 15, 2016
Date

MAR 17 2016

STATE OF ILLINOIS)
) ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MIKE KRISFALUZY
Employee/Petitioner

16IWCC0626

v.

Case #: **14 WC 10337**

PERRY COUNTY HOUSING AUTHORITY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This matter was previously tried before Arbitrator Nowak pursuant to Section 19(b) of the Act. On April 3, 2015, Arbitrator Nowak rendered his decision on this matter, finding that Petitioner had sustained a compensable accident arising out of and in the course of his employment, which caused injury to his left knee. He further found that the accident caused Petitioner's previous ACL graft to rupture, necessitating medical treatment, including a total knee replacement. Arbitrator Nowak ordered Respondent to pay TTD, medical expenses, and prospective medical care of the total knee replacement. Those findings are hereby incorporated by reference. PX5.

On his date of accident, Petitioner was 57 years of age, married, with no dependent children. He was employed as a maintenance supervisor for Respondent. On August 14, 2013, Petitioner was exiting a dump truck when he twisted his left knee. Petitioner came under the care of Dr. David Wood on September 3, 3013, who recommended conservative treatment of physical therapy, a knee brace, and light duty work restrictions. Following unsuccessful conservative treatment, Dr. Wood recommended a left total knee replacement. PX5.

Petitioner testified he underwent the left total knee replacement in February 2015 and following surgery he developed pneumonia, for which he sought hospital care. He testified he was released by Dr. Wood to return to work on July 7, 2015. Since his release he has noticed if he stands for ten to fifteen minutes his knee stiffens up and he has to wait for it to get mobile. He takes care when stepping up on stairs or a curb. He testified he is unable to kneel and does not attempt to squat. It hurts to get on his knees, so he tries not to do so. Petitioner testified he walks two to three miles at least every other day, and that after two miles his left leg starts dragging a little bit. If he lifts anything heavy his left knee will hurt. If he goes up stairs he makes sure there is a handrail to assist him. Since the surgery he has noticed a little bit of a pop in the knee when he walks, which he will discuss with Dr. Wood at his next appointment.

Petitioner testified he is able to bend his knee all the way but cannot fully extend it straight out. He has noticed he limps if he has had to stand for any period of time, if he has tried to lift something heavier, or if he walks farther than two miles.

Petitioner's job with Respondent was head of maintenance/assistant director. His job duties included moving equipment and furniture, rehabbing apartments, and office work. Petitioner testified that following his work accident Respondent originally did not have light duty work available; however, in January 2014 he was called in by Respondent as light duty work had became available. He worked light duty through the last day of February 2014. At that point he testified he was told by Respondent that they could no longer accommodate his restrictions and that he would have to either resign with a letter of recommendation or be terminated. He opted to resign. Dr. Wood released Petitioner to work with no restrictions on July 7, 2015, but he was not hired back by Respondent. At the time of trial Petitioner testified he was not working but had been searching for work since his release in July 2015.

On cross-examination Petitioner acknowledged that since his full duty release in July 2015, he has sent out his resume only five times, though does plan to continue to look for work. He last saw Dr. Wood on July 7, 2015, at which time Dr. Wood did not recommend any additional treatment for his knee. He was not provided any prescriptions for pain medication or anti-inflammatories, nor is he currently taking any. He was prescribed Norco following his surgery, which he took for about a month, but has not taken any pain medication since approximately March 2015. He does not use any type of walking cane or device, except on rare occasions when he uses a walking stick. He does not wear a knee brace. He is scheduled to follow up with Dr. Wood in April 2016. He testified that the issues he was having with his left knee prior to surgery, including pain and instability, have resolved. He occasionally has pain, maybe once a month. He has difficulty getting up and down on his knees and it causes pain which usually lasts until he can exercise the leg a little. Petitioner acknowledged he felt he had a good result from his surgery, with only occasional instances of instability. He testified he saw a physician in St. Louis at the request of Respondent, who told him it could take at least 18 months for his knee to fully heal, and that he would get better over time.

Following the accident, Petitioner began treating with Dr. John Wood at Orthopedic Institute of Southern Illinois. Dr. Wood's records document a consistent history of the accident, as well as history of Petitioner's previous reconstructive surgery of the anterior cruciate ligament with fixation hardware in 1999, and current post-traumatic degenerative arthritis of the left knee. Dr. Wood recommended a left total knee replacement. PX1, RX1.

On February 11, 2015, Petitioner underwent surgery at Memorial Hospital of Carbondale for left total knee arthroplasty and removal of internal fixation hardware. Post-operative diagnoses were left knee severe degenerative arthritis and painful internal fixation hardware. A post-operative consultation was conducted prior to discharge, at which time it was noted Petitioner's lungs were clear bilaterally on examination. PX2, RX1.

Petitioner followed up with Dr. Wood on March 10. 2015. Dr. Wood noted Petitioner had post-operative pneumonia and was hospitalized after surgery for four days. He did not reference reviewing medical records from the hospitalization, but rather stated this

hospitalization slowed the home therapy for Petitioner's left knee. He noted Petitioner had reduced range of motion as well as diffuse swelling. Dr. Wood gave Petitioner a prescription for Keflex, and advised he was to take it one hour prior to any dental cleanings or procedures for the life of his (knee) implant. He ordered outpatient physical therapy at that time. PX1, RX1.

Petitioner participated in physical therapy on March 17, 19, and 24, 2015, with an emphasis on decreasing pain, increasing range of motion and improving ambulation and stair climbing. RX1. He returned to Dr. Wood on March 24, 2015, at which time he reported he was overall improving and was able to walk a half mile a day. Dr. Wood noted he had improved range of motion with some diffuse swelling, as expected. He further noted Petitioner could work light duty, with sedentary work only and limited ambulation. PX2, RX1. Petitioner continued in physical therapy from March 26, 2015, through Aril 28, 2015, and continued to improve with goals. RX1. He returned to Dr. Wood on April 28, 2015, at which time he reported he was doing well and not using any assistive devices. He was ambulating without significant obvious asymmetry or antalgia. On examination, his range of motion was somewhat improved was but still limited. Knee x-rays showed the prosthesis to be in good position. PX1, RX1. Petitioner continued in physical therapy from April 30, 2015, through May 26, 2015, and continued to improve. As of May 26, 2015, he had minimal pain, no significant difficulty ascending stairs, some hesitation descending stairs, and was walking about a mile a day. RX1.

Petitioner returned to Dr. Wood on May 26, 2105, at which time he reported that he was doing very well. On examination he had three to five degree flexion contracture, but was able to straighten his knee out pretty good. He had a strong ligamentous exam. Petitioner related he was still having trouble with some activities, such as doing a deep knee bend to get something off the floor. Knee x-ray showed the total knee replacement to be in good position without any evidence of complication. Dr. Wood indicated the need to advance Petitioner to work hardening, and kept him on light duty of no kneeling, crawling, or ladder climbing, and limited stair climbing and walking on uneven terrain. Petitioner followed up with Dr. Wood on July 7, 2015, at which time he was doing well with no complaints. Dr. Wood noted improved range of motion and only a minimal limp on ambulation. He released Petitioner to return to work full duty with no restrictions. He again discussed with Petitioner the need for dental prophylaxis for all routine dental procedures. Petitioner was told to return to Dr. Wood in nine months. PX1, RX1.

Petitioner was examined by Dr. Michael Milne on December 7, 2015, at Respondent's request. Petitioner reported he was doing very well since the surgery, though he did have intermittent pain with quick motions or lifting heavy objects. On examination, Dr. Milne noted Petitioner lacked about three degrees of terminal extension and he had minimal atrophy of the quadriceps muscle. Knee x-rays taken that day showed the total knee arthroplasty to be intact with well-maintained components and no evidence of loosening. Dr. Milne reviewed Dr. Wood's treating records and also noted the history that Petitioner had pneumonia post-operatively. The Arbitrator notes, however, that it does not appear Dr. Milne reviewed the actual hospital records regarding the inpatient treatment of said pneumonia. Dr. Milne opined that Petitioner could work without restrictions. He further provided an AMA rating of 25% of the left lower extremity. He utilized the 6th Edition of the AMA Guidelines to Impairments, Table 16.3, page 511. RX2.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is related to the injury, the Arbitrator finds the following:

The parties stipulated that Petitioner sustained an accident which arose out of and in the course of his employment on August 14, 2013, and that he injured his left knee as a result of the accident. The parties further stipulated, pursuant to the prior 19(b) Decision, that Petitioner's left total knee replacement and his current condition of ill-being with regard to the left knee are causally related to the accident. Respondent disputed that Petitioner's episode of pneumonia in February 2015 was related to the accident. Arb.X1.

"Liability cannot be premised upon imagination, speculation, or conjecture but must arise from facts established by a preponderance of the evidence." *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that the pneumonia he contracted in February 2015 was related to his accident. In so concluding, the Arbitrator notes that no medical records were submitted into evidence regarding the diagnosis, treatment, or causal connection of the pneumonia.

In support of the Arbitrator's decision relating to issue (J), whether the medical services there were provided to Petitioner were reasonable and necessary, and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under Section 8(a) of the Act…a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill.App.3d 463,470 (4th Dist. 2011) (citing *University of Illinois v. Industrial Comm'n*, 232 Ill.App.3d 154,164 (1st Dist. 1992)).

The parties stipulated that Respondent has paid or will pay for medical services related to the diagnosis and treatment of Petitioner's left knee. The Arbitrator finds that Respondent is liable for outstanding medical bills related to Petitioner's left knee, as set forth in Petitioner's Exhibit 4. In light of the Arbitrator's finding above that Petitioner failed to prove that his bout of pneumonia was causally related to his accident, all medical bills and expenses related thereto are denied. The Arbitrator notes that the bill submitted from Memorial Hospital of Carbondale for dates of service February 17, 2015, through February 20, 2015, included services for physical and occupational therapy on February 19, 2015. While at first blush it may appear these services are possibly related to Petitioner's knee, there are no medical records to substantiate same. The

record from Dr. Wood of March 10, 2015, nearly three weeks later, states in part, "We are going to start him on outpatient physical therapy program". PX1, RX1. In addition, the physical therapy note of March 13, 2015, indicates the service that day was "Initial Evaluation/Examination". PX2, RX1. In light of these records, and in the absence of records from Memorial Hospital, the Arbitrator finds that these services are not related to Petitioner's left knee and are denied.

The parties stipulated and the Arbitrator finds that Respondent is entitled to a credit for medical benefits previously paid.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to temporary total disability benefits, and issue (N), Respondent's entitlement to any credit, the Arbitrator finds the following:

The parties stipulated and the Arbitrator finds that Petitioner was temporarily and totally disabled from November 12, 2013, through July 7, 2015, and that Respondent paid TTD benefits from November 12, 2013, through July 12, 2015. The Arbitrator finds that Respondent overpaid TTD benefits for five days (5/7 week) and is entitled to a credit of same. In so concluding, the Arbitrator notes that Dr. Wood released Petitioner to return to work full duty on July 7, 2015. The parties stipulated that Petitioner's average weekly wage at the time of the accident was $935.31, yielding a TTD rate of $623.54 per week. The Arbitrator finds that Respondent is entitled to a credit of 5/7 week, or $445.39.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring after September 1, 2011, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors:

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, Dr. Milne opined that Petitioner sustained an impairment of 25% of the left lower extremity in accordance with the AMA Guides to the Assessment of Permanent Impairment, 6th Edition, Table 16.3, page 511. Dr. Milne based his impairment rating on his review of Petitioner's medical records, Petitioner's subjective complaints, and the objective physical examination. Petitioner did not offer his own impairment rating. The Arbitrator recognizes that impairment and permanent partial disability as defined by the AMA Guides are not the same, and the Arbitrator makes note of this distinction when assessing the weight given to Dr. Milne's impairment rating at issue and in determining the permanency award. The Arbitrator gives significant weight to this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reflects that Petitioner was employed as a maintenance supervisor at the time of the accident. His job duties included moving equipment and furniture, rehabbing apartments, mowing grass, and office work. Petitioner resigned from his employment with Respondent in February 2014. He was released without restrictions by his treating physician, Dr. Wood, on July 7, 2015. Since his release,

Petitioner has not worked. He testified he has been looking for work, but in the six months following his release he has only sent out his resume five times. There is no evidence that Petitioner is unable to perform the full duties of his prior occupation or any other occupation. The Arbitrator gives some weight to this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 57 years old at the time of the accident. He was released to return to his prior position without restrictions. Given his age, he would have to work with the ill effects of his injury for only a short period of time. The Arbitrator finds that over time Petitioner's condition could improve, stay the same, or get worse. However, there was no evidence offered to indicate with any degree of likelihood how his age would impact his disability, and the Arbitrator does not speculate as to same. The Arbitrator gives some weight to this factor.

In regard to factor **(iv) the employee's future earning capacity**, Petitioner was released to work full duty, with no restrictions. He resigned his employment with Respondent in February 2014, while under light duty work restrictions. Neither party offered any evidence to show that Petitioner's future earning capacity has been impacted, and the Arbitrator has no basis to expect he will have any decreased earning capacity in the future. The Arbitrator gives little weight to this factor.

In regard to factor **(v) evidence of disability corroborated by the treating medical records**, the Arbitrator notes Petitioner underwent a left total knee replacement. The medical records document Petitioner's complaints of pain and limitations throughout his treatment. However, at his final examination by Dr. Wood on July 7, 2015, Petitioner reported he was doing very well with no complaints and did not have to use any assistive devices. Dr. Wood noted good range of motion and only a minimal limp on ambulation. Petitioner testified his knee tends to stiffen up if he stands for ten or fifteen minutes, that he is unable to kneel or squat, that he takes care when going up stairs, and that he is able to walk two to three miles a day. He also testified he cannot fully extend his knee straight out and that he notices he limps after standing for a short period of time or if he has tried to lift something heavier or if he walks farther than two miles. The Arbitrator gives significant weight to this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that Petitioner has sustained a 40% loss of use of the right leg (86 weeks) pursuant to Section 8(e) of the Act. The Arbitrator finds that Petitioner's average weekly wage is $935.91 and further finds that his permanent partial disability rate is $561.55.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jesus Hernandez,

Petitioner,

vs.

NO: 14 WC 11928

Highland Baking Company,

16IWCC0581

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 30, 2015, 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.

16IWCC0581

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 $13,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP - 8 2016
TJT:yl
o 8/30/16
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

HERNANDEZ, JESUS
Employee/Petitioner

Case# **14WC011928**

HIGHLAND BAKING COMPANY
Employer/Respondent

16IWCC0581

On 10/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0815 LUIS A ACEVES & ASSOC PC
EMILIANO PEREZ JR
1931 N MILWAUKEE AVE
CHICAGO, IL 60647

4234 RIPES NELSON BAGGOT ET AL
KIMBERLY A SCOTT
2353 HASSELL RD SUITE 115
HOFFMAN ESTATES, IL 60169

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook

16IWCC0581

☐ Injured Workers' Benefit 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)

Jesus Hernandez
Employee/Petitioner

v.

Highland Baking Company
Employer/Respondent

Case # 14 WC 11928

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 **9/1/15**. 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 **Prospective medical (back surgery)**

16IWCC0581

FINDINGS

On the date of accident, **02/28/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,176.80**; the average weekly wage was **$503.40**.

On the date of accident, Petitioner was **43** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of **$16,758.00** for TTD, **$n/a** for TPD, and **$n/a** for maintenance benefits, for a total credit of **$16,758.00**. Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$4,976.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid.

Respondent shall pay Petitioner temporary total disability benefits of **$335.60/week** for **75-5/7th** weeks, commencing **3/21/14** through **9/1/15**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for TTD already paid for the awarded time period.

Respondent shall authorize and pay for the surgical recommendations made by Dr. Erickson, including all reasonably anticipated related medical 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

10/29/15
Date

OCT 30 2015

BACKGROUND 16IWCC0581

Jesus Hernandez ("Petitioner") and Highland Baking Company ("Respondent") proceeded to arbitration on 9/1/15 on all disputed issues in case number 14 WC 11928 for which Petitioner alleged a 2/28/14 accident and lumbar spine injury arising out of and in the course of his employment with Respondent. At issue were the following: accident, causal connection, liability for unpaid medical bills, temporary total disability benefits and future medical under Section 8(a). Ax1, Px6, Rx4.

FINDINGS OF FACT

Jesus Hernandez ("Petitioner") testified via Spanish interpreter/translator Olivia Alfaro, that he was employed by Highland Baking Company ("Respondent") for about one year prior to 2/28/14. He worked for this bakery as a packager, picking up packages from a an assembly line, loading the boxes onto a skid then taking the skid to get wrapped. He said he would pack the boxes on top of a skid. Each skid carried about 40 boxes and each box weighed about 33 kilos. After loading a full skid, he would move the skid and load another. The full skid would then be shrink-wrapped. He would move a full skid by first pulling it then pushing the skid up a ramp. He said he was the one who removed the boxes and the pallet. He was rotated throughout various positions.

On 2/28/14, Petitioner said he worked for Respondent and was injured when he was pulling and pushing the skid full of boxes up the ramp to take them to get wrapped. He used a jack to push and pull up the ramp and that is when he felt immediate pain and pulsating (pointing to the back). On cross, he stated that the day in question, he worked with product that was able to fill a box with about 12 breads. He said the incline was small and that the pallet jack was hydraulic. On cross, Petitioner testified and clarified that he is alleging that he feels he was injured while pushing the loaded pallet of breads. Petitioner testified he reported his injury that same day to Raul, his supervisor. On cross, he stated that after reporting that he then spoke to Dan Cintron. Petitioner attempted to obtain medical care that same date but the company clinic doctor was not in. He said an appointment was made the next day, on Saturday.

On 3/1/14, he began and first sought treatment with Northshore and Dr. Susan Piazza. Px1. Records show that Petitioner complained of low back pain at the lumbar level bilaterally after pulling a pallet loaded with boxes. Petitioner reported 8 out of 10 pain, without radiation, worse with bending, relieved with positioning. Objectively, the doctor noted a normal gait, difficulty getting up from a seated position, tenderness to palpation in the right and left paraspinal area, restricted range of motion, negative straight leg raise. The doctor assessed lumbar strain and prescribed home exercise, ibuprofen, Flexeril, light duty work and follow up. He stated he was truthful and honest with the doctor and that he wanted to get better.

On cross, he state he returned to light duty and that he worked in the same amount of pain and did not feel any increase in pain while working the light duty. On cross, he said the light duty consisted of cleaning the machines and picking up bread.

On 3/13/14, he returned to Dr. Piazza. Px1. The doctor noted that since the last visit, symptoms had not changed. There was pain without radiation. Of note, pain was worse with bending and lateral bending. Petitioner reported a new symptom of left inguinal area pain worse with lateral bending and complained of a "crack" in the lower back. Objectively, gait was normal, Petitioner was able to rise from chair without difficulty, palpation showed tenderness at the mid to lower lumbar midline and right iliac crest, range of motion

restricted in flexion, negative straight leg raise. Waddell signs were negative. Lumbar x-ray showed marked degenerative changes involving the lower lumbar facet joints, mild to moderate degenerative changes of the lower lumbar disc spaces and mild grade 1 anterolisthesis of L4 on S1 without spondylolysis. Assessment was unchanged. The doctor prescribed naproxen, Tylenol, discontinued ibuprofen, and continued light duty and follow up. Petitioner was referred to physical therapy. Petitioner said that he was terminated on 3/14/14.

On 3/25/14, Petitioner returned to Dr. Piazza. Px1. The doctor noted that Petitioner was generally improved but presented with pain worse with extension first thing in the morning and with working fast. She noted he had not been working. Back pain was without radiation, gait was normal, straight leg raise was negative but Petitioner showed difficulty getting up from a chair. Waddell was negative. The doctor assessed lumbar strained improved but not resolved. She ordered flexion-based physical therapy, continued home exercise, restrictions and follow up.

On 4/11/14, Petitioner began treating with Michigan Avenue Medical Associates and Dr. Robert Erickson. Px2. The date of injury listed was 2/28/14. Petitioner testified he communicated with the doctor using the office's Spanish interpreter/translator. The doctor wrote that Petitioner was injured at work after he stood upright and experienced a sudden pain the back. Immediately prior, Petitioner had been stacking boxes weighing between 30-35 pounds and he was loading a skid and that he then bent with that load. Petitioner reported pain in the low back and numbness in the palms on both sides. On exam, Petitioner stated he was able to sit and walk for one hour and that he had increased pain with extension. Exam showed bilateral sacroiliac tenderness and negative straight leg raise. Therapy, an MRI of the lumbar spine and medications were prescribed. The doctor opined that "this recommendation for further testing and treatment is to be regarded as a result of the injury occurring March 28, 2014." Petitioner testified that he told the doctor that day he was doing both packing and stacking and that he was giving a description of the job duties.

On 4/15/14, an MRI of the lumbar spine was completed. Px3. Dr. Djordje Boskov interpreted the scan as showing diffuse lumbar spondylosis with multi-level annular disc bulging and hypertrophy of posterior elements and at L4-5 a 3.5mm diffuse disc/osteophyte complex and hypertrophy of posterior elements causing mild spinal and mild/moderate bilateral neural foraminal stenosis. Grade 1 anterolisthesis of L4 on L5 was also visualized.

Thereafter he began physical therapy with Premier Physical Therapy. Px4. He testified he performed therapy 3 times per week and he testified it was helping. The mechanism of injury reported in the therapist's records is that on 2/28/14, Petitioner injured himself at work after unloading 30-35 pound boxes off of a conveyor belt.

On 5/16/14, he followed up with Dr. Erickson. Px2:5. Somatosensory evoked potential testing (SSEP) showed significant delay primarily on the right side concerning L5 with lesser delay on the left. Dr. Erickson interpreted the MRI as showing darkening of L4-5 interspace with a grade 1 listhesis and consequent lateral recess stenosis. The doctor noted Petitioner may have mild carpal tunnel syndrome bilaterally based on his palmar pain and that he was without neck pain. Subjectively, Petitioner stated that he has mild pain while seated, could stand for 1 to 2 hours and walk 1 to 2 blocks at a time. The doctor recommended EMG/NCV testing to confirm evoked potentials and recommended possible lumbar injections. The doctor diagnosed non-radicular low back pain probably related to the listhetic change present at L4-5. Further, the doctor opined that his recommendations were regarded as the consequences of the work injury.

On 6/12/14, Petitioner began treating with Dr. Neeraj Jain. Px2:11. The doctor noted that on 2/28/14 Petitioner injured his low back after standing upright following bending over to lift a box. Dr. Jain noted back pain without radiation, increased with prolonged activities of sitting, standing and walking. Activities of daily living were limited. Exam showed normal gait, hamstring tightness following straight leg raise, severe pain to palpation bilaterally at the lumbosacral junction, increased with some extension and flexion. Petitioner exhibited reproducible pain over the sacroiliac joint bilaterally. Dr. Jain interpreted the SSEP results as showing evidence of bilateral radiculopathy as confirmed on MRI, which he interpreted as showing disc herniation at L3-4 and L4-5 with anterolisthesis at L4-5. The doctor noted that axial back pain that was extension based was worse. The doctor believed Petitioner could benefit from lumbar facet joint injections at L3-4, L4-5 and L5-S1 to address symptoms. The doctor noted that Petitioner had some preexisting facet arthropathy and was not previously symptomatic with pain. Petitioner was taken off of work. The doctor opined that Petitioner's preexisting condition was rendered symptomatic as a result of the injury and that treatment was reasonable and necessary. On cross, Petitioner stated he told Dr. Jain that he was both stacking and moving the boxes on the pallet.

On 7/7/14, physical therapists noted that Petitioner was without any bilateral lumbar spine region pain approximately 75% of the time. Px4:1. However, bending or twisting of the back continued to provoke pain. Petitioner had no lower extremity radicular pain and/or paresthesias bilaterally. Additional therapy was recommended.

On 7/17/14, Petitioner followed up with Dr. Jain. Px2:16-19. Petitioner reported improvement with therapies, medications and patches but that he still had pain in the lower back radiating to the groin area down the front part of the leg all the way to the foot. Petitioner also reported increased pain with bending back, limited daily activities and that he was sedentary. He rated his pain at 5 out of 10 with rest and 7 out of 10 with activity. Physical exam and recommendations were unchanged from prior visit.

On 7/24/14, Petitioner underwent a bilateral L3-4, L4-5 and L5-S1 facet joint injection. Px5:1. Diagnosis was lumbar facet syndrome, lumbar discogenic pain and lumbosacral radiculopathy. He underwent the first injection at Gold Coast Surgery Center with Dr. Jain. Petitioner testified that he felt the injections helped about 50% but that the improvement lasted only about one week. Petitioner followed up with Dr. Jain and reported 70-80% improvement. Px2:20. Exam showed axial low back and pain at the lumbosacral junction bilaterally, increased with 15 degrees of extension and rotation. Due to excellent response, additional facet injections were recommended. Petitioner's medications, off work status and therapy were continued. Petitioner followed up again on 9/4/14 and recommendations were largely unchanged. On 9/4/14, Petitioner was discharged from therapy per doctor order. Px4:88. Prior to discharge, Petitioner reported he was without any lumbar spine region pain approximately 90% of the time. Bending and twisting provoked pain but was improved. *Id.* at 89-91. On 9/24/14, Petitioner underwent additional bilateral L3-4, L4-5 and L5-S1 facet joint injections. Px5:19.

On 10/2/14, Petitioner followed up with Dr. Jain, who noted Petitioner had some benefit and rated his pain 3 out of 10. Petitioner complained of stabbing sensations in the lower back and limited ability to bend and lift. Exam showed lumbar axial pain, pain to palpation in the paraspinal muscles with hypertonicity, pain with extension and negative straight leg raise bilaterally. The doctor recommended bilateral L3 through S1 medial branch block to prognosticate the efficacy of a longer lasting lumbar rhizotomy. The doctor opined that although Petitioner had some preexisting asymptomatic facet changes, they were noncontributory to his current pain.

On 10/16/14, Petitioner underwent bilateral L3, L4, L5 and dorsal root of L5 medial branch nerve blocks for the facet joints at L3 through S1. Px5:36. In follow up, Petitioner reported 90% improvement with an overall 80% improvement. Pain was still located bilaterally in the low back, along with clicking and crepitus with range of motion. The doctor noted that activities of daily living were limited due to inability to lift, bend or tolerate sitting or standing for prolonged periods of time. Exam showed 2 out of 10 pain at rest, 6-7 out of 10 pain with bending or activity. Extension based pain was noted bilaterally to 15 degrees at midflexion. Based on Petitioner's response, Dr. Jain recommended a second step with 2% Lidocaine without steroid followed by possible radiofrequency ablation. The doctor also noted that Petitioner had plateaued in therapy and only additional therapy would be warranted if definitive procedure was done. Px2:33-34.

On 11/20/14, Petitioner underwent a second round of medial branch nerve blocks at the same levels. Px5:54. On 12/9/14, Petitioner followed up with Dr. Jain and described 80% improvement with both rounds of injections. Petitioner also noted improved numbness bilaterally into the lower extremity. He complained of stiffness, pain at night and pain with lifting or bending. He has limited activities of daily living. The doctor opined that because of Petitioner's response to the two medial branch blocks, he predicted a likely positive outcome and long term relief with radiofrequency ablation of the medial branch blocks. The doctor opined Petitioner's condition causally related to his work injury and related the medical treatment and recommendations as related to the work injury. Px2:37-38. Petitioner remained off of work.

On 1/5/15, Petitioner was re-examined by Dr. Jain who noted that Petitioner continued with moderate to severe bilateral low back pain, occasionally radiating to the right lower extremity with constant stiffness and only transient response to physical therapy. Opinions and recommendations were unchanged. Px2:45-46, 49-50. On 1/22/15, Petitioner underwent left L2-L5 and dorsal root of L5 medial branch block radiofrequency ablation. Px5:71. On 2/12/15, Petitioner followed up with Dr. Jain and reported an overall 20% improvement. Pain remained primarily axial and non-radiating. Exam showed 2 out of 10 pain and pain that was extension-based. The doctor recommended additional therapy and continuation with ablation on the right. If pain persisted, discogram would be considered. Petitioner remained off work. Px2:53-54. On 1/29/15, Petitioner underwent right L2-L5 and dorsal root of L5 radiofrequency ablation. Px5:89.

On 3/12/15, Petitioner followed up with Dr. Jain and reported substantial continued benefit from ablation. Most radicular pain had abated but he continued with centrally located lumbar pain rated at 2 out of 10 with occasional shooting pain when transitioning from sitting to standing or heavy lifting. The doctor noted Petitioner had plateaued with therapy and it was discontinued. Petitioner was continued off work and was referred to Dr. Erickson for neurosurgical consult. Px2:61-62. On 3/20/15, Petitioner was evaluated by Dr. Erickson. *Id.* at 64. The doctor noted that sufficient time had passed with treatment to recommend surgical treatment to address the L4-5 stenosis related to the grade 1 anterolisthesis and nerve root compression. SSEP testing was repeated to confirm delay at L5, which was found worse on the right side. The doctor diagnosed mechanical low back pain due to traumatic alteration at L4-5. The doctor recommended L4-5 surgery with a transforaminal approach on the right side, which he opined to be the result of Petitioner's work accident. On 7/10/15, Dr. Erickson again continued to recommend decompression and fusion. *Id.* at 76.

On 5/7/15, Petitioner was evaluated by Dr. Michael Kornblatt at the request of Respondent. Rx3. The doctor wrote a report and testified, consistent with that report that Petitioner complained of primarily low back pain without radicular leg pain. Exam showed normal objective findings. He diagnosed two level lumbar degenerative disc disease with L4-5 degenerative spondylolisthesis. He did not believe the conditions were caused, aggravated or accelerated by the work accident, as Petitioner did not present with a pinched nerve, radiculopathy or spinal stenosis. The doctor recommended work restrictions based on inactivity rather than any

work injury. Regarding treatment, the doctor concluded that Petitioner had received excessive and unnecessary medical treatment. He did not believe Petitioner was a surgical candidate. The doctor prepared an impairment rating and found a 0% whole person impairment rating.

In August 2015, Dr. Kornblatt testified via evidence deposition. Rx3. He testified Petitioner's intial treatment record showed Petitioner injured himself lifting boxes. The doctor stated he did not appreciate any evidence of radiculopathy on much of the medical notes he reviewed. He conceded that the SSEP results suggested L5 radiculopathy but that he had never used the test. He testified that Petitioner's injections and ablation would primarily be used to address mechanical low back pain and that he did not believe Petitioner had any evidence of mechanical low back pain. He testified Petitioner was not a surgical candidate.[1]

Petitioner testified that he wished to undergo the surgery. Petitioner testified that he suffers from back pain on a daily basis and that the nerves go all the way down and the same pulsating sensations he had. Petitioner testified he has trouble sleeping due to back pain. He is able to sleep 3 hours before he is awakened. He has trouble walking due to back pain and can do so about 30 minutes. He said he has trouble sitting or standing and has to move position. On cross, he acknowledged he had been sitting for the near entire hour of trial during his testimony. He testified that prior to the date in question, he did not have treatment for the low back, had no prior back pain, that the was able to perform his duties of Respondent without problem.

Petitioner testified he recalled an evaluation with 5/5/15 Dr. Kornblatt at the request of Respondent. Petitioner recalled he performed and exam of the low back that lasted about 10 minutes. On cross, Petitioner recalled that an interpreter was provided at that time. He denied telling him he felt 50% pain relief. Petitioner testified he is not currently receiving TTD and that the last TTD benefit received was through 5/21/15.

Testimony of Daniel Cintron

Daniel Cintron testified he works for Respondent and has been so for 6.5 years. He works as safety manager for last 3 years, whose duties include making sure rotating on regular basis and if there is an injury he is the one filing with insurance company. He said the south packing line has about 32 employees, consisting of 2 quality inspectors, 2 packers packing bread once its shrink wrapped, others make sure line is full of boxes and the wrapper who wraps and takes the stack to the shrink wrap machine. Not each employee works the same, every two hours the employees rotate. He said Petitioner worked as a stacker by placing boxes on a pallet. Once the pallet was filled, it was pushed/pulled onto the wrapper for wrapping and loaded elsewhere. That person then returned to stacking again. The amount of pieces per box depends on the product. Hamburger breads weighed 15 pounds per box, pan bread weighed 30 pounds per box and they also had other breads.

Cintron testified that the pallet is equipped with a hydraulic system to aid in raising and lowering the pallet. Once positioned, one can pull the jack loaded with the pallet. He estimated that it took about 25 pounds of pressure to get the pallet to move.

Regarding work place injuries, Cintron testified workers are to report to main supervisor, such as Raul. Then, Cintron, HR and Omega are involved, in that order. Cintron then files the form 45 with the carrier. Workers learn this process through monthly safety training. Cintron testified Petitioner followed this procedure with respect to his incident.

[1] Respondent exhibit 3 was entered into evidence with only deposition exhibits 1 and 15.

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He recalled Petitioner reported incident around 2pm and that he claimed his back was injured. Cintron testified Petitioner told him Petitioner was taking skids to the stretch wrap machine and that as he went to put it on the stretch wrapper he twisted his back. Cintron recalled Petitioner was stacking cases on that date. Cintron identified Rx1 as the injury form 45 completed by himself and that bore his signature.

Following the report, Cintron offered Petitioner medical attention with Omega. He recalled Petitioner returned to light duty work and that he would have been assigned to sweeping, wiping machines, quality control and/or packing the bread. He testified he had an opportunity to observe Petitioner work light duty tasks with comfort. On cross examination, Cintron said he made his observations while making his hourly rotations. He admitted he has not received training in behavior observation. As part of his rounds, however, he ensures workers follow restrictions and he looks for facial grimacing. Cintron said light duty work was available after Petitioner's termination date. He said they still have light duty work available today.

CONCLUSIONS OF LAW

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

The Arbitrator has carefully considered all testimonial evidence and medical evidence and concludes that Petitioner has credibly and persuasively proven by a preponderance of the evidence that on 2/28/14, he suffered an accident arising out of and in the course of his employment. In so finding, the Arbitrator relies on the testimony of Petitioner and Daniel Cintron, as well as the medical evidence. In support thereof, the Arbitrator incorporates the findings of fact as though fully set forth herein.

Petitioner testified that he injured his low back while trying to push and pull a loaded pallet jack up ramp where he was taking it to be shrink-wrapped. Petitioner's trial testimony is consistent with Cintron's testimony. Specifically, Cintron testified that Petitioner was stacking boxes on the date of the accident. Cintron described the job of stacking boxes as not only stacking boxes, but loading the boxes onto the pallet and taking the pallet via a pallet jack to be wrapped. Cintron testified, consistent with his injury report in Rx1 that Petitioner injured himself pushing up a pallet onto the plastic wrap machine. Cintron testified that at the time of the accident, Petitioner was assigned to stacking boxes. Read as a whole, it is clear that Petitioner was completing the last step in the process of stacking boxes when he became injured.

Petitioner's and Cintron's accident report is also consistent with Dr. Piazza's first history, which noted that Petitioner was injured at work after pulling a pallet loaded with boxes. The Arbitrator does not appreciate any significant difference between the description of pulling and/or pushing, as Petitioner testified that he both pushed and pulled the loaded pallet up the ramp. When Petitioner presented to Dr. Erickson, the doctor noted that Petitioner was injured at work after standing upright. Immediately prior, Petitioner had been stacking boxes, loading a skid and that he then bent with that load. Petitioner stated he used a translator/interpreter to communicate with the doctor. Again, read on the whole, the Arbitrator finds that Petitioner was describing to the doctor the end of the stacking process of working with the loaded pallet. This is consistent with Dr. Erickson's note that immediately prior to feeling pain upon standing upright; Petitioner was bent with the loaded pallet. When Petitioner began treating with Dr. Jain, the doctor noted back pain after standing upright from picking up a box. Petitioner stated he again used a translator/interpreter to communicate with the doctor. The Arbitrator resolves this apparent discrepancy in favor of Petitioner, as all other treatment records and accident report closer in time to the accident are most consistent not only with Petitioner's testimony and

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recollection but also with one another. In summary, the Arbitrator concludes that on 2/28/14, Petitioner sustained an accident arising out of and in the course of his employment with Respondent.

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

The Arbitrator concludes that the preponderance of the medical evidence shows that Petitioner's current condition of ill-being with respect to his lumbar spine is causally related to his work accident. Medical records indicate that prior to the date of accident; Petitioner's medical history was negative for any evidence of prior lumbar spine injury, symptoms or conditions. The Arbitrator finds Petitioner was otherwise in a state of good health prior to the onset of the low back and lumbar pain, which was the result of his work accident.

Dr. Piazza read x-rays to show mild grade 1 anterolisthesis of L4 on L5 without spondylolysis. The MRI was interpreted to show spondylosis with multi-level annular disc bulging and hypertrophy of posterior elements and at L4-5 a 3.5mm diffuse disc/osteophyte complex and hypertrophy of posterior elements causing mild spinal and mild/moderate bilateral neural foraminal stenosis. Grade 1 anterolisthesis of L4 on L5 was also visualized. Twice, SSEP testing confirmed delay at L5 on the right. Dr. Erickson interpreted the MRI as showing low back pain as a result of the listhetic changes at L4-5 caused by the work accident.

Where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is said to have been causally connected to the work-related injury and not simply the natural sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003). Thus, an injury need only be *a* cause of an employee's condition of ill-being, not the sole or primary causative factor.

Here, Drs. Erickson and Jain causally related Petitioner's pre-existing lumbar spondylosis and anterolisthesis at L4-5 as being aggravated or otherwise rendered symptomatic. This conclusion is supported by the lack of any evidence showing that these conditions were symptomatic prior to the accident in question. Dr. Jain also noted that although Petitioner had some pre-existing facet changes, those too were rendered symptomatic as a result of the work injury. Dr. Kornblatt opined that Petitioner's pre-existing conditions were not aggravated or accelerated by the work accident because Petitioner did not present with any pinched nerve, radiculopathy or spinal stenosis. However, this opinion ignores Petitioner's documented spondylosis via the initial x-ray, which was treated by Dr. Jain with facet injections to relieve the mechanical/axial low back pain. Dr. Kornblatt's opinion also ignores the evidence of radiculopathy shown on MRI and SSEP testing, treated by Dr. Jain with medical branch blocks and ablation, which is designed to treat nerve roots affected, in this case, in the facet joint areas. The Arbitrator notes that Dr. Kornblatt's opinions also contradict his opinions in his medical report wherein he opined that Petitioner suffered a strain and temporary exacerbation of pre-existing degenerative disc disease and L4-5 spondylolisthesis. Thus, the doctor previously acknowledged some degree of aggravation or exacerbation. In evaluating all medical opinions, the Arbitrator accords more weight to the treating medical opinions of Drs. Piazza, Erickson and Jain over Dr. Kornblatt. The Arbitrator concludes that Petitioner's condition as it relates to the lumbar conditions identified in the medical records to be causally related to his work accident. In so finding, the Arbitrator specifically denies any causal relationship between Petitioner's possible carpal tunnel syndromes noted in Dr. Erickson's records as there is no evidence to support same.

ISSUE (J) ***Where the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?***

At trial, Petitioner submitted the following medical bills, asserting them to be part of Respondent's liability. Ax1.

Px2a	Michigan Avenue Medical Associates	4/11/14 – 7/10/15	$156.00
Px4a	Premier Physical Therapy	4/11/14 – 9/03/14	$4,820.00

Dr. Kornblatt opined that treatment was excessive and unnecessary to treat what he considered to be a lumbar strain. There is no utilization review in the record to consider. The Arbitrator, having found Petitioner's condition of ill-being causally related to the accident, disagrees with this conclusion. There is evidence in the record that Petitioner's diagnosed conditions were appropriately treated with conservative care by way of therapy, injections and ablation. Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$4,976.00**, as provided in Sections 8(a) and 8.2 of the Act. Ax1, Px2a, Px4a. Respondent shall be given a credit for medical benefits that have been paid.

ISSUE (L) ***What temporary benefits are in dispute?***

Since the date of this accident, Petitioner has been ordered by all treating physicians to either restricted duty or off work. Petitioner's medical records show that Petitioner remains temporarily totally disabled and that his condition has not yet stabilized. *Matuszczak v. IWCC*, 387 Ill. Dec. 296 (2014). Petitioner testified that he last received benefits on 5/21/15. Pursuant to applicable case law, the Arbitrator will not consider Petitioner's termination from work with Respondent as germane to the issue of entitlement to temporary total disability. Respondent shall pay Petitioner temporary total disability benefits of **$335.60/week** for **75-5/7th** weeks, commencing **3/21/14** through **9/1/15**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of **$16,758.00** for TTD, **$n/a** for TPD, and **$n/a** for maintenance benefits, for a total credit of **$16,758.00**.

ISSUE (K), (O) ***Other – Prospective Medical Treatment***

The Arbitrator concludes that Petitioner is entitled to additional prospective medical care by way of lumbar spine decompression and fusion at L4-5 as recommended by Dr. Erickson. Medical records show that Petitioner attempted to treat the nerve compression was various facet joint injections, medical branch blocks and ablation with significant but temporary relief. At the July 2014 visit with Dr. Jain, Petitioner presented with ongoing low back pain and pain radiating down the leg to the foot. At Petitioner's most recent visit with Dr. Erickson, the doctor noted that Petitioner continued with primarily axial low back pain and some radicular pain.

The Arbitrator notes that Respondent did not submit Petitioner's request for spine surgery through utilization review in accordance with Section 8.7(i)(3) of the Act. The Arbitrator could reasonably conclude that Petitioner's denial of spine surgery is without sufficient basis. However, in addressing Dr. Kornblatt's opinion, the Arbitrator notes that Dr. Kornblatt's opinion that Petitioner was without mechanical low back pain ignores the medical evidence that Petitioner suffers from spondylosis and listhesis at L4-5 aggravated by the work injury. In stating Petitioner had no evidence of lumbar instability, Dr. Kornblatt did not address Petitioner's listhesis at L4-5. Further, the preponderance of medical evidence documents axial low back pain.

The Arbitrator finds Petitioner has properly exhausted all conservative medical care and that because he remains temporarily and totally disabled, he would benefit from the surgery recommended by Dr. Erickson.

16IWCC0581

Respondent shall authorize and pay for the surgical recommendations made by Dr. Erickson, including all reasonably anticipated related medical care.

ARBITRATOR SIGNATURE

10-29-15
DATE

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

John Marsh,

Petitioner,

16IWCC0593

vs.

NO: 14 WC 18122

G & D Integrated,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 4, 2015 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.

16IWCC0593

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 $13,800.00. 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: SEP 16 2016
KWL/vf
O-9/12/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0593

MARSH, JOHN
Employee/Petitioner

Case# **14WC018122**

G&D INTEGRATED
Employer/Respondent

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

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

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

4314 BRAD J BALKE PC
DAVID WILLIAMS
542 S DEARBORN ST SUITE 310
CHICAGO, IL 60605

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD A ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

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)

16IWCC0593

JOHN MARSH
Employee/Petitioner

v.

G&D INTEGRATED
Employer/Respondent

Case # 14 WC 18122

Consolidated cases: ___

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian Cronin**, Arbitrator of the Commission, in the city of **Geneva**, on **July 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. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the 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 ___

16IWCC0593

FINDINGS

On **April 2, 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 **$33,819.76**; the average weekly wage was **$650.38**.

On the date of accident, Petitioner was **30** years of age, ***single*** 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 **$14,593.25** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$14,593.25**.

ORDER

Prospective Medical Benefits

Respondent shall authorize and pay for Petitioner's left knee surgery, as recommended by Dr. Jason Hurbanek, in accordance with Section 8(a) and subject to Section 8.2.

Temporary Total Disability & Claimed Overpayment

Respondent shall pay Petitioner temporary total disability benefits of **$433.59** from **April 16, 2014** through **July 16, 2015**, or **65-2/7** weeks, as provided by Section 8(b) of the Act. Respondent is entitled to a credit for TTD benefits previously paid in the amount of **$14,593.25**. Based on the foregoing, no TTD overpayment was made.

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

December 3, 2015
Date

ICArbDec19(b)

DEC 4 - 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION

John Marsh,	)	**16IWCC0593**
	)	
Petitioner,	)	
	)	
v.	)	**No. 14 WC18122**
	)	
G&D Integrated,	)	
	)	
Respondent.	)	

FINDINGS OF FACT

Petitioner testified that on April 2, 2014, he was working for Respondent as a Diesel Technician. This job required him to drive in his service vehicle site to site to repair trucks. On this day, Petitioner testified, as he was climbing into the back of the service vehicle, he felt a pop in his left knee. There were two rungs of stairs on each side and just one handle. He had to grab the handle and twist himself into the vehicle. He was not sure if he bumped the knee on the back deck or if it just popped on its own. After he felt the pop, Petitioner continued, he felt a "really warm fuzzy pain."

After he felt the symptoms in his left knee that day, Petitioner saw Respondent's Safety Officer who was at the location. The Safety Officer told Petitioner to contact his Supervisor. Petitioner then contacted his Supervisor who directed him to a man in Human Resources. The HR man instructed Petitioner to go to Occupational Health in Aurora, which is affiliated with Mercy Hospital.

On April 2, 2014, Petitioner presented to Charles G. Woodward, M.D., at Presence Mercy Medical Center. Dr. Woodward recorded the following HISTORY OF PRESENT ILLNESS:

John relates that this morning he was climbing from one portion of his truck to the other, heard and felt a pop on the left knee. He has had some mild but increasing pain in the last few days. This is a considerable increase in pain. He relates that standing with the knee fully extended is not painful but that any walking does bring on some pain and that climbing is very painful. (RX 5)

Upon examination, Dr. Woodward noted swelling over the left tibial tubercle that is very tender to touch and palpation. The x-rays revealed sequela of Osgood-Schlatter disease. The doctor identified a small piece of detached bone measuring approximately 1 cm. by 8 mm., easily visible on the lateral view from the tibial tubercle. Clinically, he opined, this piece of bone possibly has detached recently and may be the source of John's pain; at this time it seems that a small piece has broken off. Dr. Woodward released Petitioner to light-duty work. (RX 5)

On April 15, 2014, Petitioner treated with Robert T. Semba, M.D., at Parkview Orthopaedic Group ("Parkview"). He complained of left knee catching, locking, and giving way. He had difficulty walking, a significant limp and moderate effusion. Dr. Semba's initial assessment was possible ACL tear or medial meniscal tear. Dr. Semba ordered an MRI scan. Petitioner refused medication. Petitioner was kept off work for the first time. (PX 1)

On April 24, 2014, Petitioner underwent an MRI on his left knee. The MRI showed a subcortical cyst involving the anterior tibia with surrounding marrow edema at the level of the patellar tendon. Henry J. Fuentes, M.D., saw Petitioner that day at Parkview and recommended physical therapy. (PX 1)

On April 29, 2014, Petitioner returned to Dr. Semba, who felt that the MRI showed tibial plateau bone bruising. Petitioner's pain increased with vigorous walking or stairs. Dr. Semba recommended more physical therapy. Petitioner was kept off work. (PX 1)

On May 8, 2014, Petitioner began physical therapy at Parkview. The plan was nine visits over three weeks. (PX 1)

On May 22, 2014, Petitioner sought a second opinion at Hinsdale Orthopaedics from Jason Hurbanek, M.D. He complained to the doctor of pain in the medial and lateral left knee, 6/10 in severity. He reported that the knee felt unstable and buckled. He was wearing a knee sleeve. Dr. Hurbanek reviewed the left knee MRI and noted the presence of some signal at the anterior tibial tubercle. Dr. Hurbanek diagnosed Petitioner with a left knee patellar tendon strain. Conservative treatment was recommended along with physical therapy. Naproxen was prescribed. Petitioner was kept off work. (PX 2)

On July 17, 2014, Petitioner returned to Dr. Hurbanek and complained of dull, sharp pain. His knee pain increased with therapy and using stairs. Swelling at the tibial tubercle was noted with tenderness. The MRI was reviewed again. Dr. Hurbanek's assessment was left tibial tubercle pain. A corticosteroid injection was given for diagnostic and therapeutic purposes. Dr. Hurbanek noted that, if the injection failed, he would recommend an open excision of the ossicles at the tibial tubercle with a small patellar tendon repair. Physical therapy was continued. Petitioner was kept off work. (PX 2)

On August 21, 2014, Petitioner returned to Dr. Hurbanek and reported that the corticosteroid injection relieved his pain for about five days. He had two hours of instant relief. Dr. Hurbanek recommended surgical removal of the tibial tubercle ossicles. Petitioner elected to proceed. Dr. Hurbanek kept him off work and sought workman's compensation approval. (PX 2)

On August 28, 2014, Coventry sought a utilization review by William Hagemann, M.D., a board-certified orthopedic surgeon. Dr. Hagemann determined that based on the clinical information submitted for this review and using evidence-based, peer-reviewed

guidelines, this request is non-certified. Dr. Hagemann apparently non-certified the surgery due to a lack of documentation as to whether the patient "received the diagnostic cortisone injection and additional therapy." Dr. Hagemann also non-certified the surgery because the "medical necessity for an open tibial tubercle debridement as opposed to an arthroscopic procedure has not been established." (RX 2)

On September 19, 2014, Petitioner returned to Dr. Hurbanek and reported knee pain at 6/10. Dr. Hurbanek again explained that his symptoms are secondary to his tibial tubercle bone spurs and that he would benefit from the removal of those ossicles with partial patellar tendon repair. He was kept off work until surgery completion. (PX 2)

On October 27, 2014, Petitioner underwent a Section 12 examination by Dr. Kevin Walsh with DuPage Medical Group. He found that Petitioner was tender to palpation at the tibial tubercle with a slight prominence due to his old Osgood-Schlatter disease. Dr. Walsh further found Dr. Hurbanek's surgical recommendation to be reasonable. However, Dr. Walsh opined that Petitioner's condition is causally related to the pre-existing condition and was not caused by the work injury. Dr. Walsh further opined:

Certainly, climbing in and out of a service truck, per se, does not cause an ununited tibial tubercle ossicle to necessarily become symptomatic. If the patient does go on to have surgery, more likely than not, it is for the pre-existing condition which never fully united at the time of the skeletal maturity, rendering the patient susceptible to pain and discomfort. The work event did not cause the ununited tibial tubercle ossicle, nor is it at all likely to have aggravated or accelerated the tibial tubercle ununited fragment. The patient simply developed pain and discomfort while in the workplace due to his ununited tibial tubercle ossicle. There is no causal relationship between the patient's proposed surgery and the work event. (RX 1)

Dr. Walsh placed Petitioner at MMI for any work injury, released him to return to work as tolerated and found his prognosis to be fair. (RX 1)

Petitioner testified that he spent five to six minutes with Dr. Walsh.

On July 16, 2015, Petitioner testified that he continues to experience pain and discomfort in the anterior part of his left knee below the kneecap, especially when climbing stairs or squatting. Petitioner denied any prior medical treatment for his left knee. However, Petitioner testified that about a week or week and a half before the accident, his left knee was a little sore. He attributed such soreness to climbing in and out of the truck 50-80 times a day to retrieve parts and tools. Petitioner testified that before the accident, he did not treat for and was not diagnosed with Osgood Schlatter disease. Petitioner also testified that he wants to proceed with surgery that Dr. Hurbanek has prescribed for his left knee.

CONCLUSIONS OF LAW

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

When an employee with a pre-existing condition is injured in the course of his employment, serious questions are raised about the genesis of the injury and the resulting disability. The Commission must decide whether there was an accidental injury which arose out of the employment, whether the accidental injury aggravated or accelerated the pre-existing condition or whether the pre-existing condition alone was the cause of the injury. Generally, these will be factual questions to be resolved by the Commission. However, the Commission's decision must be supported by the record and not based on mere speculation or conjecture. If there is an adequate basis for finding that an occupational activity aggravated or accelerated a pre-existing condition, and, thereby, caused the disability, the Commission's award of compensation must be confirmed. Sisbro, Inc. v. Indus. Comm'n, 207 Ill.2d 193, 797 N.E.2d 665 (2003)

Claimant in Sisbro, who had a history of Type II diabetes, stepped down out of a truck and into a pothole and twisted his right ankle while working for respondent. As a result, claimant experienced pain and slight swelling in the ankle, which resolved within a few days. Eleven days post-accident, claimant visited his podiatrist, Dr. Reed, for preventative foot care in relation to his diabetes. Claimant had no pain or swelling in the right ankle at that time, but reported the injury to Dr. Reed, who advised claimant to notify him if his condition changed. Over the next few weeks, claimant's ankle began to swell repeatedly and would not resolve. Soon thereafter, claimant was diagnosed with Charcot osteoarthropathy and was ordered to stay off the foot. In support of claimant's claim, Dr. Reed testified that based on a reasonable degree of medical certainty, the trauma that initiated the onset of Charcot in claimant's right ankle was the work-related, pothole-twisting injury.

In the case at bar, it is true that Petitioner did not present any expert opinion that his current condition of ill-being of his left knee, which was symptomatic as many as 7-10 days prior to the April 2, 2014 accident, is causally related to such accident.

Yet, the facts in Sisbro are distinguishable from the case at bar. In Sisbro, claimant did not treat for his twisted ankle on the date of accident, and his symptoms resolved after a few days. Subsequently, 2-3 weeks after the accident, claimant's ankle began to swell repeatedly and would not resolve.

In the case at bar, Petitioner treated for his left knee symptoms at a clinic to which Respondent sent him on the date of accident. Dr. Woodward, who is associated with such clinic, wrote that Petitioner heard and felt a pop on his left knee that morning while climbing from one portion of his truck to the other. He also wrote that Petitioner has had some mild increasing pain in the knee the last few days but that this is a considerable increase in pain. Dr. Woodward noted that x-rays of the left knee reveal a small piece of

bone that detached recently and opined that this may be the source of Petitioner's pain. Dr. Woodward's impression was a fracture of the left tibial tubercle. Petitioner has experienced consistent complaints of left knee pain and swelling since the accident. Petitioner is seeking surgery to remove the bony fragment that Dr. Woodward identified on the date of accident.

Prior to the accident, Petitioner was able to perform the full duties of a Diesel Technician for Respondent. Following the accident, Petitioner was released to light-duty work by Dr. Woodward and was subsequently taken off work completely by his other treating physicians.

The Arbitrator notes that there is no evidence of any prior medical treatment to the left knee.

A chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury. International Harvester v. Indus. Comm'n, 93 Ill. 2d 59, 63-64 (1982)

Dr. Walsh opined that Petitioner's current condition of ill-being is related to his pre-existing Osgood-Schlatter Disease. Although Osgood-Schlatter Disease usually resolves with adulthood, Dr. Walsh opined, patients will occasionally develop an ununited tibial tubercle ossicle from the old Osgood-Schlatter Disease. As Dr. Walsh noted, Petitioner's present tibial pain is due to a symptomatic ununited tibial tubercle ossicle from his Osgood-Schlatter Disease. He further opined that the work injury did not cause the ununited tibial tubercle ossicle nor did it in all likelihood aggravate or accelerate the tibial tubercle ununited fragment.

Respondent does not dispute that on April 2, 2014, Petitioner sustained an accident that arose out of and in the course of his employment. Dr. Walsh opined that the surgery Dr. Hurbanek has prescribed is a reasonable treatment option. Although Respondent disputes causation, they do not offer an alternative diagnosis. Dr. Walsh opined that Petitioner has a symptomatic, ununited left tibial tubercle ossicle and that he simply developed pain and discomfort while in the workplace due to such ossicle. Dr. Walsh's opinion suggests that it was coincidental that Petitioner's ununited left tibial tubercle ossicle became symptomatic while he was climbing and twisting to get up on the service vehicle and "heard and felt a pop on his left knee."

When workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. General Electric Co. v. Indus. Comm'n, 89 Ill.2d 432, 434, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982)

Accidental injury need not be the sole causative factor, or even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being. Rock Road Construction v. Indus. Comm'n, 37 Ill.2d 123, 127, 227 N.E.2d 65 (1967)

Petitioner's testimony is consistent with the histories of present illness, as recorded by Petitioner's treating physicians. The Arbitrator finds Petitioner to be credible.

The Arbitrator finds the treating records, particularly RX 5, and the testimony of Petitioner to be more persuasive than the opinions of Dr. Walsh. The Arbitrator finds that on April 2, 2014, Petitioner sustained an accident to his left leg that aggravated his pre-existing condition of ill-being.

Based on the facts and the law, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident of April 2, 2014.

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

Dr. Jason Hurbanek has recommended surgical excision of the ossicle with partial patellar tendon repair. As explained above, this condition was rendered symptomatic as a result of Petitioner's work injury. Petitioner testified that he wishes to proceed with the recommended surgery.

As the Arbitrator has found for Petitioner on the issue of causation, he finds that the surgery Dr. Hurbanek has recommended is reasonable, necessary and related to the accident of April 2, 2014.

Therefore, the Arbitrator finds that Respondent shall authorize and pay for such surgery, in accordance with Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision with regard to issues (L) "What temporary benefits are in dispute? TTD" and (O) "TTD Overpayment," the Arbitrator finds the following:

Since September 19, 2014, Dr. Jason Hurbanek has kept Petitioner off work until surgery, which has not yet occurred. (PX 2) Respondent made TTD payments to Petitioner until November 1, 2014, the date of Dr. Walsh's Section 12 report. Petitioner testified that he last received a TTD payment on November 18, 2014. Petitioner testified that his symptoms have gradually increased since his Section 12 examination and that he has not worked.

Given his findings and conclusions on the issue of causation, the Arbitrator finds that Petitioner is entitled to TTD benefits from April 16, 2014 through July 16, 2015.

Respondent is entitled to a credit in the amount of $14,593.25 for TTD benefits previously paid.

The Arbitrator finds that there is no TTD overpayment to date, given his findings and conclusions on issue (L).

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Altman,
Petitioner,
vs.

NO: 14WC19240

Cerro Flow,
Respondent,

16IWCC0607

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, affirms 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 17, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $20,399.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

SEP 2 2 2016

DATED:
MJB/bm
o-9/19/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALTMAN, DONALD
Employee/Petitioner

Case# **14WC019240**

CERRO FLOW
Employer/Respondent

16IWCC0607

On 3/17/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
MATTHEW R CHAPMAN
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0507 RUSIN & MACIORWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

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
NATURE AND EXTENT ONLY

Donald Altman
Employee/Petitioner

v.

Cerro Flow
Employer/Respondent

Case # **14** WC **19240**

Consolidated cases: **N/A**

16IWCC0607

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **8/21/15**. By stipulation, the parties agree:

On the date of accident, **4/22/14**, 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 **$38,552.87**, and the average weekly wage was **$786.78**.

At the time of injury, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

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

16IWCC0607

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

ORDER

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$472.07**/week for a further period of **43** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **20% loss of use of the left leg**.

Respondent shall pay Petitioner compensation that has accrued from **7/14/14** through **8/21/15**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

2/23/16
Date

ICArbDecN&E p.2

MAR 17 2016

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties stipulated and agreed that Respondent shall pay the 5/5/14 Clinical Radiologist bill in the amount of $47.50, as set forth in PX8 pursuant to §§8(a) and 8.2 of the Act.

At the time of his accident Petitioner was a 56 year old head packer for Respondent. He had worked for Respondent for 28 years. He was injured when he was stepping off of a platform after setting up a glue station. As the Petitioner stepped down off the platform which was approximately 10-12 inches high, leading with his left leg, Petitioner twisted his left knee.

Petitioner experienced immediate pain after the accident. He initially received treatment at the plant dispensary. Petitioner's knee condition progressively worsened and he sought treatment at Midwest Occupational Medicine, Respondent's company physician, on May 5, 2014. (Px 1) An MRI of the knee was ordered and took place on May 8, 2014. (Px 4) The MRI revealed evidence of a tear of the posterior horn of the medial meniscus. There was also evidence of an inner edge tear of the posterior horn of the lateral meniscus. The MRI also revealed evidence of a mild medial collateral ligament sprain as well as evidence of chondromalacia in three compartments of the knee joint with chondromalacia being most severe in the medial compartment. (Px 4)

Petitioner subsequently came under the care of Dr. Collard, an orthopedic specialist, on May 12, 2014. (Px 2) Based upon his physical examination and review of the MRI, Dr. Collard diagnosed Petitioner with a medial meniscal tear, lateral meniscal tear and a medial collateral ligament sprain. (Px 2) On May 19, 2014 Dr. Collard performed a left partial medial and lateral meniscectomy and a chondroplasty or smoothing out of the cartilage surfaces due to the degenerative arthritis of the knee. (Px 5; Rx 2, p.9) Post surgically Petitioner underwent physical therapy at APEX Physical Therapy. (Px 7) Dr. Collard released the Petitioner to return to work without restrictions on June 23, 2014 and released him from treatment as of July 14, 2014 at MMI. (Px 2)

During the course of this litigation, Petitioner underwent a §12 evaluation and AMA Impairment Rating by Dr. George Paletta. Dr. Paletta opined that Petitioner's medial collateral ligament sprain had resolved. Dr. Paletta further opined that Petitioner had a medial meniscal tear for which he underwent a partial meniscectomy. He further opined that Petitioner underwent debridement of the chondromalacia due to underlying degenerative joint disease. (Rx 2, p.16) Dr. Paletta did not believe that Petitioner's lateral meniscal tear was related to the work accident. He further did not believe that the tear contributed to any of Petitioner's symptoms. (Rx 2, p.16-17) Dr. Paletta opined that Petitioner's impairment rating was at 10%. (Rx 2, p.19)

At arbitration, Petitioner testified that he still experiences occasional pain on the inside of the knee for which he takes Ibuprofen. He has continued working his regular job duties as a head packer for Respondent since being released to regular duty work on June 23, 2014.

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 Dr. Paletta assessed Petitioner's impairment rating at 10% of the right lower extremity. However, impairment does not equal disability. The impairment rating is part of the determination for permanent partial disability benefits, but is not the sole or main factor. The Arbitrator notes that Dr. Paletta acknowledged that the AMA guides specifically state that the relationship between impairment and disability is complex and difficult, if not impossible to predict. (Rx 2, p.23) The Arbitrator therefore gives *little* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a head packer for Respondent. Petitioner's occupation is labor intensive and likely to continue to aggravate his knee symptoms. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 56 years old at the time of his injuries. Petitioner has diminished healing capacity and a low threshold for future injury as a result thereof. 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 the Petitioner was a credible witness. As a result of his accident Petitioner was diagnosed with a medial meniscal tear, lateral meniscal tear and a medial collateral ligament sprain. The Arbitrator notes that it is more probable than not that the tear of the lateral meniscus preexisted the accident. However, no surgical treatment was required prior to the accident. Petitioner underwent a left partial medial and lateral meniscectomy and a chondroplasty following the accident. Petitioner continues to experience occasional pain on the inside of his left knee. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain and injury, the Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the left leg pursuant to §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

Aida Otero,
Petitioner,

16IWCC0610

vs.

NO: 14 WC 21617

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 6, 2016, is hereby affirmed and adopted.

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

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

16IWCC0610

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 $52,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 2 2016
o9/13/16
RWW/rm
046

Charles J. DeVriendt

Joshua D. Luskin

DISSENT

I respectfully dissent from the majority decision. I would have found that Petitioner did not sustain her burden of proving she suffered an accident in the course of, and arising out of her employment, reversed the Decision of the Arbitrator, and denied compensation.

Petitioner is a flight attendant for Respondent and has been for 36 years. She lives near Atlanta Georgia, and is stationed out of Dulles Airport near Washington DC. On March 18, 2014 she returned to Dulles on a flight from London and was walking from the plane to catch a flight home to Atlanta. She testified she fell twice, once on the jet way leaving the plane and once at customs. In her testimony, Petitioner provided no explanation for her first fall. Regarding the second fall, Petitioner testified" It happened so fast, but I think I could have tripped over my bag." On cross examination, Petitioner also testified that she told her doctors that she did not know why she fell. The second fall appears to have resulted in the injuries to her spine and shoulder.

The medical records show no indication that Petitioner reported that she fell over her bags. The falls were referred to as unexplained, unexpected, or unprovoked. In addition, the medical records indicate that Petitioner had at least one fall prior to the alleged accident and some falls after the alleged accident. She had been seen by medical specialists for evaluation of her history of these falls. Petitioner also has a history of diabetes, peripheral neuropathy in her legs, and likely vascular disease. In this case, the risk of falling appears to be personal to Petitioner.

As a flight attendant Petitioner was clearly a traveling employee while *en route* between London and Atlanta. The Arbitrator did not find Petitioner's testimony about her possibly falling or tripping over her bags persuasive. She noted that Petitioner's testimony at the arbitration

16IWCC0610

hearing was apparently the first reference to such an explanation for her fall. Nevertheless, although the falls were basically idiopathic, the Arbitrator found the falls compensable because as a traveling employee Petitioner only had to show that her activities and subsequent accident were foreseeable.

The latest pronouncement concerning the traveling employee doctrine by the Appellate Court is in a decision issued on February 27, 2015, *Nee v. IWCC,* 215 Ill App (1st Dist.) 13209WC. The claimant in *Nee* was a plumbing inspector who tripped over a curb. The Court found the claimant was a traveling employee and therefore his accident occurred in the course of his employment. However, the *Nee* Court also held that "the fact that the claimant is a traveling employee does not relieve him of the burden of proving that his injury arose out of his employment." It then analyzed the "arising out of" prong. It found that the encounter with a curb was a neutral risk that the general population encounters. However, by having to be on the streets as a part of his work activities the claimant's risk of encountering the risk of falling on the curb was greater than that of the public generally and found the accident compensable.

As I interpret the latest pronouncement of the Appellate Court, the traveling nature of the employee satisfies the "in the course of employment prong" to establish compensability as long as the employee is away from home satisfying his or her employment obligations. However, in my opinion pursuant to *Nee*, a claimant must still prove that the particular accident arose out of his or her employment even if the claimant is deemed to be a traveling employee. Therefore, as written by the *Nee* Court, the claimant here must still sustain her burden of proving that the risk of accident was a risk associated with her employment rather than a risk borne equally by members of the general public.

In my opinion, the Arbitrator correctly found that Petitioner did not prove that she actually fell or tripped over her bags, which could be deemed a risk associated with her employment as a flight attendant. Petitioner's testimony was fundamentally equivocal about the explanation and there was absolutely no other reference to such a mechanism of accident in the entire record. Unexplained or idiopathic falls are not accidents which are deemed to arise out of a claimant's employment and the Commission has consistently held such falls to be not compensable. Therefore, I would have found that Petitioner did not sustain her burden of proving her unexplained and idiopathic falls arose out of her employment, reversed the Decision of the Arbitrator, and denied compensation. For these reasons, I respectfully dissent from the decision of the majority.

RWW/dw
O-9/13/16
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Ruth W. White

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

16IWCC0610

OTERO, AIDA
Employee/Petitioner

Case# **14WC021617**

UNITED AIRLINES INC
Employer/Respondent

On 1/6/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
RAFAL G DOBEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

16IWCC0610

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)

Aida Otero
Employee/Petitioner

v.

United Airlines, Inc
Employer/Respondent

Case # **14** WC **21617**

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 **June 12, 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] 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, **March 18, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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 **$45,074.83**; the average weekly wage was **$865.49**.

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 **$5,192.91** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,192.91** for other benefits, for a total credit of **$10,385.81**.

Respondent is entitled to a credit of **$1,785.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$576.99**/week for **64 4/7** weeks, commencing **March 19, 2014 through June 12, 2015**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $5,192.91 for TTD and $5,192.90 by way of a PPD advance, for a total credit of $10,385.81.

Respondent shall pay reasonable and necessary medical services of $26,755.06, as provided in Sections 8(a) and 8.2 of the Act pursuant to the fee schedule or prior agreement whichever is less.

Respondent shall be given a credit of $1,785.00 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 the surgeries and follow-up treatments recommended by Dr. Javed and Dr. Diehl.

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

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

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

Deborah L. Simpson

Signature of Arbitrator

January 5, 2016

JAN 6 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aida Otero,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 14 WC 21617**
	)	
United Airlines, Inc.,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on March 18, 2014, 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 notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $45,074.83, and that her average weekly wage was $865.49.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of employment; (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 Respondent paid all appropriate charges for all reasonable and necessary medical services; (4) Is Petitioner entitled to TTD from March 19, 2014, through June 12, 2015; (5) Should penalties or fees be imposed upon Respondent; and (6) Is Petitioner entitled to future medical treatment.

STATEMENT OF FACTS

Petitioner, Aida Otero, was employed at United Airlines as a flight attendant for 36 years. Petitioner first testified that she had three prior workers' compensation injuries, including two prior back surgeries and a right knee surgery in 2006. She has worked in a full duty capacity with no other work injuries since 2007. (T.R. 17-18).

Petitioner testified that she lives in Atlanta, Georgia, but has been based out of Washington Dulles since 1989. She flies from Atlanta to Dulles in order to begin her flight assignments. (T.R. 19). On March 18, 2014, Petitioner was flying on a United Airlines flight from London to Washington Dulles and landed around 4:00 p.m. After allowing the passengers to disembark, Petitioner proceeded to go through security, bypass customs, and go to the kiosks. (T.R. 20). Petitioner's flight to return home was scheduled to depart at 5:00 p.m.

As Petitioner exited the plane, she fell on the jet bridge because she was in a hurry to catch her 5:00 p.m. connecting flight to Atlanta. (T.R. 21). Petitioner explained that she had two tote bags, one of which was a rolling bag and the other bag was stacked on top of the rolling tote. She was pulling the totes with her right hand when she fell. (T.R. 21-22). According to Petitioner Jet bridges are long and narrow and she encounters them at least 16 times per month while performing her job duties. (TR p.22) Petitioner testified that as a result of this fall, she injured her left arm, both wrists, her neck, ankles, and clavicle. (T.R. 22). Petitioner also testified that during this fall she fell straight onto her buttocks. (T.R. 39).

After getting up, Petitioner proceeded to retrieve her luggage and to pass through part two of customs when she fell for a second time. Petitioner testified that she tripped over her bag, fell to the ground, and experienced a whiplash to her neck. She also aggravated the same body parts as she had injured when she fell the first time that day. (T.R. 23-24). The fall happened so fast, Petitioner believes "I think I could have tripped over my bag." (T.R. 23)

After clearing customs, Petitioner was supposed to do a debriefing as required by her job, but she had to catch her connecting flight to Atlanta. (T.R. 24). Petitioner missed her 5:00 flight so she took her return flight home on a Delta flight because the United Airlines' flight was full. Petitioner testified that she was in pain and she did not know what to do so she went to the emergency room at Northside Hospital on March 20, 2014. (T.R. 25, 27). She testified that she has been off work since March 18, 2014. (T.R. 25-26).

After Northside Cherokee Hospital, Petitioner saw Dr. Valvani and then Dr. Diehl. Petitioner had previously treated with Dr. Diehl for her right knee injury. (T.R. 27-28). Petitioner testified that she wants to undergo left shoulder surgery because she has a large tear and cannot work. She testified that she engaged in physical therapy but did not have any injections and is now currently undergoing dry-needling. (T.R. 28-29). Petitioner admitted that she told Dr. Diehl that she did not know why she fell. (T.R. 60).

Petitioner testified that her back pain resolved after she had an epidural in November of 2014, but her neck and shoulders are still problematic. Petitioner testified that her neurologist, Dr. Green, referred her to Dr. Javed for treatment of her neck. (T.R. 30). Petitioner testified that she had an epidural steroid injection, physical therapy, and that Dr. Javed is now recommending cervical surgery which she wishes to have. Petitioner testified that she continues to have left arm problems and that her fingers and arms feel numb. Petitioner has pain in the shoulder that goes up to her jaw and causes her jaw to lock. Petitioner testified that she is unable to do household work or cook because of the condition of her neck after the falls. (T.R. 31-32).

Petitioner testified that she saw Dr. Glantz, at the request of the Respondent pursuant to Section 12 of the Act. Petitioner testified that Dr. Glantz was the first, and only, doctor to inform her that she had a vascular problem that was causing her to fall. After the Section 12 examination, Petitioner saw Dr. Ballard who performed a vascular examination and found no problems. (T.R. 33-34). Petitioner testified that she told Dr. Glantz that she did not feel dizzy or have any warning signs prior to her fall and that she did not know why she fell. (T.R. 55).

Petitioner testified that she fell at her home on March 5, 2014 when she tripped over an extension cord injuring her left hip and back. (T.R. 22-23). Petitioner testified that she told Dr. Neely that she tripped on a cord and that the same was reflected in the medical records. (T.R. 35). Petitioner explained that she fell forward onto her hands which broke her fall but she did not have a big fall. (T.R. 37-38).

Petitioner was seen by Dr. Bloom at Northside Hospital on March 20, 2014. She stated that she told him that she has been falling quite a bit lately and did not have an adequate explanation for the falls. She also stated that she told him that she felt like she was tripping over her own feet. (T.R. 42). Petitioner further explained that she had no other falls besides the two that occurred on March 18, 2014. She stated that she was in a hurry and had work material with her when she fell. (T.R. 34-35).

Petitioner's diabetes was not well controlled at the time of her fall; it is currently under control. (T.R. 44). Petitioner testified that she had other medical conditions such as blood clots and deep vein thrombosis. (T.R. 45).

Petitioner said that she saw Dr. Green seeking an explanation for why she fell. (T.R. 47). She explained that Dr. Green only diagnosed her with carpal tunnel and mild neuropathy. (T.R. 46). Petitioner stated that she told Dr. Green on April 10, 2014 that she was feeling fine and as she exited the plane onto the jet way she fell forward unexpectedly. She confirmed that she did not feel dizzy and had not tripped. (T.R. 48-49). She testified that Dr. Green opined that she may be falling due to a sudden drop in her blood pressure. (T.R. 52). Petitioner denied telling Dr. Green that she had 5 unprovoked falls or why she fell. (T.R. 53). Petitioner also testified that she was unsure if she told any of her doctors why she fell. (T.R. 56-58). She testified that she did not report any defects with the jet way and was not sure if she told United Airlines personnel how or what made her fall. (T.R. 56-57).

Petitioner confirmed that she received TTD and medical benefits from United Airlines through about May 27, 2014, around the time of the first IME with Dr. Walsh. (T.R. 60-61). She also testified that she has group insurance, with Aetna. (T.R. 61).

The medical records indicate Petitioner was first treated by Dr. Kathryn Neely on March 13, 2014 for left hip, buttock, and pain down the left leg that began about 5 days ago. Petitioner reported that she fell 7 days ago while she was preparing to go to work. (RX. 6).

Petitioner sought medical treatment at North Side Hospital Emergency Department on March 20, 2014 and was seen by Dr. Glen Bloom. She reported left shoulder, left hip, left leg, neck, and lower back pain as a result of a fall. Petitioner conveyed a history of injury that included falling forward while at work and hitting the ground hard. Dr. Bloom noted that Petitioner reported left hip pain for at least a month. Dr. Bloom also noted that Petitioner had mini-strokes in the past but that she never saw a neurologist. Dr. Bloom notes that Petitioner informed him that she had been falling quite a bit lately, did not have an adequate explanation for why she was falling, and "felt that legs just went." She indicated that she knows she is going to pass out and just trips over her feet. Petitioner was diagnosed with lumbar and cervical spinal spondylosis, osteoarthritis, left ankle pain, left hip pain, neck pain and low back pain. (RX 7)

On April 3, 2014, Petitioner was seen by Dr. Rajeev Valvani with Pinnacle Orthopedics. Petitioner presented with complaints of neck, left shoulder and left hip pain that started a month ago from "no inciting event." Petitioner noted that symptoms were exacerbated after falling at work two times and she was unsure why she fell. She denied tripping, passing out, or loss of consciousness. Dr. Valvani diagnosed Petitioner with shoulder sprain and lumbar degenerative disc disease. Dr. Valvani noted that he will need to work up the reason why Petitioner fell; he placed Petitioner on light-duty work. (PX. 2).

Petitioner returned to Pinnacle Orthopedics and was seen by Dr. Mark Diehl on April 9, 2014. Dr. Diehl noted that Petitioner has new complaints and injuries starting from March 5, 2014 when she fell at home. He indicated that Petitioner had some pain in her left hip by which she meant her lower back and left hip. She then reported falling two more times at work on March 18, 2014 which caused whiplash to her neck and back and she complained of pain in her neck, back, left shoulder, left hip and bilateral ankles. (PX. 2).

Petitioner was then seen by Dr. Green on April 10, 2014. She reported injuring herself on March 18, 2014, while returning from an international flight. She reported exiting a plane and walking down the jet way when she fell forward unexpectedly. She indicated that she did not feel dizzy, did not trip, and had no loss of consciousness. While walking through customs, she fell forward and injured her neck and left shoulder and hip. Petitioner also reported one other fall on March 5, 2014, while at home from which she noticed pain in the low back and left hip. It was noted that Petitioner presented to Dr. Neely and had an X-ray, which did not reveal any abnormality. Petitioner also reported experiencing numbness in the left leg, which was frequent from two previous back surgeries. (RX. 5).

Dr. Green noted that Petitioner had three unprovoked falls to date with no indication that she tripped, had any warnings symptoms prior to the fall, and no loss of consciousness. Dr. Green also noted that Petitioner had no other focal deficits to suggest these were transient ischemic attacks, though Petitioner did have multiple vascular risk factors. Dr. Green indicated her concern about automatic instability secondary to diabetes and recommended Petitioner undergoes a cardiac evaluation for dysrhythmia. She also opined that Petitioner may simply have sensory ataxia but the sudden onset of these events was unexpected. Additionally, Dr. Green noted that Benazapril was added to Petitioner's medication regimen before the falls started, and Dr. Green indicated she would discuss with Dr. Neely to see if the addition of the ACE inhibitor was responsible for her falls. (RX. 5).

On April 18, 2014, Petitioner underwent a brain MRI with American Health Imaging. It was noted that Petitioner was a 58-year-old female with memory loss and confusion. The MRI revealed moderate to severe generalized volume loss, which was significantly advanced for Petitioner's age. There was also moderate to severe paraventricular and subcortical white matter hyper intensities generally. Dr. David Owens noted that the findings were consistent with chronic small vessel ischemic change and was advanced for Petitioner's age. (RX. 9).

On May 2, 2014, Petitioner returned to Dr. Green and reported that Dr. Neely took her off Benazapril. She reported she had a brain MRI, which showed some global atrophy and moderate

vascular disease with no acute infarct. Petitioner reported two additional falls; one when she tripped over a bag, and another when she fell forward in her living room with no loss of consciousness. To date, Dr. Green noted Petitioner had at least five unprovoked falls with no indication she had tripped or she had prior warnings. (RX. 5).

Dr. Green reviewed the CT scan of the head which revealed micro vascular disease but no other acute findings. The CT scan of the cervical spine revealed degenerative changes most significant at C5-6. An MRI of the brain revealed moderate paraventricular micro vascular changes with no acute infarct and no hemorrhage. Dr. Green opined that Petitioner may have sensory ataxia but with the sudden onset of the events it seemed quite acute. She also opined that medication may have effects also, but the elimination of Benazapril had not resolved the issue, but the other possibility may be Tizanidine. Dr. Green diagnosed Petitioner with diabetes mellitus, idiopathic peripheral neuropathy, and lumbar radiculopathy. (RX. 5).

Petitioner returned to Dr. Green on May 7, 2014, with complaints of diabetes and recent balance difficulties with multiple falls. Petitioner also underwent an EMG/NCV. Dr. Green noted that the nerve conduction studies revealed length dependent sensory polyneuropathy with evidence for concurrent lumbar radiculopathies, worse on the left. There was also evidence of bilateral carpal tunnel syndrome. Dr. Green recommended a cervical spine MRI to rule out cervical myelopathy. (RX. 5).

Petitioner enrolled in physical therapy on May 16, 2014 with Canton Institute for Physical Therapy for treatment of balance dysfunction. It was noted that Petitioner had a fear of falling at a community level so she would use a cart to keep balance in a grocery store and does not attend stores that do not offer carts. On May 20, 2014, Petitioner stated that she fell twice on March 18, 2014, while working. She reported falling while walking in the jet way and a few minutes later while walking in the hallway. Prior to that, she indicated she fell at home on March 5, 2014 and when she fell, she injured her neck. Petitioner also reported two back surgeries in 1999 and 2002, and since that time she has had problems with both legs feeling numb at times. A nerve study showed peripheral neuropathy and a brain scan showed evidence of two previous strokes. Petitioner was a diabetic with her blood sugar usually under control, but with recent medication, it went up. (PX. 6).

On June 26, 2014, Dr. Diehl reviewed Petitioner's EMG which showed bilateral mild findings for carpal tunnel. The cervical spine MRI showed a borderline spinal canal at C5-6, left asymmetric foraminal stenosis, foraminal narrowing at C6-7 and slight retrolisthesis. There was a fairly high grade foraminal stenosis at C5-6 on the left. (PX. 2).

Petitioner was treated by Dr. Javed for the first time on August 25, 2014 for neck pain. Petitioner reported complaints of neck pain beginning as a result of a fall at work in March 2014. She denied pain radiation into her upper extremities, but she did have bilateral shoulder pain with her left shoulder hurting worse than the right. Petitioner indicated that she had cervical epidural steroid injections, physical therapy, and anti-inflammatories and muscle relaxers without significant relief of her symptoms. (PX. 11).

Petitioner returned to Dr. Javed on August 29, 2014. Dr. Javed reviewed the cervical MRI which revealed cervical disc osteophyte complex towards the left causing foraminal stenosis. Dr. Javed recommended a cervical epidural injection with the caveat that if the condition does not improve then surgery was an option. Dr. Javed diagnosed Petitioner with degeneration of the L4-5, L5-S1 disc collapse of the disc and cervical spondylosis. (PX. 11).

On January 26, 2015, Petitioner underwent a left shoulder MR arthogram. The diagnostic testing revealed a full thickness supraspinatus tendon tear with extension medially along the under surface with no atrophy. There was also severe biceps tendinosis or partial thickness tearing for a long segment of intra and extra-scapular components with a complex tenosynovitis. There was also mild AC joint degenerative change without under surface spurring. (PX. 2).

On January 28, 2015, Petitioner returned to Dr. Javed complaining of a lot of neck pain and pain in the sub-occipital area associated with pain radiating to her left shoulder and left arm. Dr. Javed noted Petitioner tried an injection without complete pain relief and has cervical spondylosis with foraminal stenosis at C5-6. Dr. Javed recommended an anterior cervical discectomy fusion. (PX. 11).

On May 1, 2014, Petitioner was examined by Dr. Kevin Walsh, at the request of the Respondent pursuant to Section 12 of the Act. Petitioner reported injuring herself on March 18, 2014 when she fell in a customs hall onto her hands and knees. She reported low back, shoulder, and leg pain that she believed was related to a March 18, 2014 injury. (RX. 3).

Dr. Walsh opined that the Petitioner suffered a contusion of her knee and wrist and may have suffered a strain of her neck and lower back. He opined that Petitioner could have suffered an acute left rotator cuff tendinitis as a result of the slip and fall and may have suffered an ankle strain at the time. Dr. Walsh concluded that Petitioner had an objectively normal physical examination with no objective abnormalities despite Petitioner's subjective complaints of pain and discomfort. (RX. 3).

Dr. Walsh opined that Petitioner's current significant subjective complaints were not causally related to the slip and fall in March of 2014. Petitioner's subjective complaints were disproportionate to the mechanism of injury and did not correlate with the objective abnormalities in the physical examination. Dr. Walsh noted there was evidence of pre-existing degenerative disease and that Petitioner may have suffered an acute traumatic injury. Her subjective complaints at this time are not related to the acute injury. He opined that Petitioner required no further treatment and certainly did not require surgical intervention and did not need physical therapy. Dr. Walsh concluded that Petitioner could return to full-duty work at this time. (RX. 3).

Petitioner was also examined by Dr. Russell Glantz at the request of the Respondent pursuant to Section 12 of the Act, on November 17, 2014. Petitioner reported that she has been evaluated for her falls but that her doctors have not discovered the reason for her falls. She reported that on March 18, 2014, she just fell twice without any warning symptoms or dizziness, and she did not trip or slip. She first fell onto her buttocks and then fell forward onto her hands.

Dr. Glantz confirmed Dr. Green's diagnosis of idiopathic peripheral neuropathy based on his examination and opined that Petitioner's lumbar radiculopathy was not acute but chronic which was consistent with an individual who has had two prior back surgeries. (RX. 1).

Dr. Glantz noted that Petitioner had an acute fall with no indication that she tripped or slipped while at work. He also noted the prior fall at home and that Dr. Green noted that Petitioner had two subsequent falls. He opined that the falls were not related to her work duties and were not aggravated by the same. He further explained that Petitioner had some form of drop attack with a sudden give out of her legs without warning. Based on his review of the records and the examination, he opined that the etiology is likely vascular in nature pertaining to the vascular portion of her neck or brain. He opined that it could be the result of a sudden cardiac arrhythmia. He noted that Dr. Green pointed out that Petitioner's medications, including her blood pressure medication, might have played a role in her sudden drops. (RX. 1).

As a result of the falls, Dr. Glantz diagnosed Petitioner with some self-limiting soft tissue sprains as pointed out by Dr. Walsh. Based on the cervical MRI, he opined that Petitioner did not have cervical myelopathy and such a diagnosis would not be caused or aggravated by the fall on March 18, 2014. He further explained that the peripheral neuropathy is related to diabetes and is not related to the work accident. Dr. Glantz opined that Petitioner could return to full duty work as it relates to her lumbar radiculopathy and peripheral neuropathy but she cannot return to unrestricted work due to her multiple falls without any warning. (RX. 1).

Dr. Mark Diehl testified by way of evidence deposition taken by the parties on April 8, 2015. Dr. Diehl testified that he first saw Petitioner on April 9, 2014, when she presented with complaints of injuring her neck, back, left shoulder, left hip and both ankles. (PX. 2: pg. 8 lines 21-24; pg. 9 lines 7-14). Petitioner told Dr. Diehl that she first injured herself on March 5, 2014, when she fell at home injuring her left hip and low back. (PX. 2: pg. 9 lines 6-8). Petitioner then reported that on March 18, 2014, she was working as a flight attendant when she fell in the jet way and then later fell in the airport injuring her left shoulder, neck, back, and left hip. (PX. 2: pg. 9 lines 6-8).

With respect to his medical examination on April 9, 2014, Dr. Diehl testified that he noted that Petitioner had a hard time walking as a result of her right ankle, and had tenderness on her left shoulder with movement. (PX. 2: pg. 10 lines 21-25; pg. 11 lines 1-10). He placed Petitioner off of work for three to four weeks and began a conservative plan of treatment. (PX. 2: pg. 12 lines 2-4).

Dr. Diehl also testified that he was aware of Petitioner's hypertension, diabetes, deep vein thrombosis, blood clots, and breast cancer. (PX. 2: pg. 13 lines 16-19). He also testified that Petitioner's diabetes and medical problems were not under the best of control. (PX. 2: pg. 13 lines 23-25). Dr. Diehl testified that he recommended a left shoulder rotator cuff repair. (PX. 2: pg. 14 lines 4-12).

Next, Dr. Diehl testified regarding his May 1, 2014 examination, which mainly focused on Petitioner's neck condition and upper extremities. (PX. 2: pg. 14 lines 17-24). Dr. Diehl testified that rotator cuff and neck symptoms can sometimes overlap and mask the etiology of the

problem. (PX. 2: pg. 15 lines 3-5). He also testified that Petitioner's cervical injury was diagnosed as disc degeneration with a herniated disc, and she had bone spurs that resulted in nerve compression. (PX. 2: pg. 15 lines 10-16).

Dr. Diehl was questioned about his narrative report prepared on February 9, 2015. (PX. 2: pg. 16 lines 16-19). Dr. Diehl testified that the report primarily focused on the left shoulder; and that he would defer on the issue of the neck to Dr. Valvani. (PX. 2: pg. 17 lines 4-9). He did opine that the neck condition was exacerbated by the fall on March 18, 2014. (PX. 2: pg. 16 lines 13-18). Dr. Diehl testified that Petitioner's left shoulder condition was preexisting, but was aggravated by the fall. (PX. 2: pg. 18 lines 21-23). Dr. Diehl also testified that the left shoulder MRI taken on January 26, 2015, revealed a full thickness tear that was caused by the fall and required orthopedic surgery. (PX. 2: pg. 18 lines 15-18).

Dr. Diehl testified that he obtained the history of the accident from Petitioner; (PX. 2: pg. 23 lines 13; 24-25). The Petitioner told him that she was walking through a jet way and fell and then fell again for a second time. (PX. 2: pg. 25 lines 14-17). He also testified that Petitioner reported falling on March 5, 2014, while at home, but provided no other details than "just falling at home." (PX. 2: pg. 26 lines 1).

Dr. Diehl was aware of her diabetes, degenerative lumbar and cervical disease, peripheral neuropathy, and vascular disease such as deep vein thrombosis. (PX. 2: pg. 26 lines 10-25). Dr. Diehl testified that he was unaware that Petitioner was falling unexpectedly until he reviewed the IME report of Dr. Glantz. (PX. 2: pg. 27 lines 5-9). Dr. Diehl admitted that Petitioner's falls were idiopathic in nature as the sources of the falls were unknown. (PX. 2: pg. 28 lines 17-21).

With regard to Dr. Glantz's IME report from November 17, 2014, Dr. Diehl testified that he did not know what caused Petitioner's sudden falls, but agreed that a vascular problem, peripheral neuropathy, or back weakness could be causes for the falls. (PX. 2: pg. 30 lines 12-21). He agreed that these medical conditions would not be related to her work. (PX. 2: pg. 31 lines 1).

Dr. Diehl also testified that if Petitioner experienced subsequent falls, it was possible that these falls could have exacerbated her left shoulder condition and her cervical/lumbar conditions. (PX. 2: pg. 32 lines 19-24; pg. 33-34 lines 24-25; 1-6). Given that Petitioner had degenerative changes in her left shoulder; Dr. Diehl agreed that it was possible that the natural degenerative process could be the cause of her current left shoulder problems. (PX. 2: pg. 34 lines 12-16).

Dr. Diehl testified that he was not an expert on the cervical spine, but only had general experience. (PX. 2: pg. 35 lines 17-19). He would also defer causation of the cervical spine to a spinal expert such as Dr. Javed. (PX. 2: pg. 36 lines 7-10).

Dr. Tariq Javed testified by way of evidence deposition on April 24, 2015. Dr. Javed testified that he had an independent recollection and remembers first seeing Petitioner on August 25, 2014, on referral from Dr. Green, her neurologist. (PX. 11: pg. 8 lines 1-2; pg. 9 lines 4-7). Dr. Javed noted that Petitioner prepared a new patient form indicating that her accident occurred on March 18, 2014, when she fell at work. (PX. 11: pg. 10 lines 18-21). Dr. Javed testified that

he did not take additional information with regards to the mechanism of injury as his focus was solely on the symptoms of the neck, back, and right shoulder. (PX. 11: pg. 10 lines 22-25; pg. 12 lines 1-3). Dr. Javed testified that Petitioner had no prior history of neck pain, but did have two prior back surgeries, degenerative disc disease and diabetes, along with high blood pressure and other surgeries. (PX. 11: pg. 11 lines 13-25).

Dr. Javed also testified that the treatment Petitioner received for her neck pain and radicular symptoms was a common starting point for conservative treatment. (PX. 11: pg. 12 lines 20-25). On examination, Dr. Javed noted Petitioner showed weakness in her hand and difficulty with walking, weakness with her left arm and neck pain. (PX. 11: pg. 13 lines 19-25). Dr. Javed opined that Petitioner likely had a pinched nerve in her neck that caused the left arm and hand weakness. (PX. 11: pg. 14 lines 12-18).

Dr. Javed testified that the EMG that was taken indicated carpal tunnel syndrome likely caused by a pinched nerve in the wrist. (PX. 11: pg. 15 lines 1). He noted that Petitioner had peripheral neuropathy and lumbar radiculopathy. (PX. 11: pg. 15 lines 6-9). With respect to the CT scan of the neck, Dr. Javed testified it showed arthritic changes, namely at the C5-6 and C4-5 levels, with severe foraminal stenosis at C5-6, left greater than right. (PX. 11: pg. 16 lines 14-25). Dr. Javed opined that the cervical radiculopathy caused the left arm symptoms as a result of a pinched nerve, which is more consistent than the possible carpal tunnel syndrome diagnosis. (PX. 11: pg. 18 lines 1-11). Dr. Javed agreed that Petitioner's neck problems could also be a "double crush syndrome," which is caused by diabetes. (PX. 11: pg. 18 lines 22-25; pg. 19 lines 1-11).

In spite of Petitioner's numerous medical issues, Dr. Javed diagnosed Petitioner with neck/nerve pain caused by a cervical spondylosis and foraminal stenosis that she had for many years, but was aggravated as a result of the fall. (PX. 11: pg. 20 lines 1-12; pg. 20 lines 25). Dr. Javed specifically noted that Petitioner had no prior history of pain, treatment or symptoms coming from the neck. (PX. 11: pg. 20 lines 12).

According to Dr. Javed, on August 29, 2014, Petitioner returned to Dr. Javed's office after diagnostic tests were taken. He noted that the tests revealed narrowing on the left side at the C5-6 level with spurs, abnormal discs, osteophytes with some similarity at the C4-5 level. Dr. Javed testified that the narrowing of spurs was present for years caused by arthritis in the spine. (PX. 11: pg. 22 lines 11-20). Based on the tests, he indicated a plan of treatment including cervical epidural steroid injections and surgery if conservative treatment failed. (PX. 11: pg. 24 lines 24).

Next, Dr. Javed testified that the Petitioner returned to see him on January 28, 2015, with continued complaints of pain in the back of the neck and headaches with left shoulder and hand weakness. He testified that Petitioner informed him that the epidural steroid injection helped a little. At this time, Dr. Javed recommended a C5-6 anterior discectomy to help with the neck and arm pain. He further testified that surgery was reasonable and necessary, and he was awaiting approval of the same. (PX. 11: pg. 25).

Dr. Javed testified that petitioner only informed him that she fell while walking at work with some indication that this fall was spontaneous by Dr. Green. (PX. 11: pg. 31 lines 15-25). He also was unaware of any falls outside of work. (PX. 11: pg. 33 lines 10-16). Dr. Javed testified that he was aware of petitioner's numerous conditions, including the diabetes, peripheral neuropathy and vascular disease, but he testified there was no evidence of a stroke. (PX. 11: pg. 32-33). With regard to petitioner's idiopathic falls, Dr. Javed testified that there was no identified direct cause of the falls and he had no history from petitioner with regard to any defect of the jet way or concourse of the airport as she traversed it. (PX. 11: pg. 33-34). Dr. Javed testified that petitioner may be falling because she is unsteady on her feet, which may be caused by spinal stenosis. (PX. 11: pg. 38 lines 1-9). He further opined that petitioner may be falling due to a combination of the narrowing of her spine and her diabetes. (PX. 11: pg. 39 lines 12-17).

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987).

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of" is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

As long as a "but-for" relationship exists between the original event and the subsequent condition, the employer remains liable. *International Harvester Co. v. Industrial Commission,* 46 Ill.2d 238, 263 N.E.2d 49 (1970). *See also Vogel v. Industrial Commission,* 354 Ill.App.3d 780, 821 N.E.2d 807, 290 Ill.Dec. 495 (2d Dist. 2005).

For compensability of a claimed injury, where a pre-existing condition exists, recovery will depend on the employee's ability to show that a work-related injury aggravated or accelerated the pre-existing condition such that the employee's current condition of ill-being is

said to have been causally connected to the work-related injury and not simply the natural sequela process of the pre-existing condition. *Sisbro Inc. v. Industrial Comm'n,* 207 Ill. 2d 193, 278 Ill. Dec.70, 797 N. E. 2d 665 (2003).

Employment need only remain a cause, not the sole cause or even the principal cause, of a claimant's condition. *Rotberg v. Industrial Comm'n,* 361 Ill.App.3d 673, 682, 297 Ill.Dec. 568, 838 N.E.2d 55 (2005).

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,*58 Ill. 2d 226, 317 N.E.2d 515 (1974)

The courts presume that when a person seeks treatment for an injury, he will not falsify statements to a physician from whom he expects to receive medical aid. *Shell Oil Co. v. Industrial Comm'n, 2 Ill.2d 590, 592 119 N.E. 2d 224, 226 (1954).*

Proof of an employee's state of good health prior to the time of injury, and the change immediately following the injury, is competent as tending to establish that the impaired condition was due to the injury. *Westinghouse Electric Co. v. Industrial Commission,* 64 Ill. 2d 244,356 N.E. 2d 28 (1976).

Risks to employees fall into three groups: (1) risks distinctly associated with employment; (2) risks personal to the employee, such as idiopathic falls; and (3) neutral risks that have no particular employment or personal characteristics. *Id.* For an injury caused by an unexplained fall to arise out of employment, a claimant must present evidence that supports a reasonable inference that the fall stemmed from a risk related to the employment. Id. at 106. An injury resulting from a neutral risk, to which the general public is equally exposed, does not arise out of employment. Id. An injury resulting from an idiopathic fall arises out of the employment only where the employment conditions significantly contributed to the injury by increasing the risk of falling or the effects of the fall. *Stapleton v. Industrial Comm'n.*, 282 Ill. App. 3d 12, 16 (1996).

If an employee is required to travel and is involved in the performance of reasonable services of the employer at an appropriate time and place, an injury that occurs will be considered in the course of employment. In *Urban v. Industrial Commission,* 34 Ill.2d 159, 214 N.E.2d 737 (1966) a travelling salesman was held to be in the course of the employment from the time that he left home until he returned, on the basis that one cannot separate going to and coming from work from the moment that the salesman is actually calling on a customer.

If the claimant is required to travel away from the employment premises to perform work out of state, he or she is considered a travelling employee. In *Chicago Bridge & Iron, Inc. v. Industrial Commission,* 248 Ill.App.3d 687, 618 N.E.2d 1143, 188 Ill.Dec. 573 (5th District 1993), the claimant was a boilermaker who drove to Minnesota, located the jobsite and spent the night in a motel. He was paid mileage to travel to the jobsite. The Court affirmed the Commission's decision that the claimant's employment began in Illinois when he was hired and that he was a travelling employee engaged in reasonable and foreseeable conduct at the time of his injury.

It would be obviously unreasonable and contrary to the intendment of the Worker's Compensation Act and its purposes to say that a travelling employee has the protection of the Act only when in the physical act of performing selling or other duties and only in the course of a normal business day. *David Wexler & Co. vs. Industrial Commission*, 52 Ill.2d 506, 288 N.E.2d 420, 422 (1972) A traveling salesman was killed in an automobile accident on a legal holiday while on an extended business trip. He had been returning to his motel from a recreational activity and not from an appointment with a prospective buyer. The court held that the accident was in the course of his employment.

In support of the Arbitrator's decision with regard to whether Petitioner sustained accidental injuries that arose out of and in the course of her employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

In this case, the testimony of the Petitioner regarding the mechanism of her fall, tripping on the bridge and again at the customs counter is inconsistent with what she stated to the various treating and examining doctors. The first time that there is any indication that the Petitioner tripped over her tote bags when experiencing both of her falls on March 18, 2014, was the day she testified at the hearing. On all other occasions the Petitioner was quite explicit in telling the doctors, both those she chose and the Section 12 examiners chosen by the Respondent, that she did not know why she fell. She sought treatment from one doctor, Dr. Green, seeking an explanation for her "unprovoked falls." The Respondent did not present any evidence or argument denying that the Petitioner fell on two occasions on March 18, 2014, the Respondent denied that the falls arose out of and in the course of the Petitioner's employment with the Respondent.

The Petitioner was a flight attendant, on international flights for the Respondent. Petitioner lives in Atlanta, Georgia, but has been based out of Washington Dulles since 1989. She flies from Atlanta to Dulles in order to begin her flight assignments. On March 18, 2014, Petitioner was flying on a United Airlines flight from London to Washington Dulles and landed around 4:00 p.m. Petitioner is clearly a traveling employee. After allowing the passengers to disembark, Petitioner proceeded to go through security, bypass customs, and go to the kiosks. It was during this last sequence of events that the Petitioner fell on two occasions in a short period of time. The first fall was on the bridge, used to exit the plane and enter the airport and the second in the customs area.

In order to catch a return home flight, which was scheduled to leave at 5:00 PM, the Petitioner testified that she was hurrying from the flight she had just finished working to the customs area so that she could be cleared through customs and then get to her return flight home. Because of the tight timetable, Petitioner was skipping the debriefing that she would normally take part in upon her return from a foreign flight.

The Arbitrator notes the law is clear regarding a traveling employee. "The test for determining whether an injury arose out of and in the course of employment is the reasonableness of conduct in which Petitioner was engaged in and whether it might normally be anticipated or foreseen by the employer." *Wright* 62 Ill. 2nd 2d. at 69-70, 338 N.E. 2d 379. The Wright court delineated a three prong test to determine the reasonableness and foreseeable of an employee as follows: (a) Acts that an employer instructs the employee to perform, (b) Acts which the employee has a common law or statutory duty to perform for the employer, or, (c) Acts whish the employee may reasonably be expected to perform incident to the assigned employment. *Wright, Id.*

The employee need only to satisfy one of the three prongs to have the conduct considered reasonable and foreseeable. In this case the Petitioner satisfies two of the three categories. The analysis for travelling employees does not appear to include an analysis of the nature of the fall when determining whether a travelling employee's accidental injury is compensable.

In applying the three prong analysis, the Petitioner satisfies at least two of the three prongs. Once the plane lands and the passengers are all safely out of the plane and in the airport, the Petitioner must disembark the airplane, when a flight attendant arrives from a flight that originates from a foreign country, he or she must clear customs. Petitioner's falls happened while she was exiting the plane, on the bridge that would bring her into the airport so that she could comply with the United States custom process as required. The Respondent employer should reasonably expect that a flight attendant, at the end of her scheduled flight, would disembark a flight via a jet bridge and then head to customs to clear customs when arriving in the United States from a foreign country pursuant to her job duties so that she could return to her home.

The Arbitrator finds Petitioner sustained an accidental injury which arose out of and in the course of her employment.

In support of the Arbitrator's decision with regard to whether Petitioner's present condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Dr. Diehl testified that Petitioner's left shoulder condition was preexisting, but was aggravated by the fall. Dr. Diehl also testified to the left shoulder MRI taken on January 26, 2015, which revealed a full thickness tear that was caused by the fall and required orthopedic surgery. Dr. Diehl testified that he primarily obtained the history of the accident from Petitioner; that Petitioner told him that she was walking through a jet way and fell and then fell again for a second time. He also testified that Petitioner fell on March 5, 2014, while at home, but provided no other details than "just falling at home." Dr. Diehl admitted that he was aware of her numerous medical conditions, including diabetes, degenerative lumbar and cervical disease, peripheral neuropathy, and vascular disease such as deep vein thrombosis.

Petitioner testified that although she had previous injuries and treatment in the past, and had fallen at home about nine days before the falls at work, she was able to perform her job duties, fully and completely without restrictions until she fell on the jet bridge and again at the customs counter.

Dr. Javed noted Petitioner showed weakness in her hand and difficulty with walking, weakness with her left arm and neck pain. He opined that Petitioner likely had a pinched nerve in her neck that caused the left arm and hand weakness. He testified that an EMG was taken, which indicated carpal tunnel syndrome likely caused by a pinched nerve in the wrist. He also noted Petitioner had peripheral neuropathy and lumbar radiculopathy. He agreed that the tests may not clearly show any cervical problem because her diabetes can have an effect on the testing.

Dr. Javed also testified to a CT scan of the neck which showed arthritic changes, namely at the C5-6 and C4-5 levels, with severe foraminal stenosis at C5-6, left greater than right. He opined that the cervical radiculopathy caused the left arm symptoms as a result of a pinched nerve. Dr. Javed agreed that Petitioner's neck problems can be what are called a "double crush syndrome," which is caused by the diabetes.

Although Petitioner had a number of problems, Dr. Javed diagnosed Petitioner with neck/nerve pain caused by a cervical spondylosis and foraminal stenosis that she had for many years, but was aggravated as a result of the fall. Dr. Javed specifically noted that Petitioner had no prior history of pain, treatment or symptoms coming from the neck.

For these reasons, the Arbitrator finds Petitioner's treating doctors, Dr. Javed and Dr. Diehl more credible than the Section 12 examiners with respect to the injuries Petitioner suffered as result of the falls and the causal connection to the fall on March 18, 2014. The Arbitrator finds that Petitioner current state of ill-being is causally related to her work injury.

In support of the Arbitrator's decision with regard to whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Most if not all of the treatment Petitioner has received to date has been conservative in nature. Dr. Javed specifically testified at his deposition that the treatment Petitioner received for her neck pain and radicular symptoms was a common starting point for conservative treatment.

Based upon the foregoing discussion, The Arbitrator finds that the treatment received by Petitioner was reasonable and necessary, and related to her work injury. Respondent is therefore liable for the cost of the treatment, pursuant to the fee schedule.

In support of the Arbitrator's decision with regard to the amount due for temporary total disability, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner has been off of work because of her injury since March 18, 2014. There were recommendations by the Section 12 examiners that Petitioner should be released to return to work for the injuries to her neck, arm and back, but that she should not return due to the unexplained nature of her falls. Since that caveat was put in the recommendations, Petitioner cannot be faulted for not at least trying to return to work. She has maintained that she has been in continuous pain, with no relief from the conservative medical treatments that she has received to date. Petitioner is therefore entitled to TTD from March 19, 2014, through June 12, 2015

Based upon the foregoing discussion, the Arbitrator finds Petitioner's alleged period of temporary total disability, from March 18, 2014 to June 12, 2015, to be supported by the record.

In support of the Arbitrator's decision with regard to the whether the Petitioner entitled to future medical treatment, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

On August 29, 2014, Petitioner returned to Dr. Javed's office after diagnostic tests were taken. He noted that the tests revealed narrowing on the left side at the C5-6 level with spurs, abnormal discs, osteophytes with some similarity at the C4-5 level. Based on the tests, he indicated a plan of treatment including cervical epidural steroid injections and surgery if conservative treatment failed. Dr. Javed testified that Petitioner returned to his office on January 28, 2015, with continued complaints of pain in the back of the neck and headaches with left shoulder and hand weakness. Petitioner informed him that the epidural steroid injection helped a little. Dr. Javed recommends a C5-6 anterior discectomy to help with the neck and arm pain. He testified that surgery was reasonable and necessary, and he was awaiting approval of the same.

Dr. Diehl testified at his deposition, that Petitioner suffered a lumbar disc aggravation as a result of the accident as well as a torn left rotator cuff and that each of these injuries are casually related. Dr. Diehl further testified that Petitioner is in need of a left rotator duff surgery as conservative treatment has failed.

Based upon the history and treatment received by the Petitioner to date, the Arbitrator finds that the treatment recommendations made by the treating doctors, Dr. Diehl and Dr. Javed, are reasonable and necessary. The Respondent shall authorize and pay for the costs of said treatment.

In support of the Arbitrator's decision with regard to whether penalties or fees should be imposed upon the Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates the above-referenced findings of fact and conclusions of law as if fully restated herein.

Petitioner requested penalties and fees for failure to authorize the surgery recommended by Dr. Javed and the surgery recommended by Dr Diehl. Section 19(k) of the Illinois Workers' Compensation Act states that "[i]n cases where there has been any unreasonable or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay, then the Commission may award compensation additional to that otherwise payable under this Act equal to 50% of the amount payable at the time of such award.

Section 19(l) of the Act states that "[i]f the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30.00 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000.00. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.

Section 16 of the Act states that "[w]henever the Commission shall find that the employer, his or her agent, service company or insurance carrier has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee within the purview of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional under-payment of compensation benefits, or has engaged in frivolous defenses which do not present a real controversy, within the purview of the provisions of paragraph (k) of Section 19 of this Act, the Commission may assess all or any part of the attorney's fees and costs against such employer and his or her insurance carrier.

The Arbitrator notes that "[s]pecific procedures or treatments that have been prescribed by a medical service provider are 'incurred' within the meaning of section 8(a) even if they have not been performed or paid for." *Bennett Auto Rebuilders, Inc. v. Industrial Comm'n,* 306 Ill. App. 3d 650, 655-56 (1999). The claimant bears the burden of proving, by a preponderance of the evidence, his or her entitlement to an award of medical care under section 8(a). *Westin Hotel v. Industrial Comm'n,* 372 Ill. App. 3d 527, 546 (2007).

Although Respondent relies on the opinions of Dr. Walsh and Glantz to deny the surgeries recommended by Dr. Javid and Dr. Diehl, a conflicting medical opinion does not present an absolute defense to imposition of 19(l) penalties. "The test is not whether there is some conflict in medical opinion. Rather, it is whether the employer's conduct in relying on the medical opinion to contest liability is reasonable under all circumstances presented. *Continental Distributing v. Industrial Comm'n,* 98 Ill.2d 407 (1983).

In this case, the statements made by the Petitioner to all of the examining and treating doctors were that she did not know why she fell, and that she had at least two other falls, possibly three, one before and two after which were also being considered as part of her medical

history. She denied feeling faint, passing out, or seeing any defects on the bridge or the floor in the customs area. All the doctors were considering the falls to be idiopathic in nature. The doctors agreed that here current health conditions and medications as well as her previous treatment could have been a contributing factor or a cause of the falls. The finding that a particular workers' compensation claimant is a traveling employee does not exempt that claimant from proving that an injury arose out of the course of the employment.

Given these factors, Respondent's actions are not unreasonable and vexatious. Respondent had a valid, reasonable, and good faith basis in disputing treatment. Fees and penalties are denied.

ORDER OF THE ARBITRATOR

Respondent shall pay Petitioner temporary total disability benefits of **$576.99**/week for **64 4/7** weeks, commencing **March 19, 2014 through June 12, 2015**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $5,192.91 for TTD and $5,192.90 by way of a PPD advance, for a total credit of $10,385.81.

Respondent shall pay reasonable and necessary medical services of $26,755.06, as provided in Sections 8(a) and 8.2 of the Act pursuant to the fee schedule or prior agreement whichever is less.

Respondent shall be given a credit of $1,785.00 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 the surgeries and follow-up treatments recommended by Dr. Javed and Dr. Diehl.

Deborah L. Simpson

January 5, 2016

Signature of Arbitrator

Date

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Anthony Houston-Sullivan,
Petitioner,

Vs. NO: 14WC 23160

Get Fresh Produce,
Respondent,

ORDER

Petition for Review having been filed by the Respondent on April 15, 2016, herein, due notice having been given, this cause came on for hearing before the Commission on September 20, 2016, in Chicago, Illinois. The Commission having jurisdiction over the persons and subject matter, being advised in the premises finds:

On September 20, 2016, this matter was set before the Commission on a Rule to Show Cause as to why the Respondent's Petition for Review should not be dismissed, in that, an authenticated Arbitration Transcript was not submitted and or authenticated on the Return Date on Review of July 15, 2016, in accordance with the **NOTICE OF RETURN DATE ON REVIEW** dated May 12, 2016. If an authenticated arbitration transcript were filed by August 21, 2016, the Rule to Show Cause would have been satisfied.

However, Respondent failed to appear and file an authenticated transcript.

Upon consideration of the above, the Commission is of the opinion that Respondent's Petition for Review should be dismissed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Petition for Review filed April 15, 2016, is hereby dismissed.

DATED: SEP 2 9 2016
CJD/jrc
R092016
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

JESSICA VONDERHEIDE,

Petitioner,

vs.

NO: 14 WC 25780

STEAK & SHAKE,

16IWCC0624

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

After considering the entire record, the Commission vacates the award for disfigurement to the right middle finger. The Commission finds that although the undisputed accident of July 16, 2014, caused a laceration which required medical attention, it did not cause any permanent disfigurement under §8(c).

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the award of disfigurement benefits pursuant to §8(c),of $403.85 per week for 1 week, because the injuries sustained caused the disfigurement of the right middle finger, is hereby vacated.

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

16IWCC0624

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

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

DATED: SEP 29 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

CJD/dm
O: 9/16/16
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VONDERHEIDE, JESSICA
Employee/Petitioner

Case# **14WC025780**

14WC025781

STEAK & SHAKE
Employer/Respondent

16IWCC0624

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:

0071 BONIFIELD & ROSENSTENGEL PC
JON E ROSENSTENGEL
16 E MAIN ST
BELLEVILLE, IL 62220

4301 HELPER BROOM
DAVID G KOWERT
211 N BROADWAY SUITE 2700
ST LOUIS, MO 53102

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
NATURE AND EXTENT ONLY

JESSICA VONDERHEIDE
Employee/Petitioner

v.

STEAK & SHAKE
Employer/Respondent

Case # **14** WC **25780**

Consolidated cases: **14 WC 25781**

16IWCC0624

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 28, 2016**. By stipulation, the parties agree:

On the date of accident, **July 16, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**35,000.16**, and the average weekly wage was $**673.08**.

At the time of injury, Petitioner was **40** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $ **N/A** for TTD, $ **N/A** for TPD, $ **N/A** for maintenance, and $ **N/A** for other benefits, for a total credit of $**0**. The parties stipulated that the Respondent is entitled to credit for paid medical benefits pursuant to Section 8(j) of the Act, and that Respondent shall hold Petitioner harmless for the expenses to for which credit is taken.

16IWCC0624

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

Permanent Partial Disability: Disfigurement

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 1 week, because the injuries sustained caused the disfigurement of the right middle finger, as provided in Section 8(c) of the Act.

Credits

Respondent shall be given a credit for medical benefits that have been paid via employer provided group health benefits, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

March 8, 2016
Date

ICArbDecN&E p.2

MAR 14 2016

16IWCC0624

STATEMENT OF FACTS

This matter was heard on January 28, 2016 in Collinsville, Illinois. The parties stipulated to both alleged accidental injuries (June 3, 2014 and July 16, 2014), that the Petitioner's injuries were causally related to her employment, and that the Respondent would be allowed credit under Section 8(j) for medical and lost time disability payments from its group plans. The sole issue in dispute in both of the consolidated cases was the nature and extent of Petitioner's disability.

Petitioner was 42 years old at the time of the hearing. She testified that she worked as a manager for Respondent, Steak 'n Shake. She had worked in various positions at various locations in her five years of employment with Respondent. Her job generally entailed picking up trash from the parking lot and premises in the morning, performing inventory, performing various inspections, supervising servers, and often working the line work stations. The work stations included grilling burgers, operating deep fryers, dressing burgers, dipping shakes, packaging food and working the drive through. With regard to the grill, she testified that this required her to use a fork and a flipping tool to cook the burger patties. She testified that she worked five 10-hour shifts per week, and that her work consistently involved use of both hands. She noted that at times she worked 14 or 15 hour shifts.

The parties stipulated that the Petitioner sustained various repetitive trauma injuries that were related to a 6/3/14 accident date. The parties also stipulated to a 7/16/14 accident date involving a laceration to the right middle fingertip.

The Petitioner initially sought treatment with Dr. Kosit Prieb on 6/24/2013. She complained of an eight month history of pain and locking in the right thumb, noting a February injection hadn't helped. Dr. Prieb prescribed surgical release of the right trigger thumb, which was performed on 7/3/13. At a 7/15/13 follow up Dr. Prieb noted no complaints with no clicking or locking. Good results were indicated and she was released to return as needed. The Petitioner testified she was diagnosed with bilateral carpal tunnel syndrome, but it appears she may have had the date confused.

On 10/17/13, Dr. Prieb noted complaints of left hand numbness with locking of the left middle and ring fingers. Diagnosis was flexor tendon tenosynovitis of the left middle and ring fingers at the A-1 pulley area, and left carpal tunnel syndrome, and the fingers were injected. Dr. Prieb also noted dilated median nerve at the distal wrist crease compatible with left carpal tunnel syndrome. (Px3).

On 6/2/2014 the Petitioner reported pain, numbness, and tingling in her right elbow, extending into her right hand. (Px3). Nerve conduction studies (NCV) were performed on the right hand/wrist on 6/12/2014, indicating right carpal tunnel syndrome. Dr. Prieb preformed a right carpal tunnel release on 7/29/2014. She was held off work from the date of surgery until 9/15/14. On 10/13/2014, Dr. Prieb indicated that the Petitioner reported no further numbness or pain in the right hand, and that she was quite pleased with the results of the surgery. She was released from care to return as needed. (Px3).

The Petitioner sustained a work-related laceration to the right middle finger on 7/16/14, and this was sutured. Sutures were removed on 7/24/14, and she was released from care to return as needed at that time. (Px1 & 2). The residual scar was described at hearing as narrow and approximately ½-inch in length just below the right middle fingertip. The Arbitrator viewed the scar during the hearing.

As to the left hand, the Petitioner reported numbness, tingling, and pain with dropping of objects to Dr. Prieb on 3/26/15. She was diagnosed with both left carpal tunnel syndrome and a left ganglion cyst. A 4/16/15 left NCV

reflected moderate left carpal tunnel syndrome. Petitioner underwent both resection and removal of the ganglion cyst, as well as a left carpal tunnel release on 6/10/2015. The parties have agreed that the left ganglion cyst is not being claimed as a work related condition. On 6/25/15 and 7/23/15, Petitioner reported some ongoing left wrist numbness and pressure, and ongoing soreness and weakness on 8/20/15. She was held off work from the date of surgery until 8/24/15. On 8/31/2015, Dr. Prieb noted the Petitioner reported that her hand was fine. (Px3).

During that same period of time, The Petitioner also complained of a two month history of locking symptoms with pain in her right ring and middle fingers on 3/26/15, and of similar symptoms in the left middle finger on 4/23/15. All three fingers were diagnosed with flexor tendon tenosynovitis, and the conditions were addressed with injections to the A-1 pulley areas (on 3/26/15 to the right middle and ring finger, and on 4/23/15 to the left middle finger). (Px3).

On 1/15/15 the Petitioner was evaluated by Dr. Howard of Orthopedic Specialists at Respondent's request, and reported no symptoms in her right hand including a complete resolution of her numbness and tingling. Dr. Howard assessed disability as 5% of the right hand according to the AMA guidelines. Dr. Howard also noted the right trigger thumb condition was causally related to Petitioner's work duties, but that her symptoms appeared to be completely resolved with no need for further treatment. While he commented on the right ring finger as showing triggering, his examinations and reports took place prior to the finger being injected, and prior to the left carpal tunnel treatment and release surgery. As such, he did not comment with regard to permanency involving the right middle and ring finger, the left middle finger or the left carpal tunnel condition. (Px4).

At hearing, the Petitioner reported "very rare" numbness and tingling, but did note stiffness in her hands after a full work shift. She testified to ongoing locking of the bilateral middle fingers a few times a week. As to the right ring finger, she reported some difficulty bending the finger, and a locking of the digit a few times a week. On the right thumb, she described stiffness and a loss of range of motion which was demonstrated at hearing as approximately 2/3 of normal. Petitioner advised she was performing her full and regular job activities in an unrestricted fashion as of the date of hearing with no ongoing difficulties.

CONCLUSIONS OF LAW

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

Pursuant to §8.1b of the Act, a set of criteria and factors are to be weighed in order to determine the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011. The criteria and factors are:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level by a physician of impairment pursuant to AMA guidelines;

(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.

Because this matter involves only a minor laceration and disfigurement, none of the enumerated factors carry any weight with the Arbitrator. There is no evidence whatsoever of functional disability as a result of the laceration to the right middle finger, or any impact on the Petitioner's employment, age or earnings, and has not resulted in any impairment or disability.

The Arbitrator viewed the Petitioner's right middle finger at the arbitration hearing. The disfigurement at issue involved a very faint, narrow, approximate ½" scar just below the fingertip. The scar is barely visible, and not in an obvious location. The Arbitrator finds the level of disfigurement to be one week of PPD.

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

JESSICA VONDERHEIDE,

Petitioner,

vs.

NO: 14 WC 25781

STEAK 'N SHAKE,

16IWCC0625

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue(s) of nature and extent of Petitioner's permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission clarifies that the manifestation date for Petitioner's right carpal tunnel injuries and left carpal tunnel injuries are June 3, 2014. Public Act 97-18 changed the Workers' Compensation Act such that the maximum value for a hand if the accidental injury involves carpal tunnel syndrome due to repetitive or cumulative trauma, shall be 190 weeks if the accidental injury occurs on or after June 28, 2011. The Arbitrator erred in his calculation for the loss of use of the right hand and loss of use of the left hand, so the award is corrected to reflect the appropriate calculation. We modify the Arbitrator's decision to find that Petitioner has sustained the loss of use of 10% of the left hand and loss of use of 10% of the right hand for a total permanent partial disability award of 19 weeks, each.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $403.85 per week for a period of 19 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the right hand.

16IWCC0625

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $403.85 per week for a period of 19 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $403.85 per week for a period of 3.8 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the left middle finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $403.85 per week for a period of 3.8 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the right middle finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $403.85 per week for a period of 2.7 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the right ring finger.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $403.85 per week for a period of 7.6 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the right thumb.

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 $22,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP 2 9 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

CJD/dm
O: 9/13/16
49

السعد ما الملحدة

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VONDERHEIDE, JESSICA
Employee/Petitioner

Case# **14WC025781**

14WC025780

STEAK & SHAKE
Employer/Respondent

16IWCC0625

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:

0071 BONIFIELD & ROSENSTENGEL PC
JON E ROSENSTENGEL
16 E MAIN ST
BELLEVILLE, IL 62220

4301 HEPLER BROOM
DAVID G KOWERT
211 N BROADWAY SUITE 2700
ST LOUIS, MO 63102

16IWCC0625

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
NATURE AND EXTENT ONLY

JESSICA VONDERHEIDE
Employee/Petitioner

v.

STEAK & SHAKE
Employer/Respondent

Case # **14** WC **25781**

Consolidated cases: **14 WC 25780**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 28, 2016**. By stipulation, the parties agree:

On the date of accident, **June 3, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,000.16**, and the average weekly wage was **$673.08**.

At the time of injury, Petitioner was **40** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $ **N/A** for TTD, $ **N/A** for TPD, $ **N/A** for maintenance, and $ **N/A** for other benefits, for a total credit of **$0**. The parties stipulated that the Respondent is entitled to credit pursuant to Section 8(j) of the Act for paid medical and lost time benefits, and that Respondent shall hold Petitioner harmless for the expenses to for which credit is taken.

16IWCC0625

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

Permanent Partial Disability: Disfigurement

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 7.6 weeks, because the injuries sustained caused the 10% loss of the right thumb, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 3.8 weeks, because the injuries sustained caused the 10% loss of the right middle finger, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 2.7 weeks, because the injuries sustained caused the 10% loss of the right ring finger, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 3.8 weeks, because the injuries sustained caused the 10% loss of the left middle finger, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 20.5 weeks, because the injuries sustained caused the 10% loss of the right hand, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $403.85 per week for 20.5 weeks, because the injuries sustained caused the 10% loss of the left hand, as provided in Section 8(e) of the Act.

Credits

Respondent shall be given a credit for medical benefits and lost time benefits that have been paid via employer provided group plans, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

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

Signature of Arbitrator

March 8, 2016
Date

ICArbDecN&E p.2

MAR 14 2016

STATEMENT OF FACTS

This matter was heard on January 28, 2016 in Collinsville, Illinois. The parties stipulated to both alleged accidental injuries (June 3, 2014 and July 16, 2014), that the Petitioner's injuries were causally related to her employment, and that the Respondent would be allowed credit under Section 8(j) for medical and lost time disability payments from its group plans. The sole issue in dispute in both of the consolidated cases was the nature and extent of Petitioner's disability.

Petitioner was 42 years old at the time of the hearing. She testified that she worked as a manager for Respondent, Steak 'n Shake. She had worked in various positions at various locations in her five years of employment with Respondent. Her job generally entailed picking up trash from the parking lot and premises in the morning, performing inventory, performing various inspections, supervising servers, and often working the line work stations. The work stations included grilling burgers, operating deep fryers, dressing burgers, dipping shakes, packaging food and working the drive through. With regard to the grill, she testified that this required her to use a fork and a flipping tool to cook the burger patties. She testified that she worked five 10-hour shifts per week, and that her work consistently involved use of both hands. She noted that at times she worked 14 or 15 hour shifts.

The parties stipulated that the Petitioner sustained various repetitive trauma injuries that were related to a 6/3/14 accident date. The parties also stipulated to a 7/16/14 accident date involving a laceration to the right middle fingertip.

The Petitioner initially sought treatment with Dr. Kosit Prieb on 6/24/2013. She complained of an eight month history of pain and locking in the right thumb, noting a February injection hadn't helped. Dr. Prieb prescribed surgical release of the right trigger thumb, which was performed on 7/3/13. At a 7/15/13 follow up Dr. Prieb noted no complaints with no clicking or locking. Good results were indicated and she was released to return as needed. The Petitioner testified she was diagnosed with bilateral carpal tunnel syndrome, but it appears she may have had the date confused.

On 10/17/13, Dr. Prieb noted complaints of left hand numbness with locking of the left middle and ring fingers. Diagnosis was flexor tendon tenosynovitis of the left middle and ring fingers at the A-1 pulley area, and left carpal tunnel syndrome, and the fingers were injected. Dr. Prieb also noted dilated median nerve at the distal wrist crease compatible with left carpal tunnel syndrome. (Px3).

On 6/2/2014 the Petitioner reported pain, numbness, and tingling in her right elbow, extending into her right hand. (Px3). Nerve conduction studies (NCV) were performed on the right hand/wrist on 6/12/2014, indicating right carpal tunnel syndrome. Dr. Prieb preformed a right carpal tunnel release on 7/29/2014. She was held off work from the date of surgery until 9/15/14. On 10/13/2014, Dr. Prieb indicated that the Petitioner reported no further numbness or pain in the right hand, and that she was quite pleased with the results of the surgery. She was released from care to return as needed. (Px3).

The Petitioner sustained a work-related laceration to the right middle finger on 7/16/14, and this was sutured. Sutures were removed on 7/24/14, and she was released from care to return as needed at that time. (Px1 & 2). The residual scar was described at hearing as narrow and approximately ½-inch in length just below the right middle fingertip. The Arbitrator viewed the scar during the hearing.

As to the left hand, the Petitioner reported numbness, tingling, and pain with dropping of objects to Dr. Prieb on 3/26/15. She was diagnosed with both left carpal tunnel syndrome and a left ganglion cyst. A 4/16/15 left NCV

reflected moderate left carpal tunnel syndrome. Petitioner underwent both resection and removal of the ganglion cyst, as well as a left carpal tunnel release on 6/10/2015. The parties have agreed that the left ganglion cyst is not being claimed as a work related condition. On 6/25/15 and 7/23/15, Petitioner reported some ongoing left wrist numbness and pressure, and ongoing soreness and weakness on 8/20/15. She was held off work from the date of surgery until 8/24/15. On 8/31/2015, Dr. Prieb noted the Petitioner reported that her hand was fine. (Px3).

During that same period of time, The Petitioner also complained of a two month history of locking symptoms with pain in her right ring and middle fingers on 3/26/15, and of similar symptoms in the left middle finger on 4/23/15. All three fingers were diagnosed with flexor tendon tenosynovitis, and the conditions were addressed with injections to the A-1 pulley areas (on 3/26/15 to the right middle and ring finger, and on 4/23/15 to the left middle finger). (Px3).

On 1/15/15 the Petitioner was evaluated by Dr. Howard of Orthopedic Specialists at Respondent's request, and reported no symptoms in her right hand including a complete resolution of her numbness and tingling. Dr. Howard assessed disability as 5% of the right hand according to the AMA guidelines. Dr. Howard also noted the right trigger thumb condition was causally related to Petitioner's work duties, but that her symptoms appeared to be completely resolved with no need for further treatment. While he commented on the right ring finger as showing triggering, his examinations and reports took place prior to the finger being injected, and prior to the left carpal tunnel treatment and release surgery. As such, he did not comment with regard to permanency involving the right middle and ring finger, the left middle finger or the left carpal tunnel condition. (Px4).

At hearing, the Petitioner reported "very rare" numbness and tingling, but did note stiffness in her hands after a full work shift. She testified to ongoing locking of the bilateral middle fingers a few times a week. As to the right ring finger, she reported some difficulty bending the finger, and a locking of the digit a few times a week. On the right thumb, she described stiffness and a loss of range of motion which was demonstrated at hearing as approximately 2/3 of normal. Petitioner advised she was performing her full and regular job activities in an unrestricted fashion as of the date of hearing with no ongoing difficulties.

CONCLUSIONS OF LAW

WITH RESPECT TO THE ISSUE OF THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;

(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b) as it pertains to the right hand, the Arbitrator notes that Dr. Howard determined that Petitioner had sustained impairment pursuant to AMA guidelines of 5% to the right hand. He also noted a complete resolution of symptoms, which is supported by Dr. Prieb in his note of 08/13/2014. The Arbitrator gives this factor a medium degree of weight. No AMA impairment rating was presented by either party with regard to any other injuries, and thus this factor carries no weight with regard to any body parts outside of the right hand.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner remains a full time manager of a restaurant, which was her job prior to the accident at issue. She testified that she is able to perform her job without significant issues. She did indicate that she has stiffness in her hands and wrists after a work shift, and that she continues to have some minimal ongoing locking in the fingers. The Arbitrator finds the injury has resulted in a minimum impact to her occupation.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 42 years old at the time of the accident. There was no evidence presented with regard to how this factor could be weighed by the Arbitrator. The Petitioner is of a medium work age, and thus the Arbitrator gives no significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no evidence was presented indicating that the this capacity has been diminished. Petitioner testified that she continued to work her full and regular job duties. The Arbitrator therefore gives no significant 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 no significant residual complaints or symptoms described in the final medical reports of Dr. Prieb for any of the Petitioner's various conditions. That said, the Arbitrator did find the Petitioner credible with regard to her complaints of ongoing locking of her fingers, and stiffness in her wrists after 10 hour or longer shifts. Overall, there appears to be a relatively minimal level of ongoing complaints regarding her hands/wrists and injured fingers.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of each hand, 10% of the right thumb, and 10% of each of the right ring, right middle and left middle fingers, pursuant to 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

Frankie Hines,

Petitioner,

vs.

16IWCC0571

NO: 14 WC 26434

RJB Properties,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, reasonableness and necessity of 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 October 27, 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.

16IWCC0571

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

DATED: SEP - 7 2016
KWL/vf
O-8/30/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0571

HINES, FRANKIE
Employee/Petitioner

Case# **14WC026434**

RJB PROPERTIES
Employer/Respondent

On 10/27/2015, 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 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN CAIRO
DEBORAH BAKER
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
TAMMY A PAQUETTE
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

16IWCC0571

Frankie Hines
Employee/Petitioner

v.

RJB Properties
Employer/Respondent

Case # 14 WC 26434

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0571

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 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 **$9,548.40**; the average weekly wage was **$636.56**.

On the date of accident, Petitioner was **59** years of age, ***married*** with **0** dependent children.

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

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

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

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

ORDER

Benefits are hereby denied as Petitioner failed to prove an accident arising out of and in the course of his employment, nor did he prove notice of an alleged work injury.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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

10-26-15
Date

OCT 27 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Frankie Hines	)	16IWCC0571
Petitioner,	)	
vs.	)	No. 14 WC 26434
RJB Properties	)	
Respondent.	)	

Arbitrator's Findings of Fact

The Petitioner, Frankie Hines, testified that he was employed by RJB Properties as a janitor at Gwendolyn Brooks College Prep High School. He stated that his duties included sweeping, mopping, dusting, disinfecting, and moving furniture.

Five days prior to the alleged work accident, the Petitioner underwent a CT-scan of his abdomen at Union Health Services. (PX #1)

On July 14, 2014, Petitioner testified that he was unloading a truck with furniture with other engineers when he felt a pain in his abdomen. He stated that he continued to work the rest of the day. Petitioner also testified he already had a doctor's appointment set for the next day.

Petitioner originally testified that telephoned notice of the accident to his employer, but could not recall whom he called, but later stated it was Shateau Shorter, his supervisor.

On July 15, 2014, Petitioner presented to Union Health Services, the facility with whom he already had an appointment scheduled, with complaints of bilateral inguinal hernias and two sebaceous cysts. Petitioner noted the hernia was worse on the right and it appeared after he lifted at work on the 14th. (PX 1).

On July 24, 2014, Petitioner underwent surgery which included laparoscopic bilateral inguinal hernia repairs and excision of two sebaceous cysts. The post-operative diagnosis at that point was a right inguinal hernia and a recurrent left inguinal hernia as well as two sebaceous cysts. (PX 2).

Petitioner continued his post-operative treatment at Union Health. His treatment was somewhat postponed because the doctors later discovered the Petitioner had gallbladder cancer. (PX 1). Ultimately, Petitioner was released from care on September 16, 2014. (PX 1).

Petitioner eventually returned to work full duty with Respondent.

With regard to (C), whether an accident arose out of and in the course of Petitioner's employment with the Respondent and (D), the date of accident, the Arbitrator finds the following:

Petitioner bears the burden of proving every aspect of his claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992). "Liability under the Workmen's Compensation Act may not be based on imagination, speculation, or conjecture, but must have a foundation of facts established by a preponderance of the evidence..." *Shell Petroleum Corp. v. Industrial Commission*, 10 N.E. 2d 352 (1937) The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment there is no right to recover. *Revere Paint & Varnish Corp. v. Industrial Commission*, 41 Ill.2d. 59. Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. *Spankroy v. Alesky*, 45 Ill. App.3d 432 (1st Dis. 1977).

Petitioner testified that on July 14, 2014, he was unloading a truck with furniture with other workers when he felt a pain in his abdomen, but worked the remainder of the day. Petitioner also testified he already had a doctor's appointment set for the next day.

The Arbitrator finds that Petitioner's version of the events raises some questions. First, The Union Health billing records show that Petitioner was billed for a CT Scan of the abdomen on July 9, 2014, five days before the alleged accident. (PX #1) There are no treatment records that correspondent with bill, as the subpoena requested on records from July 18, 2014 to the present. (PX #1) The Arbitrator notes that CT-Scans are sometimes used to determine the presence of inguinal hernias.

Petitioner's original Application for Adjustment of claim listed a date of accident as July 18, 2014, three (3) days after he was initially seen by Union Health for his complaints. It is on the day of trial that the Application was amended to reflect a date of loss of July 14, 2014, to correspond to the medical records.

The Petitioner was billed $1,225.10 for a CT Scan of his abdomen (CPT Code 74170) that occurred four days before the alleged accident. (PX #1) No explanation of this procedure was given by the Petitioner on direct examination, nor was Petitioner cross-examined about it. Incidentally, it does not appear to be related to the Petitioner gall bladder cancer that was discovered later; after the Petitioner's hernia surgery.

Additionally, Petitioner, admitted on cross examination that he knows how to report a work injury due to, not only the fact that he had a prior workers compensation claim, but also that he was provided a handbook and took a new hire employment test indicating work injuries were to be reported immediately. (RX 2 and RX 3). The Arbitrator finds inconsistencies in Petitioner's testimony in this regard. Initially, Petitioner could not identify whom he gave notice to the accident, but later stated he reported it to his supervisor, Shateau Shorter.

Finally, when presented the RJB Leave of Absence Application, which Petitioner testified he read before signing, he claimed he had never seen the first page of the document,

which indicated he was requesting a personal medical leave from July 24, 2014 through August 11, 2014. (RX 1). Petitioner claimed he read the document and that was his signature but he never questioned the location of the first document page which included line items #1 and #2.

Shateau Shorter testified that Petitioner never report a work injury. She went on to testify that all employees were trained to contact her in the event of a work injury. If she was not at the work site, the employees were to call her cell phone.

Looking at the totality of the evidence presented at trial, the Arbitrator finds that there are many inconsistencies in Petitioner's testimony and version of events. He also finds that Ms. Shorter's testimony was credible and persuasive. The abdominal CT-Scan four days before the accident was not addressed and raises credibility questions. The Petitioner had recent, prior workers' compensation claim and ostensibly, should have been better about documenting his injury and requesting workers' compensation instead of a personal medical leave. Based on this, the Arbitrator finds that Petitioner has failed to prove an accident arising out of and in the course of his employment.

With regard to (E), whether timely notice of the accident was given to the Respondent, the Arbitrator finds the following:

While the Arbitrator finds the Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment, he also finds that Petitioner failed to meet his burden with regard to notice as the Arbitrator does not find his testimony persuasive.

Petitioner testified that on July 14, 2014, he felt a sharp pain while at work and continued to work. He went on to testify that he already had a doctor's appointment scheduled for the next day and he called his employer to notify them of the accident, but could not recall whom he notified. Later, he testified that he informed his supervisor, Shateau Shorter.

Ms. Shorter contradicted Petitioner's testimony and stated no notice is ever given by Petitioner. Further, stated all employees were trained to provide immediate notification. Petitioner never contacted her regarding an alleged work injury. Moreover, she testified that employees are required to attend safety meetings, which include training on reporting work injuries. Petitioner agreed that he was provided a handbook which indicated he was to report injuries immediately. (RX 3). In addition, Petitioner took the Chicago Public School New Hire Orientation Custodial Services Test on March 24, 2014 wherein, one of the questions was "how long should I wait to report an injury?" The answer which was "immediately." (RX 2). Finally, the Petitioner executed a Leave of Absence Application (RX 1), instead of going on workers' compensation. Petitioner had a prior workers' compensation claim in 2012.

Looking to a totality of the evidence presented at trial, the Arbitrator finds that Petitioner failed to present evidence establishing he gave timely notice of an accident to the Respondent and denies all compensation.

The lack of notice could have easily prejudiced the Respondent's ability to defend the claim. If the employer had proper notice, it could have determined the job duties the Petitioner was performing on the alleged date of loss and whether any co-workers could corroborate the

Petitioner history of the accident. Finally, if the Petitioner had immediately notified his employer of the occurrence, he could easily demonstrate the hernias "abdominal bulges" to his supervisor to corroborate his history.

With regard to (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

The Arbitrator adopts his findings in Sections C and E above, that Petitioner did not sustain accident injuries arising out of and in the course of his employment, nor did he provide timely notice of an alleged accident, to the Respondent, therefore, this issue is moot.

With regard to (J), whether medical services that were provided to Petitioner were reasonable and necessary and whether or not Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

As the Arbitrator finds Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment, Petitioner's claim for medical expenses is hereby denied.

With regard to (K), whether TTD is owed, the Arbitrator finds the following:

As the Arbitrator finds Petitioner failed to prove he sustained an accident arising out of and in the course of his employment, Petitioner's claim for TTD is hereby denied.

With regard to (L), what the nature and extent of the injury is, the Arbitrator finds the following:

As the Arbitrator finds that the Petitioner failed to prove he sustained an accident arising out of and in the course of his employment, permanency is hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Alvarado,
Petitioner,
vs.

NO: 14WC 26513

GSG Material Testing,
Respondent

16IWCC0582

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 30, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,533.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: SEP - 8 2016
MJB/bm
o-08/30/16
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVARADO, JUAN
Employee/Petitioner

Case# **14WC026513**

GSG MATERIAL TESTING INC
Employer/Respondent

16IWCC0582

On 12/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4129 WOLFE LAW PC
KENNETH WOLFE
200 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

4743 ORENSTEIN & ASSOC
DANIEL ORENSTEIN
2970 MARIA AVE SUITE 203-205
NORTHBROOK, IL 60062-2017

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JUAN ALVARADO
Employee/Petitioner

v.

GSG MATERIAL TESTING, INC.
Employer/Respondent

Case # **14** WC **026513**

Consolidated cases: _____

16IWCC0582

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **LYNETTE THOMPSON-SMITH**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 18, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0582

FINDINGS

On **March 21, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$78,000.00**; the average weekly wage was **$1,500.00**.

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*** 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

Medical Bills
For reasons stated in the decision, none of the claimed medical bills are deemed compensable and no medical benefits are awarded, pursuant to Section 8(a) of the Act.

Temporary total Disability
For reasons stated in the decision no temporary total disability benefits are awarded pursuant to Section 8(b) of the Act.

Permanent Partial Disability
Respondent shall pay Petitioner 20 weeks of permanent partial disability at $721.66 per week because Petitioner sustained permanent partial disability to the extent of 4% loss of the whole person pursuant to §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.

16IWCC0582

FINDING OF FACTS

The disputed issues in this matter are: 1) accident; 2) causal connection; 3) medical bills; 4) temporary total disability; and 5) the nature and extent of Petitioner's injury. *See,* AX1.

On March 21, 2014, (hereafter referred to as "the incident date"), Mr. Juan Alvarado, (the "petitioner"), a 46 year old, single male with no dependent children, worked for GSC Material Testing, (the "respondent"), as a driller's helper. The petitioner worked in that capacity for over a year prior to the incident date. His job duties were physical in nature.

On the incident date the petitioner alleges he injured his neck, low back and person as a whole while working. The petitioner alleges he first felt pain in his neck and back a year earlier, but that pain eventually subsided and he never reported an injury at that time. On the incident date The petitioner alleged he was lifting a 40 pound drill when he felt pain in his neck and back. He reported the incident to the Respondent on March 25, 2014.

The petitioner first sought medical treatment for this incident on April 4, 2014. At that time he presented to his primary care physician; Dr. Julio Mora, for evaluation and treatment for complaints of low back pain for the past three weeks. The petitioner stated his pain was sharp and constant and he rated the pain as 8/10 in severity He indicated that the pain was worse with activities and got better after resting. The petitioner stated that the pain started after return to work and lifting of greater than 50 pounds of weight. He stopped working on March 24, 2014 because of the pain, and he was feeling dizzy. The petitioner was anxious, worried, and unable to sleep. He also had some tremors. Dr. Mora diagnosed the petitioner with low back pain. Physical examination was within normal limits. The petitioner was referred to Dr. Gary Shapiro for anxiety, lumbago, and central hypertension, which was benign.

On April 14, 2015, the petitioner presented to Dr. Gary Shapiro at Illinois Bone and Joint Institute. The petitioner was 25 days post-alleged work incident. He was referred by Dr. Mora. The petitioner indicated he had a one year history of neck and low back pain as well as pain in his bilateral knees and wrists. He had numbness and tingling which was non-dermatomal in both upper and lower extremities. He had not undergone any physical therapy to date. The petitioner had been off work for the past three weeks, secondary to vertigo. X-rays revealed loss of disc height space at C5-C6. Lumbar x-rays revealed unremarkable results. The petitioner was diagnosed with chronic neck and low back pain. Physical therapy, neck and low back MRIs and a rheumatologic work-up was recommended.

The petitioner had his initial physical therapy evaluation at Illinois Bone and Joint Institute on April 24, 2014. He presented with sharp pains in the middle and left of his lower back which started about a year ago but recently he had vertigo and it got worse. He had increased pain from prolonged standing at work. He could have pain with standing 5 minutes one day, and 45 minutes the next day.

He had problems getting out of the car at the end of the day due to pain. His pain went from severe to manageable. X-rays were unremarkable. He also experienced right upper extremity numbness previously, but not recently. He worked in construction on a drilling rig. He was off work secondary to vertigo and did not know when he would return. The petitioner indicated that his pain was 2/10 in severity. Physical therapy goals were outlined and therapy was recommended two times per week for 4-6 weeks.

On May 7, 2014, a physical therapy progress report was prepared by Illinois Bone and Join Institute. The petitioner had attended a total of six physical therapy sessions with no cancellations. He stated that his back continued to tighten up and cause him pain when he was on his feet for a long period of time; especially at the end of the day. He felt he was getting stronger with exercises but was nervous about returning to work, due to the repetitive lifting. The left side of his back continued to be the main area of spasms and pain. He worked in construction on a drilling rig which included a lot of heavy and repetitive lifting. The petitioner was off work due to vertigo and did not know when he would return. He described his pain as 7/10 in severity. He was making steady progress in therapy and was able to lift 15 pounds, with good mechanics without pain. He would continue to increase gradually to perform his job requirements. Short-term and long-term goals were updated. Further therapy was recommended two times per week for 4-6 weeks.

The petitioner followed-up with Dr. Shapiro on May 8, 2014. He had been doing physical therapy but continued to have neck and low back pain. MRI's and a rheumatologic work-up were again recommended. On May 13, 2014, the petitioner underwent an MRI of the lower back/lumbar spine, which revealed a tiny left paracentral disc protrusion at L5-S1; with no central stenosis or neural foraminal narrowing. The same day the petitioner underwent an MRI of the cervical spine, which revealed moderate to severe left neural foraminal narrowing at C6-C7.

The MRI films were reviewed by Dr. Shapiro on May 15, 2014, who noted that films showed cervical disc bulging, but no significant central stenosis. There was left-sided foraminal narrowing at C6-C7. The lumbar MRI films revealed a small left-sided, paracentral disc herniation at L5-S1. Conservative treatment with physical therapy and rheumatologic work-up was recommended. The petitioner was to be evaluated by Dr. Bello and kept off work.

On May 19, 2014, the petitioner presented for rheumatologic evaluation with Dr. Alfonso Bello. He presented with more diffuse musculoskeletal pain, which had been going on for a year. An MRI revealed a small herniation at L5-S1. The petitioner was diagnosed with inflammatory polyarthritis suggestive of rheumatoid arthritis. A blood work-up and Prednisone were recommended.

The petitioner followed-up with Dr. Bello on May 27, 2014. He continued to have radicular symptoms down the left leg despite the Prednisone. Lab work revealed that the petitioner had adverse reactions to the medication. Dr. Bello diagnosed the petitioner with inflammatory polyarthritis and

an adverse reaction to Prednisone. An epidural injection was recommended. The petitioner underwent the injection on June 5, 2014.

On June 10, 2014, a physical therapy progress report was prepared at Illinois Bone and Joint Institute. The petitioner had attended a total of twelve physical therapy sessions with two cancellations and zero no-shows. He reported that the exercises and stretching helped loosen up his back, but he felt that it stiffened up in-between sessions. The petitioner was still off work and had been trying to be more active, but was unable to walk for long periods of time without having to sit and rest. He stated that he had an epidural injection the previous Thursday; and felt numb to all the pain but stated that on June 9, 2014, the pain started coming back. The petitioner was not working and felt limited with being on his feet for longer than an hour and a half; as he needed to rest. He complained of pain 2/10 in severity. Physical therapy goals were outlined and additional therapy was recommended two times per week for four weeks.

On July 8, 2014, the petitioner was discharged from physical therapy at Illinois Bone and Joint Institute, due to a lack of follow-up. He had attended a total of 17 physical therapy sessions with 4 cancellations and zero no-shows.

On July 15, 2014, the petitioner presented to Dr. Mora with complaints of intermittent dizziness, insomnia and heartburn. He was being seen by Dr. Shapiro because of a herniated lumbar disc. The petitioner was told that his blood pressure had elevated in the past few weeks; he was anxious and had been taking a Medrol Dosepak the previous week. The petitioner's heartburn was worse; and he had an epidural injection on May 15, 2014. He was feeling better for three weeks after the injection until the pain on the left side started again. The petitioner complained of swollen, tender area in the left axilla in the previous two weeks, with some sero-sanguinolent drainage. He denied any fever or chills. The petitioner was diagnosed with gastro-esophageal reflux disease, abscess of axilla on the left, anxiety, and a lumbar herniated disc. He was provided with hydrocodone and acetaminophen.

The petitioner presented for follow-up with Dr. Mora on August 22, 2014. He indicated that, in general, he felt okay, but since his lower back pain and sleep irregularities, he felt anxious. He was being treated for a herniated disc by Dr. Shapiro and his pain was intermittent. The petitioner was diagnosed with benign essential hypertension, mixed hyperlipidemia, anxiety, lumbar herniated disc and cervicalgia. He was provided with neck exercises and referred back to Dr. Shapiro.

On August 25, 2014, the petitioner followed-up with Dr. Bello. He was last seen on June 5, 2014 for an epidural steroid injection, which gave him good relief for about three weeks. Since then, the petitioner started having recurrent back pain, but also increased polyarthritis. His arthritis got better with the corticosteroid therapy. He had some side effects to medication therefore the prescriptions were discontinued. The petitioner was again started on a Dosepak, which partially improved some of his symptoms. The petitioner continued to have morning stiffness of about 1-2 hours in duration. He

denied fevers, rash, nausea, vomiting, diarrhea, sicca symptoms, or Raynaud phenomenon. Dr. Bello diagnosed the petitioner with inflammatory polyarthritis and a lumbar herniated disc and planned to start him on prednisone and physical therapy.

On September 10, 2014, the petitioner resumed physical therapy at Illinois Bone and Joint Institute. He was referred to physical therapy by Dr. Alfonso Bello due to diagnoses of displacement of lumbar intervertebral disc without myelopathy; unspecified inflammatory poly-arthropathy; and lumbago.

The petitioner reported a history of gradually increasing low back pain, which began around March, 2014; it was not associated with his specific mechanism of injury. The petitioner reported he had to do a lot of heavy lifting as a driller's helper and noticed pain while working. He also experienced an episode of vertigo. He went to his doctor for evaluation and treatment of his vertigo and back pain. The vertigo was resolved, but the back pain persisted. The petitioner had one injection into his low back which helped initially, but the pain returned. He reported starting to feel shooting pain and numbness in all four extremities.

Previous treatment with physical therapy was somewhat beneficial for improving flexibility and strength. The petitioner stated he just started taking prednisone two weeks ago and felt that the medicine was helping significantly with his pain. The petitioner rated his pain as 3-4/10 in severity. He had an MRI which revealed a tiny left paracentral disc protrusion at L5-S1, with no central or neural foraminal narrowing. Physical examination revealed low back pain, hip mobility, strength and endurance deficits associated with lumbar disc degeneration. Short and long term intervention goals and strategies were outlined. The petitioner was to attend therapy two times per week for 4 weeks.

A physical therapy progress report was prepared at Illinois Bone and Joint Institute on October 1, 2014. The petitioner stated that he felt better since starting therapy and no longer had constant back pain during the day. He had pain at night which he rated 2/10 in severity. The pain was in the same areas as usual, but it was less intense. The petitioner had improved low back mobility with reports of decreased pain intensity overall, but he continued to have fatigue and weakness. He had normal pain-free active range of motion of the lumbar spine but continued to lack endurance and strength at moderate activity levels. He also lacked endurance and strength to perform repeated lifting activities, without pain. Continued therapy was recommended.

On October 28, 2014 Dr. David Robertson conducted an IME of the petitioner, at the request of Petitioner's counsel. Dr. Robertson noted a history from Petitioner. In the third quarter of 2013, the petitioner began experiencing intermittent episodes of low back pain. On March 21, 2014, as the petitioner was lifting a heavy auger, he felt a sharp pain in the lower back on the left side that radiated down the front of the left thigh to the knee. He also had pain in his left scapular area as well as pain in both arms, which extended to the fingers. The petitioner was initially seen by his primary care physician who started him on non-steroidal anti-inflammatory medication. When the petitioner

failed to improve he was referred to Dr. Shapiro (an orthopedist) and Dr. Bello (a pain specialist). The petitioner was placed on steroids and received injections with temporary relief. X-rays of the cervical and lumbar spines were unremarkable.

The petitioner again underwent physical therapy with moderate relief of his pain. Upon examination, the petitioner complained of intermittent episodes of low back pain as well as intermittent pain in both knees and wrists. His pain was worse with strenuous activities. Physical examination was essentially within normal limits with the exception of a leg length discrepancy of at least 1 inch, the left leg being shorter. He had full range of motion of the lumbosacral spine, with complaints of pain at the limits of range of motion, especially at the limits of flexion. Straight leg raise testing was negative bilaterally, both sitting and supine. Neurologic examination was within normal limits. Dr. Robertson opined that the petitioner suffered from a chronic low back sprain, which was caused by performing manual labor that had been ongoing for several years. The doctor further opined that the March 21, 2014 episode aggravated his condition.

On January 14, 2015, Dr. Robertson prepared an addendum report indicating that in his initial report, he omitted stating that he had seen a DVD of the petitioner's lumbar spine MRI and the radiologist's report. Dr. Robertson concurred with the reading that there was a small disc herniation at the L5-S1 level, which did not compress the nerve roots. There was a degeneration of the disc space, which explained the petitioner's current symptoms and was caused by the heavy labor he performed.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner had a pre-existing condition to his lumbar spine, prior to March 21, 2014. Based upon the facts presented, the Arbitrator finds that the March 21, 2014 incident caused a temporary aggravation of this pre-existing condition. The petitioner had back pain over one year prior to the March 21, 2014 incident. The Arbitrator finds the petitioner did not report any pain prior to the incident date as being work-related.

The petitioner is not automatically precluded from receiving benefits because he has a pre-existing condition. The Respondent takes the petitioner as he finds him. If a pre-existing condition was aggravated, exacerbated or accelerated by an accidental injury, the petitioner is entitled to benefits. *Rock Road Construction Co. v. Industrial Commission,* 37 Ill.2d 123, 227 N.E.2d 65, 67-68 (1967).

Before compensation can be awarded, there must be proof that there was an accidental injury that arose out of the employment. The development of pain, discomfort, stiffness, without a cause or traumatic event, does not meet the test. The accident may be a blow, a fall, or in this case the

repetitive lifting of a forty (40) pound drill, resulting in the break-down of body structures. *Gilster Mary Lee Corp. v. Industrial Commission,* 326 Ill.App3d 177, 759 N.E.2d 979 (5th Dist. 2001).

In the instant case it is a close call as to whether or not the incident of March 21, 2014 resulted in an aggravation of the petitioner's pre-existing condition. The petitioner admits to low back pain in the year preceding the March 21, 2014 incident and the petitioner never reported any work related injury prior to March 21, 2014. Further, the petitioner waited 4 days to report the March 21, 2014 incident to the Respondent and did not seek medical attention for two weeks after the incident occurred.

The Arbitrator finds the opinions of Dr. Robertson compelling, i.e., that the events of March 21, 2014, aggravated his pre-existing low back condition. Based upon the above the Arbitrator finds the petitioner experienced an exacerbation his pre-existing low back condition.

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

The Arbitrator finds the petitioner had a low back condition which pre-dated the petitioner's work incident of March 21, 2014. The Arbitrator finds that the March 21, 2014 incident exacerbated the petitioner's pre-existing condition.

The Arbitrator finds compelling the opinions of Dr. Robertson that the petitioner's incident of March 21, 2014 aggravated his pre-existing low back condition. The petitioner; however, has presented no evidence that the March 21, 2014 incident permanently worsened the petitioner's low back condition. The petitioner has complaints of low back pain consistently in the year leading up to March 21, 2014. The petitioner has not provided any evidence that his condition was significantly and permanently worse on March 21, 2014.

The medical evidence also reveals that the petitioner was treated for a host of conditions subsequent to the March 21, 2014 incident; most of which were unrelated to the incident. These conditions include rheumatoid arthritis, vertigo and cervical spine pain. The Arbitrator finds these conditions are not causally related to the subject case.

Based upon the above, the Arbitrator finds the petitioner's incident of March 21, 2014 exacerbated his pre-existing low back condition, as there is no evidence of permanent aggravation or ongoing need for medical treatment for which the Respondent should be liable.

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

Based upon the findings above, and based upon the nature of the treatment the petitioner received, the Arbitrator finds the Respondent is not liable for payment of medical bills in this case.

K. What temporary benefits are in dispute?

Based upon the findings above, and based upon the nature of the treatment the petitioner received, the Arbitrator finds the petitioner is not entitled to any prospective medical care. The Arbitrator finds the petitioner is not owed any temporary total disability in this matter. The medical evidence reveals that the petitioner was off work however, he was off for the non-work related condition of vertigo. No physician took the petitioner off work as result of the low back condition. The petitioner was able to work with his low back condition prior to March 21, 2014 and there is no evidence he was unable to work with the condition after that date. The petitioner is therefore not entitled to temporary total disability as a result of the March 21, 2014 aggravation incident.

L. What is the nature and extent of Petitioner's injuries?

The Arbitrator finds that the petitioner has chronic low back pain which was exacerbated by the incident of March 21, 2014. The Arbitrator further finds the petitioner is able to prove, by a preponderance of the evidence, that the small L5-S1 herniation shown on the May 15, 2014 MRI, was caused by the March 21, 2014 incident, though it does not explain the symptoms which are disabling him.

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

With regard to subsection (ii), occupation, the Arbitrator notes that petitioner was employed as a driller helper at the time of the accident. He is not able to return to work in his prior capacity, but this is due to unrelated medical issues, so the Arbitrator gives no weight to this factor.

With regard to Subsection (iii), the Arbitrator notes that Petitioner was 46 years old at the time of the injury. Because this places Petitioner at middle age and he will have to deal with the effects of the injury for quite some time yet, the Arbitrator gives greater weight to this factor.

With regard to subsection (iv), future earning capacity, the Arbitrator notes that any impact on same would be due to the unrelated medical conditions, and thus attaches no weight to this factor.

With regard to subsection (v), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the MRI examination showed a herniated disc at L5-S1; and although that does not explain the symptoms that are disabling him, the degeneration of that disc space does explain his low back pain which will be permanent in nature.

Based upon the above, the Arbitrator finds the petitioner is entitled to receive the sum of $721.66 (the statutory maximum permanent partial disability rate in effect on the date of the incident) for the period of 20 weeks. This corresponds to approximately 4% loss of use of a person as a whole pursuant

to Section 8 of the Act. Petitioner's request for Section 8(a) medical benefits under this claim are hereby denied.

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
14WC26513
SIGNATURE PAGE

L Thompson-Smith
Signature of Arbitrator

December 29, 2015
Date of Decision

DEC 30 2015

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RHONDA CRAFT,

Petitioner,

16IWCC0574

vs.

NO: 14 WC 35551

AISIN MANUFACTURING OF ILLINOIS, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, temporary disability, and permanent 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 stated below.

The Decision of the Arbitrator, filed by Arbitrator Edward Lee with the Commission, on February 2, 2016, found Petitioner did not sustain an accident that arose out of and in the course her employment, finding Petitioner's injury had no particular employment characteristics that would make her injury compensable under the Act. The Commission finds the evidence suggests the opposite.

On September 9, 2014, while on her lunch break and while on Respondent's premises, Petitioner walked on a lawn that Respondent made available for its employees' comfort. While doing so, she stepped into a hole that caused her to lose her balance and fall over a retaining wall and onto a parking lot. She sustained a fracture of her left olecranon that was treated through surgical intervention. The Commission finds Petitioner's injury, occurring while on her lunch break and in that part of Respondent's premises where she was allowed to be, was incidental to her employment and, therefore, compensable under the Act.

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The Illinois Supreme Court, in *Eagle Supermarket v. Industrial Commission*, 82 Ill.2d 331, 412 N.E.2d 492, 45 Ill. Dec. 141 (1980), found, in lunch hour cases, "the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence." *Eagle Supermarket*, 82 Ill.2d at 339. Citing previous decisions involving accidents that had occurred while an employee was on a lunchbreak, the Court found "the act of procuring lunch has been held to be reasonably incidental to the employment." *Eagle Supermarket*, 82 Ill.2d at 339. The Commission, recognizing that Petitioner was not procuring lunch at the time of her accident, finds Petitioner's injury, nevertheless falls within the scope of the *Eagle Supermarket* ruling. Petitioner was engaged in an activity on Respondent's premises while on her lunch hour that was condoned and encouraged by Respondent.

The Commission, similarly, finds the circumstances of Petitioner's injury comports with the Illinois Supreme Court's position in *Scheffler Greenhouses v. Industrial Commission*, 66 Ill.2d 361, 363 N.E.2d 325, 5 Ill. Dec. 854 (1977). An employee sustained accidental injuries while sitting on the roof the greenhouse after she had swam in the swimming pool located on the employer's premises. Despite the swimming pool being built and maintained by another employee, the Court found there to be evidence "that the employer had told the claimant and others that the pool could be used as a source of relief on hot summer days." *Scheffler Greenhouses*, 66 Ill.2d at 367. The Court continued, "When the employer has placed or permitted an employee to be placed in a position where it might be reasonably expected the employee would encounter and undertake a hazard, the court has granted recovery." *Scheffler Greenhouses*, 66 Ill.2d 369. Respondent, as did the employer in *Scheffler Greenhouses*, provided its employees an area for respite but did not make it free of hazards. Petitioner stepped in a hole in the lawn that caused her to fall over a retaining wall that was not high enough to prevent that from happening. The Commission finds, as did the *Scheffler Greenhouses* Court, injuries under such circumstances are incidental to employment.

It is recognized that an employee engaged in an activity incidental to employment must, nevertheless, conduct themselves in a reasonable manner. The Illinois Supreme Court in *Union Starch v. Industrial Commission* 56 Ill.2d 272, 07 N.E.2d 118 (1974), stated, "incidental, or nonessential acts of the employment, such as seeking personal comfort, may not be within the course of employment if done in an unusual, unreasonable, or unexpected manner." *Union Starch*, 56 Ill.2d at 277. Arbitrator Lee found Petitioner engaged in such a manner, writing "Petitioner admitted . . . that her fall occurred because she was walking, talking, eating and not watching where she was walking." Arbitrator Lee also found Petitioner had walked "down the retaining wall when there were stairs available." The Commission finds the Arbitrator misstates the evidence he cited.

Petitioner did not "admit" that her fall occurred because she was walking, talking, eating and not watching where she was walking but did state she was walking, talking, and eating when she gave her history at Logan Primary Care Services on September 10, 2014, and did state that she was "walking, talking, eating, and not watching where she walked" when she presented to The Orthopaedic Institute. Petitioner's histories are deemed to be merely a recitation of the events that caused her to seek medical care and not an admission of any sort.

Petitioner provided no statement that the Commission can interpret as indicating that she

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walked upon the retaining wall. The record indicates Petitioner stated she was walking along the wall, not upon it. Petitioner's unrebutted testimony was that she fell over the wall, an action that would not have occurred if she was walking on the wall.

The Commission, as articulated above, finds Petitioner's accident and the resultant injuries to be incidental to her employment and, accordingly, also finds her entitled to benefits under the Act.

Petitioner, as a result of her fractured left olecranon, was unable to work after September 10, 2014, until December 1, 2014. Between those dates, she underwent open reduction and internal fixation of the fracture on September 12, 2014, and then postoperative treatment, including physical therapy, at The Orthopaedic Institute of Southern Illinois. December 1, 2014, in addition to being the day she was allowed to return to work, it was also the day she last received treatment for her fractured left olecranon. On the basis of her medical treatment and her inability to work, Petitioner is entitled benefits under Sections 8(a), 8.2, and 8(b).

Petitioner is also entitled to benefits under Section 8(e) of the Act. She completed her physical therapy on November 24, 2014, with 2/10 pain with activity and testified to continuing to experiencing pain as of November 10, 2010. She continues to have the hardware that was placed in her left arm on September 12, 2014, in her left arm due to her desire not be taken off work for three months in order to recover from the surgery that would have removed it, and the hardware causes her to experience pain in her left arm when it is bumped or otherwise disturbed. She cannot completely lower her arm. She has returned to full duty without restrictions but no longer works in the position she worked in immediately prior to her accident. She, instead, is working in a position that she had prior to that more recent position.

Section 8.1b of the Act requires the Commission, when awarding a permanent partial disability award, take into consideration the level of impairment as determined within a PPD impairment report, the occupation of the injured worker, the age of the injured worker at the time of injury, the injured worker's future earning capacity, and the evidence of disability contained within the treating medical records. *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC. The Commission takes into consideration, in the instant case, that no PPD impairment report was tendered into evidence; that Petitioner's occupation prior to the accident, per her testimony, was making pallets in the aisle and, after the accident, was unspecified but was located "on the dock;" that Petitioner was 58 years old on the date of the accident; that no evidence pertaining to Petitioners' future earning was tendered into evidence; and also that Petitioner's medical records indicate she experiences pain with prolonged use of her left arm and works under the restriction that she not engage in heavy lifting with her left arm and finds Petitioner sustained permanent injuries to the extent of 25% loss of use of her left arm.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $412.92 per week for a period of 11-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

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IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $372.00 per week for a period of 63.25 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 25% loss of the use of her left arm.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,600.00. 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: SEP - 7 2016
KWL/mav
O: 07/11/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0574

CRAFT, RHONDA
Employee/Petitioner

Case# **14WC035551**

AISIN MANUFACTURING OF ILLINOIS LLC
Employer/Respondent

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

If the Commission reviews this award, interest of 0.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1187 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC0574

Rhonda Craft
Employee/Petitioner

v.

Aisin Manufacturing of Illinois, LLC
Employer/Respondent

Case # 14 WC 35551

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 10, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0574

FINDINGS

On **September 9, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$32,240.00**; the average weekly wage was **$620.00**.

On the date of accident, Petitioner was **58** years of age, *single* with **-0-** children under 18.

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

Respondent is entitled to a credit of **$1,920.88** under Section 8(j) of the Act.

ORDER

Because Petitioner's accident did not arise out of her employment with Respondent benefits are denied.

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

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

Edward Lee
Signature of Arbitrator

1/15/16
Date

FEB 2 - 2016

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Rhonda Craft,
Employee/Petitioner

v.

Aisin Manufacturing of Illinois, LLC,
Employer/Respondent.

16IWCC0574

Case 14 WC 35551

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On September 9, 2014 Petitioner had been employed by Respondent for 11 years. Petitioner testified that she took a lunch break at approximately 8:15 p.m., exited the building and walked along a retaining wall. As Petitioner walked along the retaining wall, she was talking, eating and not paying attention to her surroundings. Petitioner testified that when she reached the bottom of the retaining wall (indicated by an "X" on Petitioner's Exhibit 3) she stepped in a hole, tripped over the wall and landed on her left elbow. Petitioner testified that it was dark at the time of her fall.

On September 10, 2014 Petitioner received medical treatment at Logan Primary Care Services. She reported that she was walking, talking and eating when she fell over a concrete wall and injured her left elbow. (P.1). Petitioner provided no history of having stepped in a hole immediately prior to the fall. She was referred to Herrin Hospital for x-rays of the left elbow. Those revealed a displaced fracture of the olecranon process of the ulna. (P.1). Petitioner was thereafter referred to the Orthopedic Institute of Southern Illinois where she came under the care of orthopedic surgeon Steven Young on September 11, 2014. In conjunction with the initial encounter with Dr. Young, Petitioner completed an intake form on which she indicated that she was walking, talking, eating and not watching where she was going when she fell. (P.2). The intake form does not reflect that Petitioner stepped in a hole nor does the history reported by Dr. Young reflect that Petitioner stepped into a hole.

Dr. Young diagnosed a left elbow olecranon fracture. On September 12, 2014 he performed an open reduction and internal fixation of the left elbow. Postoperative diagnosis was left olecranon fracture. (P.2).

Postoperatively Petitioner underwent physical therapy through November 24, 2014. She advised the therapist on November 24, 2014 that she would continue home exercises and was ready to return to work. Petitioner was noted to have met all therapy goals. She reported her resting pain level at 0/10 and with activity at 2/10. She characterized the pain as "dull". She reported only slight pain after a long day of activities with resolution within two hours thereafter. Elbow range of motion was 0 to 147 degrees with full strength. Left wrist range of motion was within normal limits with 5/5

There are three types of risks to which employees may be exposed: (1) risks that are distinctly associated with employment; (2) risks that are personal to the employee, such as idiopathic falls; and (3) neutral risks that do not have any particular employment or personal characteristics. *Potenzo v. Illinois Workers' Compensation Comm'n*, 378 Ill.App.3d 113, 116, 881 N.E.2d 523 (2007). Injuries resulting from a neutral risk generally do not arise out of the employment and are compensable under the Act only where the employee was exposed to a risk to a greater degree than the general public. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2013 IL.App. (4th) 120219WC, ¶27, 990 N.E.2d 284. The increased risk may either be qualitative (*i.e.* when some aspect of the employment contributes to the risk) or quantitative (such as when the employee is exposed to the risk more frequently than members of the general public by virtue the employment). *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1014, 944 N.E.2d 800 (2011).

In this case, Petitioner was injured when she tripped over a wall. There was no evidence that the construction or configuration of the wall was defective or unusual. The Arbitrator finds that the risk of injury confronted by Petitioner was not distinctly associated with her employment but rather was a neutral risk of everyday living faced by all members of the general public. Accordingly, Petitioner's injury is only compensable if she was exposed to this risk to a greater degree than the general public.

The Arbitrator finds that Petitioner's injuries occurred not because of an increased risk created by her employment but rather due to a personal risk in that Petitioner admitted, consistent with the histories contained in the records from Logan Primary Care Services and the Orthopedic Institute of Southern Illinois, that her fall occurred because she was walking, talking, eating and not watching where she was walking. (P.1 at 12, P.2).

Moreover, the Arbitrator from P EX 3 the picture of accident site finds the Petitioner created the risk herself by walking down the retaining wall when there were stairs available.

Therefore, Arbitrator finds that Petitioner's injuries did not "arise out of" her employment and therefore denies benefits.

CAUSAL CONNECTION, MEDICAL EXPENSES, TTD, NATURE AND EXTENT

Consistent with the Arbitrator's finding with regard to accident, the additional disputed issues are rendered 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

Tony J. Brown,
Petitioner,

vs.

NO: 14WC 39121

Dynegy Midwest Generation,
Respondent,

16IWCC0606

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner, herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 20, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $73,200.00. 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.

SEP 2 2 2016

DATED:
MJB/bm
o-09/19/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROWN, TONY J
Employee/Petitioner

Case# **14WC039121**

DYNEGY MIDWEST GENERATION
Employer/Respondent

16IWCC0606

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:

0656 GLASS & KOREIN LLC
MICHAEL H KOREIN
7012 W MAIN ST
BELLEVILLE, IL 62223

0299 KEEFE & DePAULI PC
NEIL A GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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

Tony J. Brown
Employee/Petitioner

v.

Dynegy Midwest Generation
Employer/Respondent

Case # 14 WC 39121

Consolidated cases: n/a

16IWCC0606

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 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 – **AS TO NATURE AND EXTENT ONLY**
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the 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 4, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$87,499.36**; the average weekly wage was **$1,682.68**.

On the date of accident, Petitioner was **44** years of age, ***married*** with **4** dependent children.

The parties stipulated at the time of hearing that Respondent is liable for the unpaid medical bills submitted into evidence at the time of arbitration as Petitioner's Exhibit 3.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

The parties stipulated at the time of hearing that Respondent is liable for the unpaid medical bills submitted into evidence at the time of arbitration as Petitioner's Exhibit 3.

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$721.66/week** for a further period of **101.25 weeks**, because the injuries sustained caused **10% loss of use of the left hand and 10% loss of use of the right hand** as provided in **Section 8(e)(9)** of the Act, as well as **12.5% loss of use of the left arm and 12.5% loss of use of the right arm** as provided in **Section 8(e)(10)** 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

4/13/16
Date

APR 20 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tony J. Brown
Employee/Petitioner

Case # **14** WC **39121**

v.

Consolidated cases: **N/A**

Dynegy Midwest Generation
Employer/Respondent

16IWCC0606

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that that he is currently 46, is employed by Respondent and works at the Baldwin Power Plant. He testified that he worked there as of June 4, 2014 as well, and that he started working for Respondent in March of 1999. He testified that his job title was that of a heavy equipment operator. He testified that he used heavy equipment and moved coal for the power plant, and that the equipment that he ran included dozers, backhoes and scrapers, all of which had vibration. He testified that in terms of servicing the equipment, they would use several different power tools like air drills and ratchets.

Petitioner testified that before June 4, 2014, he had never had any workers' compensation claims and did not seek any treatment for either of his hands or arms. He testified that the symptoms in both of his upper extremities developed progressively over a period of time, but that he had the right arm and hand operated on first. He testified that his primary care physician referred him to Dr. Mirly.

Petitioner testified that he underwent surgery to the right elbow and wrist in 2014, and then underwent surgery to the left elbow and wrist in 2015. He testified that between those surgeries, he returned to work full duty. He testified that before he had the surgery for the left wrist and elbow he was seen by Dr. Strecker, and that from that point forward workers' compensation approved the surgery to the left wrist and elbow. He agreed that he was paid temporary total disability benefits from the prior surgery, and that after having surgery to the left wrist and elbow he returned to full duty in late August of 2015. He testified that he was released from Dr. Mirly's care in mid-October 2015.

Petitioner testified that he is right-handed. He testified that his arms and hands feel better, but that he still has tingling and numbness in both elbows. He testified that he has issues with the little and ring fingers on both hands, but agreed that it was substantially better than it was before the surgery. He testified that in terms of his arm and grip strength he still does not have the grip that he used to have, but agreed that it was better since the surgery. He testified that he was not back to 100%.

Petitioner testified that he has not returned to the doctor since October of 2015 because he liked his job and did not want to lose it. He testified that he believed he was as good as he was going to get. He testified that he takes Tylenol and Ibuprofen regularly for his symptoms, at least 2-3 times a day. He testified that he uses a heating pad for his elbows, He testified that he has an elbow brace that he wears

when running heavy equipment. He testified that because he has seniority, he avoids servicing and running the dozers.

Petitioner testified that he used to do a lot of sports, including playing baseball and basketball, but does not do that very often if at all anymore. He testified that he used to play in a league, but does not do that anymore. He testified that batting was difficult in that he cannot grip the bat like he used to, and that hitting the ball was not the same so he tried to avoid it. He testified that the bouncing of the basketball was difficult, and that he needs to use ice packs on both elbows if he plays. He testified that he does not do much lifting at home, and that he has two older sons that do most of the lifting for him. He testified that he tries to do the yard work, but that his sons usually cut the grass for him unless they were busy.

On cross-examination, Petitioner agreed that he has had numbness and tingling in his elbows since surgery, which comes and goes. He agreed that he last saw Dr. Mirly on October 16, 2015, and agreed that he was accurate and correct with him when he discussed his symptoms and condition with him. He agreed that he was walking with crutches at the time of arbitration due to an unrelated knee condition. He testified that the numbness and tingling was made worse by the use of the crutches.

On cross-examination, Petitioner agreed that he had been working full duty without restrictions since August 21, 2015. He agreed that when he saw Dr. Mirly he stated that he was pleased with his recovery, but testified that he told Dr. Mirly that he had a little bit of numbness which he stated was common. He agreed that he would not disagree with the accuracy of the records if it was not recorded that he had numbness. He agreed that he had been working full duty in his normal job for at least two months when he last saw Dr. Mirly in October. He denied that Dr. Mirly instructed him to contact his office if he had ongoing problems. He denied seeking treatment from any other medical professional for either his hands or elbows since seeing Dr. Mirly in October 2015. He agreed that he was working the same position that he was before with Respondent.

On cross-examination, Petitioner agreed that he has no physical restrictions on his activities according to Dr. Mirly or any other doctor. He agreed that he was working as a heavy equipment operator again, and that he was earning the same rate of pay that he did before his injury. He denied ever submitting to an American Medical Association disability examination, and further denied submitting one as part of his evidence.

On redirect, Petitioner admitted that he had never seen Dr. Mirly's office notes. He agreed that the activity modifications that he had imposed on himself were only to alleviate his symptoms.

The medical records of Quality Healthcare Clinics were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on July 17, 2015 to have his sutures removed following his recent carpal tunnel release and transposition of his ulnar nerve on the left side. Petitioner's pain level was noted to be 3/10 on that date. The records reflect that Petitioner was seen on July 7, 2015, at which time he presented for medical clearance of anterior transposition of his left ulnar nerve and left open carpal tunnel release. The assessment was that of left carpal tunnel syndrome and left cubital entrapment syndrome. Petitioner was medically cleared for surgery at that time. (PX1).

The records reflect that Petitioner was seen on August 1, 2014 for suture removal following his recent right carpal tunnel and transposition of nerve entrapment of his right elbow. It was noted that Petitioner was clinically improved since surgery. Petitioner was instructed to follow-up as needed. The records reflect that Petitioner was seen on July 2, 2014 to review his recent EMG/nerve conduction study. It was noted that Petitioner had bilateral wrist pain, tingling in the fingers and weakness in the left arm. Petitioner was assessed with carpal tunnel syndrome and right ulnar nerve entrapment, and was referred to Dr. Mirly. (PX1).

The records reflect that Petitioner was seen on June 4, 2014, at which time he had complaints of increasing tingling and numbness over his 4th and 5th right fingers, as well as increased weakness and trouble gripping things. It was noted that Petitioner had nerve conduction studies performed about seven years ago which were positive for bilateral carpal tunnel syndrome. It was also noted that there was right shoulder pain and stiffness. The assessment was that of bilateral carpal tunnel syndrome. Petitioner was recommended to undergo an EMG/nerve conduction study. (PX1).

Included within the records was an Electrodiagnostic Test Report dated June 12, 2014, which was interpreted as revealing (1) right moderate to advanced carpal tunnel syndrome; (2) left mild carpal tunnel syndrome; (3) right ulnar nerve entrapment, right across the elbow segment. (PX1).

The medical records of Dr. Mirly were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on October 16, 2015 for purposes of a final evaluation subsequent to anterior transposition of a left ulnar nerve and concurrent carpal tunnel release performed on July 10, 2015. It was noted that Petitioner had undergone similar treatment on his left arm. It was noted that Petitioner had good range of motion, that Petitioner was pleased and had no numbness and was quite pleased with the results of his surgery. Petitioner was noted to be at maximum medical improvement, and he was released from treatment. (PX2).

The records reflect that Petitioner was seen on July 24, 2015, at which time it was noted that he was two weeks out from anterior transposition of the left ulnar nerve and concurrent left carpal tunnel release. It was noted that he had similar procedures approximately one year ago on the right hand. The incisions were noted to be healing nicely, and he had improvement in his pre-operative symptoms. Petitioner was not yet allowed to return to work. Petitioner was seen on June 30, 2015, at which time it was noted that he was being seen for left hand complaints. It was noted that Petitioner had undergone an IME by Dr. Strecker, who felt that Petitioner would be a candidate for the procedures of both carpal tunnel and anterior transposition. It was noted that arrangements would be made pending authorization for a left open carpal tunnel release and anterior transposition of his ulnar nerve. (PX2).

Included within the records was a letter dated March 17, 2015 from Dr. Mirly to Petitioner's attorney, in which he opined that he believed that Petitioner's work activities were a contributing factor to his development of symptomatic carpal tunnel and cubital tunnel requiring surgical treatment. (PX2).

The records reflect that Petitioner was seen on September 5, 2014, at which time it was noted that he was six weeks out from anterior transposition of the right ulnar nerve and concurrent right carpal tunnel release. It was noted that Petitioner demonstrated full elbow flexion and extension, full wrist motion and full digital motion. Petitioner reported improvement in his pre-operative symptoms. Petitioner felt that he could return to work as a heavy equipment operator and was given a slip allowing him to return to work with no restrictions on September 8, 2014. Petitioner was instructed to return on an as-needed basis. (PX2).

The records reflect that Petitioner was seen on August 8, 2014, at which time sutures were removed. It was noted that the incisions were healing nicely. Petitioner was noted to be demonstrating reasonable range of motion, but was noted to be hypersensitive around the elbow. Petitioner was kept off work at that time. Petitioner was seen on July 11, 2014, at which time it was noted that he was referred by Dr. James with complaints of bilateral hand burning, tingling and numbness. A date of onset of June 12, 2014 was noted, but Petitioner reported that he had had symptoms for several years. Petitioner was recommended to undergo anterior transposition of the left ulnar nerve and a concurrent left carpal tunnel release. (PX2).

Included within the records was an Operative Report dated July 10, 2015 pertaining to a left open carpal tunnel release and anterior transposition of the left ulnar nerve performed at Memorial Hospital. The pre- and post-operative diagnoses were that of left carpal tunnel syndrome and left cubital tunnel syndrome. Also included within the records was an Operative Report dated July 25, 2014 pertaining to a right open carpal tunnel release and anterior transposition of the right ulnar nerve performed at Memorial Hospital. The pre- and post-operative diagnoses were that of right carpal tunnel syndrome and right cubital tunnel syndrome. (PX2).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The parties stipulated at the time of hearing that Respondent was responsible for payment of any unpaid medical bills. (AX1).

CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained an accident on June 4, 2014 that arose out of and in the course of his employment with Respondent. (AX1).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to be employed as a heavy equipment operator for Respondent. The Arbitrator finds that the nature and demands of his position will likely affect his permanent partial disability and, as such, the Arbitrator places greater on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 44 years old on his date of accident. Given the relatively young age of Petitioner and the fact that his treating clinician, Dr. Mirly, gave him a full duty/no restriction release, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to his pre-accident employment with Respondent and testified that he was earning the same rate of pay that he did before his injury. As such, there was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that his arms and hands feel better, but that he still has tingling and numbness in both elbows. He testified that he has issues with the little and ring fingers on both hands, but agreed that it was substantially better than it was before the surgery. He testified that in terms of his arm and grip strength he still does not have the grip that he used to have, but agreed that it was better since the surgery. At his final office visit with Dr. Mirly on October 16, 2015, it was noted that Petitioner had good range of motion, that Petitioner had no numbness and was quite pleased with the results of his surgery. Petitioner was noted to be at maximum medical improvement, and he was released from treatment. (PX2). The Arbitrator concludes

that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were not corroborated by his treating records at the conclusion of his treatment with Dr. Mirly. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the left hand and 10% loss of use of the right hand as provided in Section 8(e)(9) of the Act, as well as 12.5% loss of use of the left arm and 12.5% loss of use of the right arm provided in Section 8(e)(10) 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

Joseph Northington,
Petitioner,
vs.

16IWCC0611
NO: 15 WC 6606

HTH Company,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, 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 December 30, 2015 is hereby affirmed and adopted.

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

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

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

DATED: SEP 23 2016
KWL/vf
O-919/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0611

NORTHINGTON, JOSEPH
Employee/Petitioner

Case# **15WC006606**

HTH COMPANY
Employer/Respondent

On 12/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0333 SHAY & ASSOC LAW FIRM LLC
STEPHANIE I SHAY-WILLIAMS
260 E WOOD ST
DECATUR, IL 62523

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

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)

16IWCC0611

JOSEPH NORTHINGTON
Employee/Petitioner

v.

HTH COMPANY
Employer/Respondent

Case # 15 WC 6606

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 **Springfield**, on **October 29, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

16IWCC0611

FINDINGS

On **January 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.

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

In the year preceding the injury, Petitioner earned **$31,532.80**; the average weekly wage was **$606.40**.

On the date of accident, Petitioner was **59** years of age, ***single*** with **0** dependent children.

Respondent shall be given a credit of **$3,459.74** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$3,459.74**.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner's Motion to Strike July 29, 2015 Addendum and Certain Opinions of Dr. Jesse Butler Regarding the July 29, 2015 Addendum is denied.

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.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall receive a credit of **$3,459.74** for temporary total disability benefits paid under Section 8(a) of the Act.

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

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

Melinda M. Rose Gallivan

Signature of Arbitrator

12/28/15

Date

DEC 30 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0611

Joseph Northington
Employee/Petitioner

Case # 15 WC 6606

v.

Consolidated cases: N/A

HTH Company
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is employed by Respondent HTH Company and began working there in March 2010. Petitioner testified that he is a fifth wheel operator and has been so the entire time that he has worked for Respondent. Petitioner testified that as a fifth wheel operator he moved semi-trailers around the plant from one warehouse to another, that some trailers were loaded while others were empty, and that he closed and opened doors on the trailers. As to moving the trailers, Petitioner testified that they backed under what they called a "fifth wheel" which had a hydraulic lever. When loading or unloading the trailers, he went out the back door and hooked up an air hose, raised the trailer up, and pulled it away from the dock. Petitioner testified that he stopped the trailer, got out, went to the back and closed the trailer doors. He closed the door on the driver's side of the trailer first, and then closed the door on the passenger side. To open the door, he must back the trailer up to the dock, place it so that it was able to be locked up, and then the trailer was loaded.

As to the size of the trailers, Petitioner testified that they were generally in the range of 48-53 feet in length, but the trailer doors were all the same size. The trailer doors were in the range of 6-7 feet tall. The trailer itself was 103 inches wide, and each door was half that length. The weight of the doors varied depending on how new the doors were. On average a trailer door weighed anywhere in the range of 60 to 200 pounds. Petitioner testified that that he worked full-time, earned $16.00/hour and worked the night shift from 6 p.m. to 6 a.m. He was assigned to the Tate & Lyle plant in Decatur. As to the trailer doors, Petitioner testified that the bottom of the trailer was about chest high and that the entire trailer could not be over 13 feet 6 inches tall under Illinois law. He moved and closed the trailer doors on 30-40 trailers per shift, and the condition of the trailers varied.

Petitioner testified that that he was working the night of January 21 to January 22, 2015, and that he was injured during that shift at approximately 10-11 p.m. He felt pain in his back while closing one of the trailer doors. He testified that each door has a latch at the top and a latch at the bottom, and when you close the door sometimes the top one would not go in and you had to keep slamming or pushing it while you were trying to latch the handle. Petitioner testified that with one hand you had to latch the door and you also had to close the door in one maneuver. He testified that he was able to latch the door and as he was latching it, he felt a sharp pain in his back around his belt level. He testified that it was a sharp pain that caused him to stop. He finished what he was doing, got back in his truck and sat there for a while. There was only one person per shift acting as a fifth wheel operator.

Petitioner testified that when the doors were open they were secured to the side of the trailer. When he got out of the truck, he unlatched the driver's side door, swung it around and slammed it. He testified that oftentimes you had to hit with your right hand up as high as you could, and at the same time you were throwing the latch on the bottom. He testified that he then got the other door and did the same process. Petitioner testified that the procedure could not be done with one hand.

With respect to the condition of the door of the particular trailer that he was attempting to close, Petitioner testified that it really took a lot of effort on some of the trailer doors and that they all differed, but that the one he was closing was average and not good. Petitioner testified that the door he was attempting to close when he got hurt was very hard to close. He testified that he was attempting to close the top latch when he was hurt. Petitioner testified that the handle was neck or shoulder height, and that he slammed the door, got the trailer handle into the latch and used his left hand to latch the door while using his right hand to slam the door. He testified that he was closing the driver's side (*i.e.*, left) door when he first had pain. He testified that his right hand was above his head.

Petitioner testified that he reported the accident during the shift to Tim Onay, who was the night safety man at the time. He testified that he reported the accident at approximately 4:30 or 5:00 a.m. the next morning. He testified that he filled out an accident report that day as well. He testified that Tim Onay called Gary Hart, who was the main safety man on day shift. Petitioner testified that a plant protection person also came over and checked his vitals. He testified that Gary Hart came in, talked to him and took him to the emergency room at St. Mary's Hospital. Petitioner testified that Hart drove him directly from the plant.

Petitioner testified that he went to St. Mary's Hospital on January 22, 2015 and had diagnostic studies performed. He testified that he was instructed to follow up with St. Mary's Occupational Health and Wellness Center. He testified that when we was at St. Mary's his right leg was completely numb, he was having trouble walking, and there was a lot of pain in his lower back.

Petitioner testified that he treated at St. Mary's Occupational Health and Wellness Center, where he was given prescription medications which he testified were not really helpful and barely provided any relief. He testified that he was off work until he saw Dr. Butler the first time. Petitioner then changed his testimony and indicated that he was given work restrictions of no lifting, pushing or pulling over 30 pounds, to apply cold packs to the injury site, sitting/standing as needed, mostly a sitting job, and no bouncing, twisting or jerking which his work accommodated but he was unable to tolerate. Petitioner testified that when he first went back he was still on a 12-hour night shift, so he would just sit around for 12 hours. Petitioner testified that there was no light duty work and he could not walk and take the pain, so he returned to Dr. Fabrique. Petitioner testified that he was in a lot of "extreme" pain in his back and all down his right leg.

Petitioner admitted that he had similar symptoms on his right side more than 20 years ago after a work injury. He testified that he worked on a freight dock for ABF in Springfield, where he unloaded trailers. He testified that he hurt his back moving some freight. He testified that he treated and his symptoms went away, and he denied having symptoms in his low back right before the January 21, 2015 accident. He denied having any sort of issues or flare-ups with his back other than the ABF incident.

Petitioner testified that Dr. Fabrique on January 26th modified his restrictions, gave him medications and ordered physical therapy. He testified that his employer was still able to accommodate his modified work restrictions, but he was unable to tolerate them. He testified that he still had extreme pain in his back, that his entire right leg was numb and that he had tingling all the time. He testified that walking aggravated his symptoms, that he could not walk very far and that he would have to stop because his leg hurt too much.

Petitioner testified that he returned to Dr. Fabrique on February 3, 2015, and that his symptoms were the same. He testified that Dr. Fabrique continued his work restrictions and his physical therapy, and also ordered an MRI of his lumbar spine which was done on February 17, 2015. He testified that prior to the MRI he returned to Dr. Fabrique again on February 11th and that he took him off work. He testified that prior to Dr. Fabrique taking him off work, he used approximately two weeks of vacation time.

Petitioner testified that he attended four physical therapy sessions at Accelerated Rehab from January 30th to February 11, 2015, at which point Dr. Fabrique discontinued the therapy. He testified that he had pain and numbness in his right leg as well as continued pain in his low back. He testified that Dr. Fabrique referred him to Dr. Rahman, a neurosurgeon at St. Mary's Hospital. He testified that prior to getting in to see Dr. Rahman he underwent an Independent Medical Examination at the request of Respondent with Dr. Jesse Butler on March 6, 2015. He testified that he was examined by Dr. Butler and spoke with him about his symptoms and his prior history, and that Dr. Butler placed him on work restrictions. He testified that he went back to work and was accommodated within the restrictions set by Dr. Butler. He testified that on April 16, 2015 he saw Dr. Rahman, who recommended surgery.

Petitioner testified that he went back to Dr. Butler again on June 5, 2015, at which point Dr. Butler recommended surgery as well. He testified that Dr. Butler agreed to do the surgery. He testified that it had been six months since Drs. Rahman and Butler recommended the surgery, and that he wanted to move forward with the procedure.

Petitioner testified that he understood that Dr. Butler issued a fifth report, that he had an opportunity to review it, and that Dr. Butler discussed some surveillance video as well as a Facebook post. As to the Facebook post, Petitioner testified that his son-in-law went fishing with his ex-wife's husband, they caught their limit of fish that day, and that Robbie (*i.e.*, Robert Weilmuenster) posted it on Facebook. Petitioner testified that that Robbie had more than one father in-law, including Petitioner and Brent Nausley who was married to his ex-wife. Petitioner testified that Robbie went fishing with Brent Nausley and not him, and that on May 30, 2015 he had appendicitis, went to the hospital and had his appendix removed that afternoon. Petitioner testified that he was not fishing with his son-in-law. Petitioner testified that they were in Shelbyville, but he was in Decatur having an appendectomy.

With respect to the surveillance video, Petitioner testified that the videos showed "snippets" of a day, that some of them were performed in mid- to late-July and that one of them was undated and he had no idea when it was taken. He testified that the video footage showed him using a cane to help him walk, and that some footage showed him using a shopping cart which he testified he used for support. He testified that when he went to Wal-Mart he always parked by the shopping carts since he hurt his back, and that he got a shopping cart immediately and used it instead of a cane to go into the store. He testified that he used the cart wherever he went, and that if he only went to the Pharmacy he still used the shopping cart for support and safety.

Petitioner testified that some of the videos showed him for a brief period of time not using any sort of assistive device. He testified that he went to his daughter's house to get his son-in-law so he could load up the lawn mower. He walked from his truck to his daughter's front porch which was about 50 feet, and then around to her back porch, and this was when he tipped over her garbage can. He testified that his daughter put plastic in the can, and that it was sitting empty and had rain in it so he tipped it over to drain the water out. He testified that he carried a plastic Wal-Mart bag that he kept his reading glasses and Rolaids in, and that he carried those with him at all times. He testified that the can weighed 2-3 pounds, and only had an inch or so of water in the bottom of it. As to the sack, Petitioner testified that it contained two pairs of glasses, some Alka Seltzer and maybe a pack of cigarettes. He testified that the weight of

those items was maybe one pound, and that in the one sack he had an empty Tupperware container. Petitioner testified that all of the items that he either carried or emptied were less than 10 pounds, which was within the work restrictions that he had at the time.

Petitioner testified that that he had a cane with him on the date of arbitration, and that he started using the cane shortly after he hurt his back. He testified that he almost fell in his apartment and told his daughter, who bought him the cane. He testified that he used the cane approximately 90% of the time. He testified that that if he was going to walk any distance, he used the cane for safety because when he got a sharp pain in his back it stopped him in his tracks. He testified that without the cane he would fall when he had the sharp pain in his back. He testified that occasionally he tested himself and did not use the cane, like when he went to his daughter's that morning. He testified that he was only going to be there a few minutes and thought he would see how it went without the cane. He testified that he never left home without the cane. Petitioner testified that he still takes Hydrocodone, and that he took two before bed and two when he got up as well as two more during the day such as at noon with a meal. Petitioner testified that for the May 30th appendectomy, he had somebody drive him. It was Sarah Weilmuenster, Robbie's mother.

Petitioner testified that at the time of arbitration his back was hurting but that his leg was not hurting that bad, and that when the pain went into his leg it only went to his thigh now. Petitioner testified that he had been working within the restrictions imposed by Dr. Butler until his back went completely out the Monday prior to arbitration for which he had to go to the emergency room. Petitioner testified that he saw his physician the Wednesday prior to arbitration, and that his physician ordered x-rays which were supposed to be sent to Dr. Rahman for his 1:00 appointment on the date of arbitration. Petitioner testified that he still wanted and needed the surgery.

On cross-examination, Petitioner testified that prior to his employment with Respondent, he worked for Railserve for ten years on the same premises doing the same job at the same plant driving the same truck. He testified that prior to that, he was a truck driver for a year and still had a Class D operating license for a truck driver. Petitioner testified that in 1995 he was working for ABF in Springfield. Petitioner admitted that he had had prior worker's compensation cases involving his back for which he received settlements.

On cross-examination, Petitioner testified that he was the only fifth wheel operator on the night shift, and that there could be anywhere from 10-30 other people working the same shift depending on what was going on. He testified that none of the other employees worked with him. He testified that his job was to get into the fifth wheel and drive it to wherever the trailer was, hook it up to the trailer and move it wherever he was told to move it. He testified that a fifth wheel was a small semi-type truck with a fifth wheel on the back of it that you pushed under the trailers, and it locked onto a kingpin. It had a hydraulic lift that would raise the trailer so they did not have to get out and dolly the trailers. He testified that his job was to also open and close the doors in order to back it up to the dock in order that product could be loaded. He denied physically staying with the truck while it was being loaded with product, and indicated that he then went and got another trailer. He testified that he carried a radio, and that he was called when a door was ready. He testified that he would then go to the location, verify that the truck was loaded and then he would close the doors. He testified that he would then take that trailer to whatever location he was instructed. He testified that if it was ready to go to Park Warehouse he would leave the doors closed and put it out behind the building. He confirmed that he did not actually do any loading or unloading, and that his job was to take the trailer to whatever location he was instructed, to open the doors and then to close the doors when they were done.

Petitioner testified on cross-examination that when he closed the doors he would walk with the door as he was closing it. He confirmed that the latch on the top and the latch on the bottom had to match

up, and that sometimes he would have to pull the door with one hand and sometimes would have to push or slam the door with his other hand. He testified that he believed it was the first door he closed which was on the driver's side with his left hand to slam and his right hand above to push.

On cross-examination, Petitioner testified that his family doctor was Dr. Elizabeth Holder in Decatur, and that she was a family practitioner. He testified that she had been his family doctor since he was told he needed to have his cholesterol checked, and that until then he had not seen a doctor for 15 years until he was hurt. Petitioner denied seeing any physicians between 2010 and 2015.

When asked about a DMH Express Care East record from May 30, 2015 pertaining to his abdominal pain which in the Past Medical History noted review of the history from January 17, 2013 with "no changes required" and listed hypertension, high cholesterol, two ruptured discs and two fractures of the L-spine, Petitioner testified that he did not know which doctor's records the physician would have reviewed going back to January 17, 2013. He denied having had two ruptured discs and two fractures of the lumbar spine prior to January 17, 2013.

On cross-examination Petitioner agreed that he was a current everyday one pack a day smoker, and had been so for the last 40 years. He denied that Dr. Butler cautioned him on cigarette smoking and the effect that would have on the recovery of his surgery. He further denied that any doctor ever cautioned him on the effect of cigarette smoking and surgery to his back.

On cross-examination, Petitioner agreed that he was taken to St. Mary's Hospital by the day safety manager and that a physical examination and CT scan were performed. When asked if he ever told them of any recent history of back problems prior to January 21, 2015, Petitioner responded that he did not have any recent back problems. He denied ever telling tell them of a history of prior herniated discs or fractures to his lumbar spine. He agreed that he was referred to St. Mary's Hospital Occupational Health, and agreed that his initial evaluation was January 22, 2015. He agreed that every time he went to St. Mary's and saw either Dr. Fabrique or anothrt doctor there, they examined him. He agreed that Dr. Fabrique gave him a work restriction of no lift, push, pull greater than 5 pounds, no repetitive bend, twist or awkward positions, and that Respondent accommodated the restrictions by having him work in the break room.

On cross-examination, Petitioner agreed that when he first went back to work on January 26, 2015, when he parked his vehicle on the premises at Tate & Lyle the parking was away from the employee entrance and he had to park his car and then show security and walk through a gate. Petitioner agreed that when he returned back to work a representative of Respondent would take him to the break room by use of a company vehicle, but Petitioner maintained that it was only on two or three occasions. Petitioner maintained that initially he walked.

On cross-examination, Petitioner testified that when he initially went back to work at HTH, the distance from where he parked his car to the break room was about 100 yards, possibly less. He testified that when he initially walked from where he parked his vehicle to the break room, he was not using a cane, he did not have a cane and did not feel it was necessary at the time. When asked approximately how long into his light duty did he walk from the parking lot to the break room without the use of a cane, Petitioner testified that he had no idea and was unable to give an estimate. He testified that the break room was located right by the office on the ground level. He testified that initially he did 12-hour shifts, but that did not last very long. Petitioner agreed that when he was working at the Tate & Lyle premises for HTH prior to his injury, he was on a schedule where he would work three 12-hour days one week and four 12-hour days the next week.

On cross-examination, Petitioner agreed that he gave Dr. Fabrique a history of having similar symptoms in his back 20 years ago, and that the back pain was from a work-related injury. Petitioner denied giving Dr. Fabrique or any physician at Occupational Health and Wellness at St. Mary's a history of two prior herniated discs or two prior fractures to his lumbar spine.

Petitioner agreed on cross-examination that the physical therapy he testified to was done for a short period of time between January 29, 2015 and February 11, 2015. He agreed that Dr. Butler examined him initially on March 6, 2015 in Champaign. He agreed that he drove himself to the examination. He testified that he used his daughter's automatic truck as he has a stick shift. He testified that the distance between where he parked his car in Champaign to Dr. Butler's office was approximately 100-150 feet. He agreed that when he went to see Dr. Butler on March 6, 2015, he used his cane and further agreed that it was a short distance. When asked what the ratio of use of the cane between January 21, 2015 and March 6, 2015 was, Petitioner responded that he did not have the cane initially but once he had the cane, he was using it all the time.

When asked on cross-examination if there were any occasions from January 20, 2015 to March 6, 2015 where he went to any store and did not use the cane, Petitioner responded that there were none that he could recall unless it was Casey's and he just had to get out of the truck and walk a few feet. Petitioner agreed that he continued to operate a motor vehicle, but he had to have his son and daughter take him to the doctor and the emergency room. Petitioner agreed that sometimes he used his car, and that it depended on how bad his back was hurting.

On cross-examination, Petitioner agreed that Dr. Butler had him answer questions about standing, sleeping, etc. and that one of the questions pertained to walking. Petitioner agreed that he indicated that he could only walk using a stick or crutches, and indicated that at that time it was correct. Petitioner agreed that Dr. Butler did a thorough examination, and that up until the last report he liked or felt comfortable enough for Dr. Butler to perform his surgery. He testified that Dr. Butler wanted him to go to Chicago to have the surgery, but his daughter and son did not like that idea. He testified that talked to a friend of his at work about Dr. Rahman, so he decided that he would ask him to do it in Decatur. He agreed that he did not return to see Dr. Butler for another evaluation until June 5, 2015.

Petitioner agreed on cross-examination that he saw Dr. Rahman on only one occasion on April 16, 2015. When asked if he gave him a history of his cigarette smoking, Petitioner responded that he probably did but did not remember. He agreed that he went there with the use of a cane. When asked if he told Dr. Rahman about his history of prior back problems, he responded that if Dr. Rahman asked he would have told him, but if he did not he would not have said anything. When asked if he gave Dr. Rahman any history of a prior herniated disc or fractures to the lumbar spine, Petitioner responded that to his knowledge he never had any herniated discs or ruptures or fractures in his spine, and that no doctor ever told him that until MRI. He testified that Dr. Butler was the first doctor to ever tell him that, which was on March 6th. He testified that Dr. Butler told him about the fractures to his spine. He denied that Dr. Rahman reviewed the diagnostic films.

Petitioner agreed on cross-examination that there was a short video of him in a Wal-Mart store, and he further agreed that it was him in the video at his daughter's house. As to the undated Wal-Mart video, when asked how many times that he had been in the Wal-Mart store not using his cane since the accident, Petitioner responded that he did not like to use his cane in the store because his granddaughter was throwing his cane "all over the place" while he was pushing the cart, and that he had gotten in the habit of just leaving his cane in the truck and getting a cart just as soon as he got out. He was unable to estimate the number of times between January 21st and May 30th he had been in Wal-Mart and had not used his cane, and indicated that he was there two or three times a week either for himself or when he would go with his daughter and granddaughter. He testified that he did not like using it, and that if he had

a cart to push he would push a cart. Petitioner agreed that it was fair to say that he had been in Wal-Mart on more than one occasion without using his cane. He testified that he has only been in one other store besides Wal-Mart in years, which was Casey's. Petitioner testified that he went to Casey's typically to get a newspaper when he would go to work in the morning, and that whether or not he used his cane would depend on how bad his back felt that day. He testified that the distance between his car and the front door could vary from 20-50 feet depending on where he parked. He testified that he walked inside Casey's no more than 15 feet to pick up his items to be purchased.

On cross-examination, Petitioner agreed that he had seen the Facebook posting from his son-in-law that was dated May 30, 2015. He agreed that he used to fish, but that he had not been fishing at all this year as he did not have a fishing license. He testified that it was approximately 25 miles from Decatur to Shelbyville. He agreed that the Facebook posting stated "had limit by noon" but did not indicate how soon prior to noon the catch was made. He agreed that he testified that he had an emergency appendectomy that day. He testified that he did not see his family physician but rather "the doc in the box" at DMH Express Care, who then referred him to the hospital. Petitioner denied arriving at 1:16 p.m. and thought it was more like 9 a.m. but was not sure of the exact time. Petitioner was unable to say what time he arrived at St. Mary's Hospital for his procedure.

On cross-examination, Petitioner agreed that he returned to Dr. Butler's office for the second evaluation on June 5, 2015, that he was still off work after his appendectomy and that his son drove him. Petitioner testified that his son dropped him off at the door, and that he came to the evaluation with his cane. He agreed that he was again asked the question about walking and that his answer was he could only walk using a stick or crutches because that was the situation at the time. He agreed that he did not disclose to Dr. Butler that 10 % of the time, for short distances or that when he went to Wal-Mart or Casey's that he would not use his cane.

Petitioner agreed on cross-examination that he saw the July 24, 2015 video where he went to his daughter's house, but denied remembering seeing video of him using a cane while walking into a medical facility. When asked if he was at his daughter's house and walked from his truck into her house without the use of a cane, Petitioner originally testified that it was not the same date but later conceded that he went to Dr. Holder's office and that the video showed him walking to her office with a cane. Petitioner agreed that the video at his daughter's house showed him not using a cane. Petitioner agreed that his attorney asked him about the video, including the dumping of the water with both hands and the carrying of a light sack containing two pairs of reading glasses, Rolaids, Alka Seltzer, and maybe a pack of cigarettes in his left hand. Petitioner agreed that the video also showed him sitting on a porch smoking with his daughter and son-in-law.

When asked if he continued to not use the cane for shorter distances, Petitioner responded that he did not use it mostly in his house and while walking from his truck to his door, but it depended on how his back felt. He testified that he had been having pain from his back to his thigh for approximately a week since the Monday prior to arbitration. He testified that when he saw Dr. Rahman his pain was in his back and down his right leg all the way to his toes. Petitioner denied seeing any other physicians for his back beyond those he had already testified to.

On redirect, Petitioner testified that he was never told anything about a herniated disc but it was his understanding that he had a degenerative condition which was aggravated by the accident. Petitioner testified that for long distances he used his cane or a shopping cart, and that for short distances he rarely attempted to not use his cane but sometimes did. Petitioner testified that he tested his boundaries. Petitioner testified that with most distances he used his cane, and that for anything further than 50 feet he wanted to have his cane. Petitioner testified that for distances 50 feet and closer, he sometimes tried not to use his cane but it was rare.

On redirect, Petitioner agreed that he testified that he parked right next to or as close to the shopping cart corral as possible, and that when he was shopping at Wal-Mart he used the shopping carts for safety and to support his back. Petitioner testified that he leaned on the shopping carts.

On redirect, Petitioner agreed that he testified that he used use the cane about 90% of the time and about 10% of the time he did not, but could not recall at what point in time he started using it in this 90/10 capacity but knew it was after the pain stopped in his right leg. When asked if he was still using it in the 90/10 capacity at the time of the June 5, 2015 IME, Petitioner initially testified that he did not remember, but if he still had pain in his right leg then he was using the cane all the time. Petitioner then testified that he did have pain in his right leg then. Petitioner testified that the pain in his right leg fluctuated.

Petitioner testified on redirect that he had a manual truck and that sometimes he did not use his truck because it was too difficult for him to push the clutch down and shift the gears, and that it hurt too much in his back. Petitioner testified that using the clutch and the brake at the same time was sometimes too much.

On redirect, Petitioner agreed that he testified that he does not have a fishing license this year, and that you can fish without a license but if you get caught you are fined. Petitioner testified that he never fishes without a license.

As to his treatment on May 30, 2015, Petitioner testified on redirect that if the records reflected that he was admitted into the emergency room 11:14 a.m., he would have no reason to dispute that. Petitioner testified that that it was fair that he was at DMH Prompt Care before 11:14 a.m. on May 30, 2015.

Petitioner called Sarah Weilmuenster to testify as a witness at the time of arbitration. She testified that Petitioner's daughter is married to her son. She testified that she has known Petitioner since 2009. As to May 30, 2015, she testified that she saw Petitioner that day and took him to the hospital. Petitioner called her 8:30-8:45 a.m. and said that he could not get ahold of anybody else because they were all out of town. She testified that Petitioner asked her if she would stop at Walgreen's to pick him up some Pepto, so she went over to the house, went in and saw Petitioner doubled over in pain and dry heaving.

Ms. Weilmuenster testified that she talked Petitioner into going to Urgent Care first at about 9-9:30 a.m., and from there they told him to go to the emergency room at St. Mary's so she took him there. She testified that it took her 10-15 minutes to get from her house in Decatur to Walgreen's where she picked up the Pepto. She testified that she was in the store maybe 15 minutes, and that she then went to Petitioner's house at about 9:00 a.m. or so. She testified that she drove Petitioner to Prompt Care, and that they were at St. Mary's at about 11:00 a.m. She testified that she stayed with Petitioner until his daughter arrived, and that it was around 2:00 p.m. when she left. She testified that Petitioner was discharged the next day after surgery. She testified that Petitioner's daughter's name was Jennifer Weilmuenster. When asked if she recalled if anybody else went to the hospital or saw Petitioner in the hospital, Ms. Weilmuenster responded that her son Robert showed up and she also thought Petitioner's son Joey was there.

On cross-examination, Ms. Weilmuenster testified that she and Petitioner were good friends and that his daughter was married to her son. She testified that her son married Petitioner's daughter three years ago on October 22, 2012. She testified that prior to the wedding, she had a casual relationship with Petitioner which included talking to him on the phone. She testified that after the wedding she and Petitioner would see each other at family get-togethers such as cook-outs. She testified that Petitioner

was at the July 4th get together this year, and that the event was held at Petitioner's son's house. She testified that Petitioner was using a cane, and that he always used a cane in her presence. She denied going shopping with Petitioner.

On-cross examination, Ms. Weilmuenster testified that her daughter's other father-in-law was named Brent Nausley and that he lived at a Decatur address. When asked if she knew where Petitioner was on the morning prior to his having called, she testified that he was home sick and had been throwing up all morning. When asked if she knew if Petitioner fished, she responded that he had not this year because he did not have a fishing license. She testified that her son and Brent asked Petitioner if he wanted to go fishing and he said he did not get a license this year, and that she learned of that on the day of arbitration. She agreed that she first learned of the lack of a fishing license on the date of arbitration. She testified that Brent thought when they were done today maybe he, Petitioner and Robbie could go fishing. Petitioner stated he could not go because he did not have a license. She testified that Petitioner's attorney asked her to come to the arbitration hearing and indicated to her that she would be asked some questions about "that day" and her relationship to Petitioner.

On redirect, Ms. Weilmuenster estimated that she would see Petitioner a couple of times per month, and that at all those times since January Petitioner has had a cane and that he did not have a cane before January.

Petitioner called Robert Weilmuenster to testify as a witness at the time of arbitration. He testified that Petitioner was his father-in-law, and that he had known him since 2007 when he was dating Petitioner's daughter. He confirmed that it was his Facebook account with the May 30, 2015 posting. He testified that he went fishing that day and that he had made the posting. He testified that he went fishing with his father-in-law Brent, and that he had two fathers-in-law. He testified that Brent was married to Petitioner's ex-wife, Karen. He testified that he and Brent went fishing in Shelbyville and used Brent's boat.

Mr. Weilmuenster testified that they dropped the boat off, got his vehicle and went back home to his house when he was first made aware that day that Petitioner was in the hospital. He then testified that his wife called him when he was out on the lake and told him that his mom was taking Petitioner to the hospital because she was out of town in Clinton. He testified that he went to the hospital after he got home to check on Petitioner, and that he talked to his wife who said that Petitioner had to get emergency surgery for his appendix.

Mr. Weilmuenster testified that he has not gone fishing with Petitioner this year because Petitioner does not have a fishing license because he had been sick and had not been able to do anything. He testified that Petitioner sometimes does not attend events depending on how he feels for the day, but the majority of things with a lot of walking around he was not able to do. He testified that to his knowledge Petitioner had not complained of any prior back issues.

When asked how frequently he had seen Petitioner since January 2015, Mr. Weilmuenster responded that he saw Petitioner all the time. He testified that every now and Petitioner would push up onto something or lean onto something, but the majority of the time Petitioner had his cane with him. He testified that if Petitioner was feeling okay to move from point A to point B he would not use his cane, but Petitioner had always had his cane "since everything happened" and that prior to the injury in January of 2015, he had never seen Petitioner use a cane before then.

On cross-examination, Mr. Weilmuenster testified that he got his fishing license at Wal-Mart and that it expired on March 31, 2016. He agreed that he had seen Petitioner not using a cane, and that he has seen Petitioner at stores not using a cane. He testified that ever since the injury Petitioner had been using

it a lot, but sometimes if he needed to lean on something he used whatever was available but had his cane the majority of the time. He agreed that on July 4th they had a family function at Petitioner's son's house, but he did not remember whether he saw Petitioner using a cane.

Petitioner called Brent Nausley to testify as a witness at the time of arbitration. He testified that he was married to Petitioner's ex-wife, Karen, and that they had been married for 11 years. He testified that he has known Petitioner for 13-14 years. He testified that on May 30, 2015 he was on Lake Shelbyville fishing with Robbie, and he confirmed that he was Robbie's father-in-law. With respect to the Facebook posting, he testified that he took the photo that was featured in the posting. He testified that they were on the water by daybreak and were done around 12-12:30 p.m. after which they drove back to Decatur. He testified that Robbie got a call when they were still on the water, and he believed that it was Jenny that called him. He testified that since Jenny was out of town and Robbie was in the middle of the lake, Robbie told her to call his mom Sarah to go over and check on Petitioner. He testified that Jenny was Rob's wife and Petitioner's daughter. He testified that he did not go to the hospital to see Petitioner.

Mr. Nausley testified that he typically saw Petitioner two or three times a month, and that since January 2015 he had seen Petitioner almost every time with a cane. He testified that Petitioner did not use his cane when he was sitting and watching TV, but if he ever got up he would grab it. He agreed that it be fair to say that the majority of the time, if not all the time, that he had seen Petitioner he had been with a cane since January of 2015. He did not think that prior to January 2015 he had ever seen Petitioner use a cane.

On cross-examination, Mr. Nausley testified that he did not go grocery shopping with Petitioner nor did he go with Petitioner to Wal-Mart. He testified that he may have gone to Auto Zone with Petitioner, but not since January 2015. He testified that he usually saw Petitioner at Robbie and Jenny's house. He agreed that Petitioner always used a cane at his daughter's house.

Respondent called Jeff Binkley to testify as a witness at the time of arbitration. He has been employed by HTH Companies for about 4 years. He is a supervisor and knows Petitioner, but does not supervise Petitioner because he typically works on the night shift. He testified that he worked from 5:30 a.m. to 6:00 p.m. He testified that a fifth wheel operator shuttled trailers back and forth from dock to dock, but he admitted that he had not done the job himself.

Mr. Binkley testified that he had occasion to run into Petitioner in a Wal-Mart store in Decatur. He testified that he had a video of Petitioner in the Wal-Mart store, and that the video was dated May 14, 2015. He testified that he gave a copy of the video to Respondent's counsel. He testified that the video was approximately 9 seconds in length, and that there was no other video that he took of Petitioner that day nor had he taken any other video of Petitioner.

Mr. Binkley testified that he had seen Petitioner at work since January of 2015, and that Petitioner walked to and from the parking lot to the break room with his cane. He testified that Petitioner always walked with his cane, and that he had not seen Petitioner at work where he did not use his cane. He denied having seen Petitioner outside in the general public other than the one occasion that he had on his phone.

On cross-examination, Mr. Binkley agreed that prior to Petitioner getting switched to the day shift that he currently worked, he had never worked the night shift with Petitioner. He agreed that it would be fair to say other than the few seconds that it took to drive past him with the truck, he had never seen Petitioner perform his job duties. He denied working directly with Petitioner on the day shift, but he had seen Petitioner during the day shift sitting in the break room filing papers. He agreed that it would it be fair to say that his interaction with Petitioner was limited at best.

Mr. Binkley agreed on cross-examination that he had seen Petitioner walking to work on occasion from his vehicle, and that he always had his cane with him. He agreed that he had not seen Petitioner walking without his cane.

As to the video of May 14, 2015, Mr. Binkley admitted on cross-examination that he saw Petitioner in the Wal-Mart store, and that he saw him when he first came into the store and Petitioner was by the Pharmacy with a cart. He agreed that Petitioner did not have a cane with him but he had a cart. He stated that Petitioner was standing with the cart but not walking when he saw him.

Mr. Binkley testified on cross-examination that his wife, Mary, actually took the video. He testified that he handed his phone to his wife and she took the video, and that he was not standing next to his wife while she took the video as he went off to do something else. He testified that the video was taken on his phone. He testified that he looked at the video and saw Petitioner pushing the cart and walking. He testified that the video was taken at 1:59 p.m. according to his phone. He testified that he did not take the video because he did not want Petitioner to see him taking the video. He testified that he took the video because he thought Petitioner was supposed to be walking with a cane, but admitted that he was not fully aware of Petitioner's restrictions. He denied trying to get Petitioner in trouble.

Mr. Binkley testified on cross-examination that when he first went into Wal-Mart, Petitioner was standing there and introduced him to his daughter. He testified that he shook Petitioner's daughter's hand and then Petitioner walked away. He testified that he told his wife to take his phone and videotape him, and that she recorded him walking down an aisle with a shopping cart. Mr. Binkley admitted that he had no reason to dispute or to not believe Petitioner as to his honesty or character, and that around the workplace, Petitioner was known as a pretty honest and good guy.

On redirect, Mr. Binkley testified that when he saw Petitioner in the store he was not walking with any assistive device, and that he had an opportunity to look at the video on his phone. He agreed that he made a copy for HTH to send to their counsel, and that he had no doubt it was Petitioner.

Respondent called Gary Hart to testify as a witness at the time of arbitration. He testified that he is the safety manager and the general foreman for HTH Companies in Decatur. He testified that he knew Petitioner as a fifth wheel operator, but admitted that he had not done that particular job. He testified that he usually worked days, but he came in on nights sometimes.

Mr. Hart testified that during the period when Petitioner worked nights, he did on occasion work with Petitioner. He testified that the fifth wheel operator moved trailers from point A to point B and usually moved them between different buildings within the property. He indicated that Petitioner did not load and unload trucks. He testified that Petitioner opened the doors before he backed them into the docks, and that he closed the doors to drive the truck after the product was in it to whatever location it needed to go. He testified that he had opened and closed the doors and indicated that he did not know the weight because they were on a couple of hinges, but that the doors were approximately 4 foot wide and 8-9 foot tall. When asked if all the doors were the same, he responded that from what he had seen they were the same but he could not guarantee it because there were a lot of trailers. When asked how much force was involved to open and close the doors, he testified that the doors that he tried did not require a lot of force.

Mr. Hart testified that after January of 2015 Petitioner had been doing light/modified duty work and that he had been doing his work in the break room. He testified that when you arrived at Tate & Lyle, the regular work force would have to park in the parking lot and walk through a turn style to get to the location they needed to be at. He testified that the distance between where Petitioner parked and the break

room was approximately 100 yards, and that he had observed Petitioner walk from the parking lot to the break room. He testified that Petitioner was always walking with a cane. He agreed that at one point Petitioner was taken by vehicle from the parking lot to the break room, but he did not remember how long it lasted or how it stopped. He testified that he remembered Petitioner was walking in without the cane from the very beginning, and then Petitioner stated that his back was hurting so bad he could not come in and that he needed assistance with the cane. He testified that it was sometime after that when Petitioner came back to work that he was given a ride in and out of the plant. He believed it was in January, and that he thought it was a week or two but he could not be certain because he did not know how or why it stopped. He testified on cross-examination that Petitioner gave him an off work slip a week or two ago, so he was not currently working light duty.

On cross-examination, Mr. Hart testified that he was hired in as a supervisor, and within three months he was moved to the safety position which was approximately July of 2013. He agreed that it was fair to say that he had always worked the day shift. He agreed that he came in for a portion of the night shift occasionally and that how frequently he did this depended on what the workloads were and whether they needed him. He testified that on the days that he came in early, he did not get to leave work early. He agreed that he had never worked the night shift with Petitioner. He agreed that he had never been a fifth wheel operator and that he had never performed the duties of a fifth wheel operator. He testified that he had seen Petitioner perform his job as a fifth wheel operator, and that he was either backing in or pulling away from a trailer from one of the docks over at the 44 building when he saw him. He agreed that he had not spent an entire shift with Petitioner. He agreed that when he had seen Petitioner performing his job, he had always performed it to the best of his ability and that he had always done things correctly.

With respect to the trailer doors, Mr. Hart agreed on cross-examination they were 4 feet wide per door, and that the height was about 3.5-4 feet off the ground which was approximately chest level when you went to close the door. He agreed that he had not opened and closed all of the trailer doors, that some of them were in different conditions, and that some of them were older. He testified that whenever the drivers told them they were damaged, they had them taken care of and fixed. He testified that there were probably more than 30 trailers, that they came and went all day long, and that they were all in different conditions. He testified that when it was reported that a trailer was in bad condition it would get fixed by Durbin Trucking, but it needed to be reported to be fixed. He agreed that there was a possibility that some doors and trailers may go for a period of time in bad condition before they were reported and fixed.

Mr. Hart testified on cross-examination that he was able to examine the trailer that Petitioner was working on the night that he was injured and that he would not say it was out of the ordinary from what he had seen in terms of functionality, but he did not have any problems with it. He agreed that he latched the door, but did not know how many doors Petitioner latched that night before he latched that particular door. He testified that he knew Petitioner told him in the morning that it was around 9 p.m. so he could go back and look at the record log to see how many it was, but he did not have the log with him at the arbitration hearing.

Mr. Hart agreed on cross-examination that he was there the night that Petitioner got hurt, and stated that it just happened to be one of the nights that he was coming in early when he got the phone call that Petitioner was hurt. He testified that he believed he was called by Bill Prater, the night supervisor. He testified that he believed at about 4 o'clock Petitioner came in and said he had done something to his back earlier in the night around 9 o'clock, and that he was on the way in, arrived at 5 o'clock and took Petitioner to St. Mary's shortly after. He testified there was an incident report filled out, but he did not have it with him at the arbitration hearing. He testified that the incident report was comprised of who was involved, where the location was, what tasks Petitioner was doing and what happened, and how to rectify the situation so it did not happen again.

When asked on cross-examination whether the trailer afterwards was ever taken out or fixed, Mr. Hart testified that from what he saw there was not any damage done to it that bad that had to be reported or to be taken out but that he would have to go back to the logs since January to see if it had been taken out. He testified that he and Petitioner talked about the incident report while he was at the hospital and he was taking down notes, and that he then he filled it out. He testified that he did not know if Petitioner had seen it or not.

Mr. Hart agreed on cross-examination that he had no reason to dispute that this occurred as Petitioner described it, and that Petitioner seemed like an honest guy as far as he knew. He testified that he had heard no complaints about Petitioner. He agreed that he was several years younger than Petitioner and could probably close the door a little bit easier than Petitioner. When asked how heavy the doors were, he testified that he had never taken one off to weigh it, but he had pushed them closed with one hand. He agreed that you closed it and then had to latch it in two different locations. He testified that it was a pendulum, and that both had to be latched in order for the door to be shut properly. He testified that Petitioner did not say he was injured latching the door, he said he was injured closing of the door.

When asked where Petitioner was when he first arrived or first became aware of the accident, Mr. Hart responded on cross-examination that he was at the office or the break room but somewhere within the 91 building. He testified that he believed that Petitioner was observed by G4S which were the EMT's on site. He indicated that he was not there when Petitioner was examined, but that when he got there he pulled in and took Petitioner to St. Mary's. He testified that he stayed there with Petitioner the whole time, and that it was roughly 5:30 or 6:00 a.m. when they arrived. He agreed that he was actually in the examination room with Petitioner. He testified that after Petitioner was discharged he took him back to his truck and made sure he was okay to drive. Petitioner said he was fine to drive, said he would be all right and would see him tomorrow.

Mr. Hart agreed on cross-examination that there was a period of time where Petitioner was transported from his car to the building, and that Petitioner had complained that he was having difficulty walking from his car to the office. He testified that the first couple of days Petitioner called him to remind him about it, that one of his supervisors had a company vehicle and that he had him go out and pick up Petitioner and then drive him into the facility. He testified that he arranged this, and that Petitioner complained to him specifically that he was having a hard time walking that distance. When asked why that stopped, he responded that he did not. He testified that if Petitioner or any employee on restricted or light duty had difficulty in making that walk, this was something that could be arranged.

Mr. Hart agreed that as Petitioner was on light duty restriction he was now on the day shift, and it was fair to say that he saw Petitioner more often now since he worked the same shift. He testified that Petitioner performed his light duty work in the break room at the 91 building. He agreed that they had accommodated his restrictions, and that Petitioner always had his cane with him. He agreed that now that he worked the same shift, he saw Petitioner on a daily basis and that he always had his cane with him. He agreed that Petitioner recently gave him a work restriction taking him completely off work. He testified that whenever Petitioner gave him the restrictions after seeking the doctor they would keep them on file, unless something changed that he was not aware of. He agreed that other than the January incident, he was unaware of any outside hobbies or anything that would have caused or been the cause of Petitioner's back injury in January.

Mr. Hart testified on cross-examination that there were two fifth wheel operators per shift, and that they rotated shifts so there was only one on every night. He indicated that if Petitioner was not there, the fifth wheel operator duties would have been covered. He agreed that it was fair to say that he and

other individuals talked in order to understand and have the full picture of what happened after an accident, but he was responsible for completion of the incident reports.

On redirect, Mr. Hart agreed that the policy of the company was to accommodate people if they were on work restrictions, and that every time Petitioner needed a work restriction the company provided it. He agreed that when someone reported an accident or injury he took them at their word from the very beginning and investigated to find out the underlying issues. He agreed that he actually had an opportunity to look at the trailer in question that Petitioner complained about, and also had an opportunity to close the doors. He agreed that he had no difficulty and that he did not remove the vehicle at that time.

When asked how often he would see Petitioner walking into work or from the break room to the parking lot to leave after the incident, Mr. Hart testified that he had seen Petitioner at least every other week and every time he had seen him he had been with a cane. He denied having seen Petitioner outside in the general public as he was not from Decatur.

Respondent called Brian Sotir to testify as a witness at the time of arbitration. He testified that he was employed by the Robison Group, which was a private investigation company. He testified he was a field investigator. He testified that prior to coming to work for the Robison Group, he was in the military for 7½ years in the Air Force and his rank was that of Staff Sergeant, E5. He denied having any prior experience in investigation work. He testified that he had one week of training that was both in class and in the field working with the equipment, and it included going through with a certified trainer that was currently working with the company.

Mr. Sotir testified that his first contact with Petitioner was on July 18th. He testified that prior to this, he had had one previous assignment by himself and had one week of assignment with a fellow investigator. He testified that the first day was actually July 17th, but he did not notice Petitioner anywhere, so July 18th was the first day he actually had any contact.

Mr. Sotir testified that on July 17th he started at approximately 7 a.m. He testified that he had gone to the provided address on Salem Drive which was where he remained for the majority of the day, and that he set up there and waited for Petitioner to pass. He testified that there was nowhere to park where he had a direct contact of the house. He testified that he was there for 8 hours and made no observations.

Mr. Sotir testified that on Saturday, July 18th he started his investigation at 7 a.m. and first went to the 2828 Jaymar Trail Road address but was only there briefly. He testified that when he did not discover any of the Petitioner's vehicles he proceeded on to 3260 Salem School Road and parked in direct route of the house. He testified that the first time he observed Petitioner was at 8:42 when he had driven past him. He testified that after he first observed Petitioner and recognized him in the vehicle he identified the plate to match what he had on file, and that was when he started surveillance and followed. He testified that the first video footage was at 8:51 at 653 Excelsior School Road in Decatur, at which time he obtained approximately 45 seconds worth of video which showed Petitioner pouring a bucket over the railing and walking back out of view.

Mr. Sotir testified that at 9:18 he obtained video of Petitioner walking into view towards a red Ford F-150. He testified that at 9:26 Petitioner was pushing a shopping cart into a Wal-Mart walking beside an unidentified male. He testified that at 9:33 Petitioner was observed standing at the pharmacy counter waiting for a prescription, and that 9:46 Petitioner was observed sitting in the vehicle in the driver's seat with an unidentified male in the passenger seat. He testified that he did not observe anything more until he took his last video at 2:15 p.m. He testified that after that, he followed Petitioner back to the Salem School Street residence where he let Petitioner go into the house and he parked off in the distance.

He testified that he had seen Petitioner driving back with the unidentified male in the passenger seat and a tractor-like lawn mower in the back end of the pick-up and proceeded to follow.

Mr. Sotir testified that he had contact with the unidentified male. He testified that the unidentified male stopped at a stop sign for a prolonged period of time. He testified that he was trailing approximately a ¼ mile behind him, and as he had gotten closer on the country road the unidentified male had gotten out of the passenger seat, came up to the driver's side window of his vehicle and asked him who he worked for and what he was doing. He responded saying that he did not know what he was talking about, and backed up the truck and departed the area. He testified that the unidentified male was Petitioner's son-in-law, whom he had seen that day at the arbitration hearing. He testified that he had no other observations of Petitioner after this.

On cross-examination, Mr. Sotir agreed that pre-surveillance had been done on June 6th but he did not know when the surveillance was originally requested nor did he know who requested it. He testified that all the video that would be seen for the next two investigators was shown after his on the disc. He testified that he did not know who performed the pre-surveillance. He agreed that he did not perform any other investigation after July 18, 2015 but there were other investigations performed by other investigators from his company on July 24th. He confirmed that the video contained all of the video that he retained from his investigation and that there was no footage that was left out, erased or deleted. He agreed that the video portion of his investigation was from 6:54 a.m. to 11:01 a.m. on July 18, 2015, and that he created the log and submitted it following that evening. He testified that he turned the log in to his field operations manager. He testified that he was requested to perform two days of surveillance, July 17th and July 18th.

On cross-examination, Mr. Sotir confirmed that other than the day of arbitration he had not seen Petitioner since July 18th, and that he had not been asked to follow Petitioner since July 18th. He testified that he saw Petitioner at 8:42 but he did not have video, and that the first video he had was at 8:51 a.m. He testified that the last video he had was at 9:46 a.m.

Respondent called Jeff Beebe to testify as a witness at the time of arbitration. He testified that he was employed by the Robison Group, and has been employed by them for 4½ years. He was a field investigator and was asked to do surveillance on Petitioner. He testified that the first day that he was out was Friday, July 24, 2015. He testified that they started their surveillance near Petitioner's residence at 3260 Salem School Road in Decatur, and that he had another person with him but they were in different vehicles. He testified that Robert Giles, the other investigator he was working with, prepared the report. He testified that he took all the time entries and forwarded them to Mr. Giles, who put them in the final report and sent them to the office. He testified that would have just included the materials that were on his videotape, and that Mr. Giles prepared the report.

Mr. Beebe testified that they were in the area of Petitioner's residence at 5:49 a.m., and that the first time he had an opportunity to observe Petitioner and take video was at 6:12 when Petitioner arrived at Casey's. When describing what was seen on the video, he described Petitioner getting out of the truck, walking around the front of the truck and then walking in front of Casey's using a cane in his right hand and entering the store. He testified that at 6:15, Petitioner was seen walking out of the store and walking back toward his truck using a cane in his right hand, and he got into the truck, backed his truck out of the parking space and departed the area.

Mr. Beebe testified that the next video was at 3:39 when Petitioner was leaving the workplace, Tate & Lyle, located at 2200 East Eldorado Street in Decatur. He testified that he did not see Petitioner walking, and that he was in his truck coming out from the rear of the plant. He testified that the next video was Petitioner arriving at St. Mary's Hospital at 1800 East Lakeshore Drive in Decatur at 3:45 p.m. He

testified that the video showed Petitioner parking in the parking lot, exiting his vehicle and walking toward the front of the hospital using the cane in his right hand again. He testified that the next entry was at 4:22 when Petitioner came from the area of the hospital and returned to his truck, entered and departed.

Mr. Beebe testified that the next entry was at 4:37 p.m. when he arrived at 653 Excelsior School Road in Decatur. He testified that it showed Petitioner driving the truck into the driveway, and then more video of Petitioner getting out of the truck. He testified that Petitioner again was using a cane in his right hand, and that he walked up the stairs, looked in the window and entered the residence. He testified that the next entry was at 4:47, that Petitioner exited the residence and sat on the porch for several minutes. He testified that at 5:35 Petitioner was sitting out on the porch with a female. He testified that the next entry was at 5:49, when Petitioner came out again and sat on the porch, smoked a cigarette and approximately 4 minutes later departed the area. He testified that he did not know if he was his son-in-law, but the unidentified male seen on the video was seen sitting outside the arbitration hearing room.

Mr. Beebe testified that at 5:54 on the video Petitioner got up, still using a cane, and walked to his truck. He testified that was the last entry on the videotape, that at 6:03 Petitioner returned to his residence on Salem School Road where he parked out of view, and that at 6:11 surveillance was terminated. He testified that he did not have occasion to perform any other surveillance on Petitioner. He testified that Mr. Giles took no video.

On cross-examination, Mr. Beebe testified that the first time that he videoed Petitioner was at was 6:12 a.m. and the last time that he recorded him was at 5:50 p.m. He agreed that there were no other days on which he was asked to either conduct pre-surveillance or perform surveillance on Petitioner where he was unable to record him. He agreed that all of the video that was documented in the log was completed by him. He agreed that there was no other video that he recorded that was not on the video surveillance.

On cross-examination, Mr. Beebe agreed that he prepared the log where the video entries were, and then his partner, Robert Giles, completed the log. He testified that the log was sent from their computers to the office which was in Troy, Michigan. He testified that he did not know when the video surveillance was initially requested, but it was requested by Zurich North America by May Lagunzad as indicated on the very front page. He agreed that the date of report was July 28, 2015, which was when it was compiled from several investigators. He did not know whether it was sent off the same day. He agreed that it was his understanding that there was no further surveillance taken by anyone after July 24, 2015.

Respondent called Robert Giles to testify as a witness at the time of arbitration. He testified that he was employed by the Robison Group and had worked there for just over 3 years. He testified that he was an investigator.

Mr. Giles testified that the first occasion that he was assigned to do an investigation of Petitioner was on Friday, July 24th and that he worked with a partner. He testified that he and his partner each had their own vehicle, and that he started at 5:59 a.m. He testified that he took no video but that his partner did. As to the report, he testified that he made all the entries where there were the time stamps. He testified that the non-video references were their collaborative observations. He testified that in terms of describing what was on the video, it was his partner's description. He testified that he had reviewed the report, and that it was consistent with what he observed. He testified that he did not do any investigation other than July 24th.

On cross-examination, Mr. Giles testified that he was in the same location as his partner when the videos were being taken. He testified that he and his partner had planned that he would be the lead tail and his partner would be producing most of the video as his vehicle was more conducive to covert video.

As to the entries, he confirmed that his partner provided him with a description of what he videoed and he compiled this into a report. He agreed that other than July 24th, he was not asked to conduct any sort of surveillance or pre-surveillance.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application for Adjustment of Claim alleged a date of accident of January 21, 2015, that Petitioner was injured while closing the door of a trailer, and that he suffered injury to his lumbar area as a result of the alleged accident. The Application for Adjustment of Claim was signed by Petitioner on February 9, 2015. (AX2).

The St. Mary's Occupational Health records were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Petitioner was seen at Occupational Health and Wellness at St. Mary's on January 22, 2015 at which time it was noted that Petitioner presented with complaints of low back pain radiating down his right lower extremity. The Date of Injury was noted to be January 22, 2015. It was noted that he was pushing a trailer door and the pain radiated down to his right leg into the foot as well as in the gluteal region, and that his pain was aggravated with walking. Diagnostic films from the Emergency Room were reviewed, which showed multilevel degenerative disease with foraminal stenosis at L4-5 and L5-S1. The Assessment was right-sided radiculopathy L5-S1 lumbar sprain. Petitioner was to be on modified work, was started on medications and instructed to follow up next week with Dr. Fabrique. (PX1).

The St. Mary's Occupational Health records reflect that Petitioner returned on January 26, 2015 for a recheck. It was noted that the low back pain radiated down the right buttock and posterolaterally down the right thigh/leg to the lower leg level. No improvement was noted in symptoms. Petitioner had similar symptoms on the right side more than 10 years ago after a work injury. The Assessment was that of low back pain with radicular symptoms. Petitioner was given work restrictions, medications, and recommended to undergo physical therapy. (PX1).

The St. Mary's Occupational Health records reflect that Petitioner returned on February 3, 2015 at which time it was noted that his symptoms were unchanged. Petitioner reported pain of 4-5/10 down the posterior and lateral aspect of the right lower extremity, and that only one physical therapy treatment had been done. The Assessment was that of follow up low back pain with radicular symptoms; rule out HNP, rule out piriformis syndrome. Petitioner was instructed to continue physical therapy, undergo an MRI, and was allowed to return to work on a modified duty basis. (PX1). Petitioner was next seen on February 11, 2015, at which time it was noted that Petitioner had worsening low back/buttock pain with right leg numbness. Petitioner stated that yesterday the pain was more severe and intolerable, and he rated his pain as 10/10. The pain was so bad in the low back Petitioner thought he was going down to the floor twice. He took Norco without relief and was unable to sleep. He stated that his daughter bought him a cane as she was worried he would fall. He noted that he had right leg numbness within seconds of standing. It was noted that Petitioner had not gone to work the past four days due to the pain. The Assessment was that of lumbar sprain/strain; right side L5-S1 radiculopathy; multilevel degenerative disc disease. Petitioner stated that he wanted no medications/scripts. Petitioner was instructed to continue physical therapy and was scheduled for an MRI on February 17th. Petitioner was taken off work February 11 – February 13. (PX1).

The St. Mary's Occupational Health records reflect that Petitioner was seen on February 13, 2015, at which time it was noted that Petitioner's low back pain was not improved. Petitioner called off work and stated even sitting bothered him a lot. The Assessment was that of follow-up low back pain with radicular symptoms and probable HNP. Petitioner was noted to be "TD status" and was given a prescription for Norco. Petitioner was next seen on February 17, 2015, at which time Petitioner's pain level was noted to be 6-7/10. The MRI of the lumbar spine showed degenerative disease of the disks,

spondylosis – foraminal narrowing. It was further noted that there was an asymmetric disk bulging sloped right and extending into the right foramina, possible disk herniation. The Assessment was that of low back pain with right lower extremity radicular symptoms; right sided disk bulge/herniation with foraminal encroachment. Petitioner was instructed to see a neurosurgeon/Dr. Rahman, and he was noted to be taken off work. Petitioner was last seen at St. Mary's Occupational Health on May 22, 2015, at which time Petitioner presented for a recheck for low back pain with paresthesias/pain to the right lower extremity. Petitioner reported no improvement. It was noted that he had another IME with Dr. Butler on June 5, 2015. The Assessment was that of low back pain with radicular symptoms and lumbar neuroforaminal encroachment. It was noted that Petitioner was temporarily disabled, was given prescriptions, and was instructed to return on June 9, 2015. (PX1).

The medical records of Accelerated Rehabilitation were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner underwent an Initial Evaluation on January 29, 2015, at which time it was noted that Petitioner sustained a work-related injury to his low back on January 22, 2015 as a result of closing a truck trailer door when he felt a pull in his back. Petitioner stated that he was about the same since the date of injury. Petitioner had not had an MRI, but his CT scan revealed sciatica. Petitioner was currently working light duty. Petitioner had right leg numbness that came and went with changing positions. Petitioner had a sharp pain with extending backwards, and he had mild trouble sleeping. It was noted that Petitioner's level of deconditioning may impact his length of stay in physical therapy, but his rehabilitation potential was good. (PX2). The records reflect that Petitioner underwent physical therapy on February 6, 9 and 11. The physical therapy note of February 11 noted that Petitioner stated that he was a little worse, and that he was using a cane for fear of falling. (PX2).

The medical records of St. Mary's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent a post-accident Rapid Drug Screen on January 22, 2015, which was noted to be negative. Petitioner also underwent post-accident Alcohol Testing on the same date, which was noted to be negative. (PX3).

The St. Mary's Hospital records reflect that Petitioner was seen in the Emergency Department on January 22, 2015 having been brought directly from work for right upper extremity pain and discomfort. It was noted that "[e]vidently at work patient twisted his back and developed acute onset of back pain with positional pattern." The pain was noted to be sharp in nature with intensity 10/10 associated with numbness and tingling in the right lower extremity. It was noted that Petitioner's pain radiated to his right upper extremity to all his toes. It was noted that Petitioner had a "history of back and sprain." Petitioner underwent a CT of the lumbar spine, which noted a history of severe low back pain radiating to the right leg after pushing on a door. The imaging was interpreted as revealing no acute bony abnormality; multilevel degenerative disc disease and facet arthropathy including bilateral neural foraminal stenosis at L5-S1. The Impression was that of back pain, and Petitioner was directed to go to the Occupational Health Clinic for ongoing evaluation and treatment. (PX3).

The St. Mary's Hospital records reflect that Petitioner underwent an MRI of the lumbar spine on February 17, 2015. The Impression of the interpreting radiologist was that of (1) Moderate asymmetric disc bulging sloping to the left at L3-4, extending into the left foramen; borderline acquired spinal stenosis was seen at this level; (2) asymmetric disc bulging at L4-5, sloping to the right and extending into the right foramen; there could be a superimposed right-sided disc herniation at this level; (3) bilateral spondylolysis at L5-S1 with grade I spondylolisthesis; bilateral foraminal narrowing. (PX3).

Additional medical records included with the St. Mary's Hospital included Emergency Department records dated May 30, 2015, at which time Petitioner presented for evaluation of sharp abdominal pain. Petitioner denied any pertinent past medical history or taking any medication for pain

relief. Petitioner was noted to be in otherwise baseline state of health and all other review of systems were negative. Petitioner was assessed with acute appendicitis and underwent a laparoscopic appendectomy. (PX3).

The interpretive report for a CT of the lumbar spine performed on January 22, 2015 at St. Mary's Hospital was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The report noted a history of severe low back pain radiating to the right leg after pushing on a door. The imaging was interpreted as revealing no acute bony abnormality; multilevel degenerative disc disease and facet arthropathy including bilateral neural foraminal stenosis at L5-S1. (PX4).

The interpretive report for an MRI of the lumbar spine performed on February 17, 2015 at St. Mary's Hospital was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The Impression of the interpreting radiologist was that of (1) Moderate asymmetric disc bulging sloping to the left at L3-4, extending into the left foramen; borderline acquired spinal stenosis was seen at this level; (2) asymmetric disc bulging at L4-5, sloping to the right and extending into the right foramen; there could be a superimposed right-sided disc herniation at this level; (3) bilateral spondylolysis at L5-S1 with grade I spondylolisthesis; bilateral foraminal narrowing. (PX5).

The IME report of Dr. Jesse Butler dated March 6, 2015 and the Addendum dated April 22, 2015 were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The IME report dated March 6, 2015 noted that Petitioner reported an injury on January 22, 2015 while working as a spotter moving trailers. Petitioner stated that he was closing a trailer door at the time of injury. Petitioner stated that the trailer did not line up well and he was slapping the door and pushing with the opposite hand to close the latch when he felt back pain. It was noted that Petitioner complained of pain in the lower back radiating to the right leg, and that the pain shot down from the right buttock to the calf and foot. Petitioner complained of numbness and tingling. It was noted that Petitioner had difficulty lying on his back with the numbness present, that he had 2-3 sessions of therapy with no relief and that he was using a cane for fear of falling as the leg had given way on several occasions. It was noted that Petitioner stated that he pulled a muscle in his back 20 years ago but denied other injury. (PX6).

The report indicated that Petitioner's gait was noted to be that of limping, that he was using an assistive device (cane with both hands) and was slow and cautious. The Assessment was that of lumbar degenerative disc disease, lumbar spondylolisthesis and lumbar spinal stenosis. Dr. Butler opined that Petitioner's treatment to date had been reasonable and necessary, and he agreed with the treatment for the injury. Dr. Butler opined that Petitioner did not seem to be capable of returning to work other than a sedentary capacity with the lifting restriction of 10 pounds, that he could sit and stand as tolerated, and that there should be limited twisting and stooping. Dr. Butler indicated that Petitioner did not describe any recent pre-existing medical issues that may have contributed to his current condition, that the description of the mechanism of injury seemed reasonable assuming his history regarding closing the trailer doors was accurate, and that he had a significant pre-existing condition that may very well have been aggravated as a result of his workplace exposure. (PX6).

The Addendum dated April 22, 2015 indicated that Petitioner required additional treatment, and that he should complete a course of physical therapy and medical management after which he was to follow up with reevaluation to assess for improvement. It was suggested that Petitioner might consider an epidural injection for the radicular pain component if physical therapy and medical management failed to address his pain and function adequately. It was further suggested that if the injections were not successful, then he could consider spinal decompression and fusion from L4-S1. (PX6).

The medical records of Neurosurgical & Orthopedic Specialists (Dr. Mohammed Rahman) were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that

Petitioner was seen on April 16, 2015 for a new patient visit with a chief complaint of back pain. Petitioner reported low back pain that radiated down the posterolateral right lower extremity, and denied any left lower extremity pain or weakness. Petitioner experienced numbness and tingling in the right leg and foot. Petitioner reported that his back pain bothered him more than the leg pain. It was noted that in January 2015 Petitioner sustained an injury at work closing a trailer door, and that after the injury he tried a few sessions of physical therapy that provided minimal relief. Petitioner had not tried injections, he was taking Norco as needed for pain and his symptoms had been getting worse. Dr. Rahman's review of the CT and MRI of the lumbar spine suggested evidence of grade 2 spondylolisthesis at L5-S1 with bilateral pars fractures, and there was also evidence of severe foraminal stenosis at L4-L5 and L5-S1 with degenerative disc disease. The Assessment was that of (1) Spinal stenosis; (2) spondylolisthesis; (3) sciatica; (4) disc degeneration, lumbar. Dr. Rahman recommended a transforaminal lumbar interbody fusion and decompressive lumbar laminectomy at L4-L5 and L5-S1. It was noted that Petitioner wished to proceed with surgery. (PX7).

The medical records of St. Mary's Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Petitioner was seen on April 16, 2015 as a new patient with a noted chief complaint of back pain; the records were identical to those for the office visit with Dr. Rahman as contained in the Neurosurgical & Orthopedic Specialists as contained in PX 7. The records also reflect that Petitioner was also seen on May 14, 2015 for a new patient visit to establish primary care. It was noted that Petitioner needed pre-operative evaluation for possible back surgery. It was noted that Petitioner was admitted overnight to St. Mary's Hospital December 19-20 for evaluation of chest pain. Petitioner was noted to walk with a cane. The records reflect that Petitioner was seen for a blood pressure check on May 21, 2015. (PX8).

The St. Mary's Family Medicine records reflect that Petitioner was seen on June 4, 2015 for a three week follow-up. It was noted that Petitioner had an emergency appendectomy on May 30, 2015 for acute appendicitis. With respect to his low back issues, it was noted that Petitioner reported that his low back pain was about the same, and that he was hoping surgery would be scheduled soon. It was noted that approximately 3-4 times daily, Petitioner had a sharp pain in his back which radiated down the right leg and his right leg went numb. He reported that his pain was worse when getting up and down, and that he still used a cane to walk. (PX8).

The St. Mary's Family Medicine records reflect that Petitioner was also seen on June 17, 2015 to discuss what needed to be done so that his back surgery could be scheduled. Petitioner had no concerns other than wanting to be released to go back to work. Petitioner was using a cane in his right hand with ambulation. Petitioner was issued a return to work slip allowing him to return on June 22, 2015 with restrictions of no climbing, no pushing/pulling, no prolonged standing/walking, no lifting over 5 pounds, no reaching above shoulders, and light duty only unless further restricted by Dr. Butler. (PX8).

The St. Mary's Family Medicine records reflect that Petitioner was also seen on July 15, 2015 for a one month follow-up. Petitioner denied any concerns. Petitioner reported that he was doing about the same, and that he still had low back pain with radiation down the right leg to his toes which was up to 5-6/10 in severity. Petitioner's right leg still went numb intermittently. Petitioner still used his cane in his right hand. Petitioner was given surgical clearance for surgery. (PX8).

The IME report of Dr. Butler dated June 5, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. Petitioner reported that he had been working three days per week since his last evaluation, and that he had been unable to complete a full week of work due to back pain. Petitioner had been taken off work recently by St. Mary's physicians. It was noted that Petitioner was now using a cane in the right hand, and that he had an emergency appendectomy the prior Saturday. Petitioner had seen a neurosurgeon who had recommended surgery for the lumbar spine. Petitioner

continued to have poor tolerance to most activities of daily living, and his pain scores varied with activity. The report indicated that Dr. Butler opined that Petitioner's current condition of ill-being was lumbar spinal stenosis with spondylolisthesis and that there was severe degenerative disc disease at L4-5 and L5-S1 which appeared to have been aggravated as a result of his work-related injury. Dr. Butler opined that Petitioner would be a reasonable candidate for a two-level decompressive laminectomy and spinal fusion, and that Petitioner would require a wide laminectomy to adequately decompress the severe stenosis present in his lower back. It was noted that the spinal fusion would also be necessary given the spinal instability manifested at L5-S1 with severe foraminal stenosis and compensatory retrolisthesis at L4-5. Dr. Butler opined that Petitioner could continue to work in a sedentary capacity, and Petitioner appeared to be poorly tolerating this due to the difficulty with any prolonged sitting and/or standing. It was further recommended that Petitioner strongly consider smoking cessation to optimize the potential outcome of his surgical procedure. (PX9).

The Addendum report of Dr. Butler dated July 14, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report indicated that Petitioner needed a laminectomy and spinal fusion as documented in the prior medical records, that he had not improved with conservative treatment and that he would likely benefit from a decompression laminectomy and fusion from L4-S1. It was noted that Petitioner may continue to work with the same sedentary restrictions recommended from the prior IME and office visit, and that Dr. Butler believed that Petitioner's need for treatment and work restrictions was related to the work injury in question. (PX10).

Various work slips were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The return to work slips were issued by Occupational Health and Wellness at St. Mary's and/or Family & Internal Medicine – Lake Shore. (PX11).

The transcript of the evidence deposition of Dr. Mohammed Rahman was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Dr. Rahman testified that he is a neurosurgeon and was board-certified in neurosurgery by the American Osteopathic Board of Surgery. Dr. Rahman testified that he treated disorders of the brain and spine. Dr. Rahman testified that 60% of his practice was related to the lumbar spine, and that he performed 150 lumbar spine surgeries on average per year. (PX12).

Dr. Rahman testified that he saw Petitioner on only one occasion – April 16, 2015 – at the referral of Dr. Fabrique, that he reviewed Dr. Fabrique's office notes from January and February 2015, and that he viewed both films and reports for the CT and MRI of the lumbar spine. He testified that Petitioner mentioned that he sustained an injury at work closing a trailer door, and he reported back pain and pain in his right lower extremity as well as numbness and tingling in the right leg and foot. He testified that Petitioner reported that he took Norco for the pain, and that his symptoms were getting worse. He testified that Petitioner reported that he had undergone a few physical therapy sessions that provided minimal relief, and that he had not had any injections. He testified that the positive findings in the Review of Systems included back pain, spasms in his lower lumbar spine, numbness and tingling in his right lower extremity along with paresthesias and difficulty walking. He testified that the positive findings from the physical examination performed included that his strength was intact in his lower extremities but he did have sciatic nerve distribution pain, which indicated to him that Petitioner's sciatic nerve was irritated. (PX12).

Dr. Rahman testified that his review of the MRI revealed that Petitioner had spinal stenosis at L4-5, L5-S1 with degenerative disc disease, and that he also had a spondylolisthesis in his lower lumbar spine which were both degenerative findings. He testified that he and Petitioner did not discuss whether he had back pain prior to the January 21st incident. He testified that the findings on the CT showed that Petitioner sustained pars fractures at L5 along with having foraminal stenosis and a spondylolisthesis, and that such findings were degenerative. He testified that he diagnosed sciatica, lumbar disc degeneration,

spinal stenosis and a spondylolisthesis, and that such findings were all degenerative. He testified that he recommended surgery, which was a transforaminal interbody fusion and decompressive laminectomy at L4-5 and L5-S1, and that Petitioner obtain medical clearance as he was over age 40. He testified that he did not recommend any sort of work restrictions as he deferred to the restrictions that had already been placed. He testified that he had not seen Petitioner since this visit. (PX12).

Dr. Rahman testified that prior to the deposition, he had opportunity to review surveillance including one undated video and a compilation of surveillance footage beginning from July 17, 2015 through July 24, 2015. He testified that he believed that Petitioner suffered a neurological injury to his lumbar spine, and that an individual such as Petitioner could have degenerative findings as found on the MRI and the CT and be without symptoms. He testified that it was possible that a person who sustained a trauma such as that described by Petitioner involving his January 21, 2015 workplace could aggravate or exacerbate an underlying degenerative condition causing him to become symptomatic, and that he felt that the workplace accident contributed to Petitioner's current condition of ill-being by aggravating his symptoms. He testified that he was still recommending surgery if Petitioner was still symptomatic, and he felt that Petitioner would continue to have his symptoms if he did not have surgery because there was significant pressure on his nerves in his spinal cord. He testified that Petitioner's need for surgery was due in part to his January 21, 2015 workplace injury because Petitioner did not have any symptoms prior to this injury. (PX12).

Dr. Rahman testified that following surgery, he would expect that initially for the first two weeks there would be lifting restrictions of no more than five pounds and after the two week mark he could lift up to 15 pounds up to two months from surgery. He testified that he anticipated that after two months there would be no restrictions on weight. He testified that initially after surgery there was no physical therapy, and that after two months if he was still symptomatic therapy may be recommended. He testified that Petitioner's medical treatment thus far had been reasonable and necessary, and that the surgery he was recommending was reasonable and necessary as well. (PX12).

Dr. Rahman testified that after reviewing the surveillance videos, his plan was still the same and that he did not alter his recommendations to Petitioner as there was nothing concerning that he saw in the videos. He testified that the surveillance videos did not alter his opinion that the January 21, 2015 injury contributed to his condition of ill-being, they did not alter his opinion regarding the need for surgery, nor did they alter his opinion that his need for surgery was at least in part related to his need for surgery. He testified that Petitioner's smoking habit would limit his ideal surgical outcome because of healing and the effect on his fusion rate. (PX12).

Dr. Rahman testified that most of the videos that he reviewed showed only clips of certain days, they showed him in various shopping locations, and they showed him leaning on or relying on shopping carts. He testified that many times shopping carts were a supportive assistive device. He testified that the videos also showed Petitioner sometimes walking without his cane, but it did not alter his opinion as to causation or the treatment plan that he had given. He testified that the videos that showed him walking with bags in his left hand had no significance to his plan, and the fact that Petitioner was carrying it in his left hand was a very common way people compensated for their pain by carrying items on the opposite side. He testified that the videos showed Petitioner pouring some sort of liquid from a canister, but he did not know what was in the canister or how much it weighed. He testified that he did not know what was in the bag, nor did he know how heavy the bag was. He testified that the videos were not following Petitioner around from sunup to sundown, and that he did not know whether Petitioner took his medication right beforehand. (PX12).

Dr. Rahman testified that Petitioner was not at a greater risk for injuring his lumbar spine if he did not have the surgery because it was a degenerative issue that limited his activities but would not

paralyze him. He testified that the aggravation of his pre-existing condition would vary but it would progress with increasing pain and possibly neurological deficits. He testified that Petitioner would sometimes worsen with strenuous activity, but his age was not a factor. He testified that if Petitioner had the surgery he was recommending, he should have a full recovery. He testified that if Petitioner continued to perform his job duties as a fifth wheel operator and did not have surgery, he expected it would become increasingly difficult for Petitioner to perform his job. He testified that he did not note any sort of symptom exaggeration when he met Petitioner, and noted that Petitioner was "actually quite believable." (PX12).

On cross-examination, Dr. Rahman agreed that there was no discussion or disclosure by Petitioner of any prior back problems or symptoms. He testified that the MRI interpretive report mentioned spinal stenosis and evidence of a spondylolisthesis at L5-S1 with foraminal stenosis, and that spinal stenosis meant compression of nerves while spondylolisthesis meant slippage in the back causing instability. He agreed that these were degenerative conditions and that they in all likelihood predated January 21, 2015. He agreed that in reviewing the MRI report, there was no evidence of an acute trauma or injury occurring on or about January 21, 2015. He testified that the CT showed spondylolisthesis along with foraminal stenosis, and that Petitioner had pars fractures at L5. He agreed that these were degenerative findings, and that they in all likelihood predated January 21, 2015. He agreed that there was no evidence on the CT scan of an acute injury. (PX12).

On cross-examination, Dr. Rahman agreed that the conditions that he identified in the MRI, CT, and in his assessment of Petitioner were conditions that were progressive in nature, and that regardless of any type of injury or aggravation they would progress with time. He testified that he did not recall how Petitioner presented in the way he ambulated, nor did he recall if Petitioner presented with the use of a cane. He agreed that his examination lasted a period of 30 minutes, and that he identified certain positive findings including numbness and tingling in his right lower extremity along with back pain and paresthesias. (PX12).

On cross-examination, Dr. Rahman indicated that he relied on Petitioner's history as to his pain starting on January 21, 2015 and that there was no way to determine whether those findings were brought on by an acute event versus the progression of his disease process. He agreed that Petitioner indicated that he was closing a trailer door, but he did not have any knowledge what force or effort that took. He indicated that he relied on Petitioner's history that the symptoms that he reported actually started on January 21, 2015. He agreed that it was possible that, given his disease process, those symptoms could have developed without any type of trauma. (PX12).

On cross-examination, Dr. Rahman agreed that the surgery he recommended was for the degenerative condition that he identified in his review of diagnostic studies and his examination, and that the purpose of the procedure was to relieve the pressure on Petitioner's spinal cord and to stabilize his spine. He agreed that he did not alter the restrictions imposed on Petitioner by Dr. Fabrique. He testified that he always recommended that patients stop smoking before he performs surgery, but rarely did patients follow his recommendations in terms of smoking. He agreed that there could be a delay in the healing process. (PX12).

On cross-examination, Dr. Rahman agreed that his opinion that there was an aggravation of the pre-existing condition was based on his believing the history that Petitioner gave was correct. He agreed that if Petitioner presented to a physician saying that he could only ambulate with the use of a crutch and surveillance film showed otherwise it would possibly put credibility into question. He agreed that given the facts that there was a degenerative condition and there were no acute findings, the sole basis for giving an opinion on causal connection was believing the veracity and accuracy of the patient. He agreed

that before he performed any type of surgical intervention, he would want to see Petitioner again. (PX12).

On redirect examination, Dr. Rahman testified that if there was severe force, rotation, deceleration or acceleration related to his back during the course of the accident, the instability in his lumbar spine could cause irritation and compression of the nerve which could start a cascade of symptoms. He agreed that the symptoms in the right lower extremity were from the radiating symptoms in his low back. He agreed that he noted nothing in his report that Petitioner either exaggerated or misled him in regard to his symptoms or how he was injured. He agreed that his opinions would not change if Petitioner had some sort of low back injury either 10 or 20 years ago. He agreed that if Petitioner had a flare-up a year prior but did not seek any medical treatment for it, this would not change his opinions. (PX12).

On redirect examination, Dr. Rahman agreed that Petitioner's need for surgery was related in part to the aggravation of his degenerative condition that his January 21, 215 workplace injury provided. He agreed that there were no restrictions to his understanding that Petitioner was required to ambulate with a cane or a crutch and that he did not place Petitioner under those restrictions. He agreed that it would be fair to say that someone in Petitioner's condition had good days and bad days, that there might be days that Petitioner would be able to ambulate without a cane and that there were some days that he would have to ambulate with a cane. He agreed that it was his practice to rely upon the history as given to him by his patient. (PX12).

On re-cross examination, Dr. Rahman testified that the incident in question because of the laxity in the bones could have irritated the nerve. He agreed that given Petitioner's degenerative condition, any activity could have aggravated it and that there was nothing in the medical exam, MRI or CT scan findings that showed what he alleged actually occurred. (PX12).

On further redirect examination, Dr. Rahman clarified that the instability would make Petitioner more prone to nerve irritation or compression. He testified that it was possible that the closing of the trailer door possibly would have worsened his symptoms in regard to the instability. (PX12).

The evidence deposition transcript of Spine Consultants, LLC's Office Manager, Lisa Mackey, was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. Ms. Mackey testified that she was the office manager for Spine Consultants and that she managed everything in the office. She testified that she spoke to Mr. Maciorowski prior to the deposition about improperly served subpoenas. She testified that Mr. Maciorowski indicated to her that Ms. Shay-Williams was to contact his office and they would respond to the subpoena on their behalf. (PX13).

With respect to Petitioner's Exhibit 5 to the deposition transcript, Ms. Mackey testified that she was unable to locate her copies of the subpoena but that Spine Consultants did send a disk complying with the subpoena. She testified that she had no involvement in gathering the information that was sent on the disk. She testified that she had involvement with sending one disk of information to Mr. Maciorowski's office, which contained the records they had. She testified that she did not know whether they were the same records sent to Shay & Associates. She testified that subpoenas received related to Petitioner's case were being sent to Mr. Maciorowski to ensure that they were properly served. (PX13).

Ms. Mackey testified that she did not receive a phone call from Mr. Maciorowski indicating that there were records on the disk that he received that were not on the disk that Shay & Associates received. She testified that there was no information that was relayed to her from Mr. Maciorowski's office that the disk that he received had additional information than the disk that Shay & Associates received. She testified that she had nothing to do with the disk that was sent to Shay & Associates. She testified that

she asked her staff to make a copy of the record and that she delivered a disk to Mr. Maciorowski's office. (PX13).

Ms. Mackey testified that she could not comment on the medical services that were provided by the physician, and that she scheduled IMEs and if necessary, sorted records. She testified that she had knowledge of the billing aspect of IMEs. She testified that the check that was sent from Exam Works to Spine Consultants was for the examination of Petitioner as well as other exams not pertaining to Petitioner. Petitioner's Deposition Exhibit 2 was for the June 5, 2015 IME that was billed to Exam Works, which was not paid. Petitioner's Deposition Exhibit 3 was the billing for the July 14, 2015 addendum for a records review, which was billed to Maciorowski, Sackmann & Ulrich but had not yet been paid. Petitioner's Deposition Exhibit 4 was the billing for the July 29, 2015 records review that was billed to Maciorowski, Sackmann & Ulrich and had been paid. (PX13).

With respect to the March 6, 2015 report, Ms. Mackey testified that there were four names listed at the top of the report – Jenna Redland, Melissa Katzman, Patrick Foley, and Robert Maciorowski -- and that the first three names were associated with Exam Works. She testified that these were the contacts they had listed in the patient's chart. She testified that the March 16, 2015 report was finalized on March 20, 2015 and was sent to Ms. Katzman, Ms. Redland and Mr. Foley on both March 20th and April 22nd by fax. With respect to the June 5, 2015 report, she testified that the four names listed at the top of the report – Jenna Redland, Melissa Katzman, Patrick Foley, and Robert Maciorowski – were the contacts associated with the file, and that the report was finalized on June 26, 2015 and sent to Ms. Katzman, Ms. Redland and Mr. Foley on June 26th by fax. She testified that the reports were sent with the entire chart based on Exam Works' protocol. She testified that they only sent IME paperwork to the people who requested the IME. She testified that the June 5, 2015 IME was scheduled by Exam Works, and that the March 6, 2015 was also requested by Exam Works. (PX13).

Ms. Mackey testified that the July 14, 2015 report was completed on July 27, 2015 and was sent to Mr. Maciorowski by fax. She testified that on July 28th the records were faxed to Mr. Maciorowski. She testified that the report was completed on July 27th. She testified that the July 29th addendum was completed on August 5th and was faxed to Mr. Maciorowski on August 6th and was also faxed to Ms. Brianne Bobcott at Exam Works on August 14th. She testified that Petitioner's Deposition Exhibit 6 was sent to Mr. Maciorowski's office via fax on July 28th. (PX13).

On cross-examination, Ms. Mackey agreed that she and Mr. Maciorowski had conversations about subpoenas she had received in the case, and that Mr. Maciorowski had indicated that some were improper. She agreed that Mr. Maciorowski indicated that he would represent Spine Consultants any time when they had an issue with a subpoena regardless of which case it was for, and that he asked her to let him handle the subpoenas in this case. She agreed that when the second subpoena was received, he told her to get the records to him for that subpoena and that on the Friday of the week prior to the deposition, he had contacted her and indicated that he did not have the records yet. She agreed that she dropped the records off to Mr. Maciorowski's office, that there was only one disk, and that he was not at the office on Friday. (PX13).

The evidence deposition transcript of Spine Consultants, LLC's Financial Advisor, Tony Garcia, was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Mr. Garcia testified that he was the Financial Advisor who performed billing and medical records-related requests. He testified that his work included billing related to IMEs as well as medical records requests. He testified that he sent the medical records to Shay & Associates for the August 24, 2015 request. He testified that to his knowledge the disk that was sent to Shay & Associates was the full and complete set of records for Petitioner, but he thought perhaps an addendum was missing. He testified that their system was not "acting well" at the time, and if something was missing then he would have faxed the missing documentation. He testified

that there was no reason that he knew of as to why Mr. Maciorowski would have been sent two disks while Shay & Associates was only sent one. He testified that he may have sent two disks of the same information. (PX14).

Mr. Garcia testified that it was possible that an addendum was missing the disk that was sent to Shay & Associates' office, but he did not know. He testified that there was an issue with their system concerning things that did not go in, which was why they had people calling their office requesting that another disk be sent. He testified that there were issues with the system after an upgrade. (PX14).

With respect to Petitioner's Deposition Exhibit 1, Mr. Garcia testified that it was a check for IME services performed by the physician, and that one of the charges for $1,500 pertained to Petitioner. He testified that the check was issued by Exam Works, that the date of the check was April 6th and that it pertained to the March 6, 2015 IME. He testified that he had no involvement with the IME reports, and that he was not responsible for sending out the March 6, 2015 IME report. (PX14).

Mr. Garcia testified that he believed that the office manager was responsible for sending out the IME report, but testified that it was not his responsibility. He testified that he thought that the first payment was received for the June 5th IME at some point in the middle of June. With respect to Petitioner's Deposition Exhibit 2, Mr. Garcia testified that it was the charge for the June 5, 2015 IME, that it was billed to Exam Works, and that it was still outstanding. With respect to Petitioner's Deposition Exhibit 3, Mr. Garcia testified that it was the charge for the July 14, 2015 record review and was billed for $250 to Maciorowski, Sackmann & Ulrich. With respect to Petitioner's Deposition Exhibit 4, Mr. Garcia testified that it was the charge for the July 29, 2015 record review, that it was billed in the amount of $500 to Maciorowski, Sackmann & Ulrich, and that the billing had been paid. He testified that the only billing that was outstanding on the account was that for the billing reflected on Petitioner's Deposition Exhibit 3. (PX14).

The DMH Medical Group records were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Petitioner was seen at DMH Express Care East on May 30, 2015 with complaints of sudden onset of stomach pain since last night. It was noted that Petitioner was currently nauseated and had 10/10 pain which improved after vomiting. Petitioner was sent to the Emergency Room for further evaluation and management. (PX15).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 16.

Petitioner's *Revised Petition for Penalties and Motion to Strike July 29, 2015 Addendum and Certain Opinions of Dr. Jesse Butler Regarding the July 29, 2015 Addendum* was entered into evidence at the time of arbitration as Petitioner's Exhibit 17.

The Dr. Holder October 21, 2015 Office Note and Off Work Slip for Temporary Total Disability Benefits was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. Petitioner was seen on October 21, 2015 with a complaint of acute increase/exacerbation of his chronic low back pain. Petitioner reported a sudden increase of low back pain in the past week, up to 10/10 in severity. Petitioner could barely walk because of pain. Petitioner noted that the pain was better if he stopped and rested. Petitioner was unable to sleep due to pain. Petitioner denied any recent trauma, falls or heavy lifting. Petitioner reported that he had only been sitting/answering phones at work. Petitioner stated that his symptoms were the same as they were in March. Petitioner reported back that was located primarily mid lower back with some radiation toward the right side. Petitioner denied any recent associated radiation of pain down either leg, although it was noted that he previously had a history of pain radiating down the right leg to the toes. Petitioner reported that he was not able to go to Occupational Health for

treatment. Petitioner stated that he was denied because they thought he had gone fishing with his son-in-law a few months ago. Petitioner stated that he had been in the St. Mary's Emergency Room yesterday for evaluation of severe back pain, and given a prescription for Norco. The records reflect that Petitioner was pleasant and smiling, and that he walked gingerly with halting steps and a cane in his right hand. The Assessment was that of (1) Cigarette smoker; (2) acute exacerbation of chronic low back pain; (3) obesity; (4) spinal stenosis; (5) spondylolisthesis. Petitioner was recommended to undergo lumbar spine x-rays, consult Dr. Rahman for further evaluation of increased back pain, given a renewal of his Hydrocodone, instructed to continue all other medications as previously ordered, and given an off work slip taking him off work until further notice. (PX18).

The Temporary Total Disability Payment History was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Medical Payment History was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

Documentation regarding Petitioner's Prior Claims was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Petitioner previously was involved in case numbers 86 WC 80660 (which was filed against A.E. Staley Manufacturing Company on February 24, 1986 related to which settlement contracts were approved on March 17, 0987 for 4% MAW); 93 WC 39148 (which was filed against Arkansas Best Corporation on July 23, 1993 related to which settlement contracts were approved on January 25, 1994 for 3.5% MAW); and 95 WC 64979 (which was filed against ABF Freight Systems, Inc. on December 6, 1995 related to which settlement contracts were approved on July 23, 1996 for 17.5% of the right arm). (RX3).

A Facebook posting for Robert Weilmuenster dated May 30 at 8:41 p.m. was entered into evidence at the time of arbitration as Respondent's Exhibit 4. A photo depicting multiple fish was featured on the posting, along with the caption "Not a bad day for me and my father in law had limit by noon." (RX4).

Various surveillance videos were entered into evidence at the time of arbitration as Respondent's Exhibit 5. The undated Wal-Mart video clip showed Petitioner standing upright and pushing a cart and did not reflect Petitioner demonstrating any type of altered gait; furthermore, Petitioner did not appear to be leaning onto the cart for support. The July 18, 2015 Robinson Group video showed Petitioner walking without any assistive device in an upright, fluid fashion and that Petitioner was carrying two plastic bags in his left hand. Petitioner was seen walking to the front porch of a residence, and then around the side to the back of the residence. Petitioner was then seen walking back to a red truck in a fluid fashion, again without any type of assistive device. Petitioner appeared to get inside the vehicle without any obvious difficulties. Petitioner was also seen walking into a Wal-Mart store pushing a shopping cart, and did not appear to be leaning onto the cart for support. Petitioner was seen at the Pharmacy counter, and at one point lifted his right leg up onto the bottom portion of the cart and rested his foot on the bottom rack of the shopping cart. Petitioner was also seen walking into a Casey's store using his cane. (RX5).

The transcript of the evidence deposition of Dr. Jesse Butler was entered into evidence at the time of arbitration as Respondent's Exhibit 6. Dr. Butler testified that he is an orthopedic spine surgeon and was certified in Orthopedic Surgery and Independent Medical Exam. Dr. Butler testified that approximately 25% of his time was spent doing IMEs and depositions as compared to care and treatment of patients. (RX6).

Dr. Butler testified that as part of any IME, he had the patient fill out the IME Patient Demographics and Information forms. With respect to Petitioner's Demographics information, Dr. Butler testified that smoking hds a direct negative impact on the potential for healing of a spinal fusion, and that it was a major comorbidity for complications associated with spine surgery. Dr. Butler testified that

Petitioner's pain scores and pain medication demonstrated that his own report of his pain required him to take four tabs of pain medicine a day, that his pain scores varied from a 4 to a 9 and he delineated some of his limitations, indicating that he could only walk when using a crutch or stick. (RX6).

Dr. Butler testified that he performed a physical examination of Petitioner on March 6, 2015. Dr. Butler testified that the history from Petitioner was that of an injury on January 22, 2015 while working as a spotter moving trailers. Petitioner stated that he was closing a trailer door at the time of the injury, that the doors did not line up and that he was "slapping" the door and pushing with the opposite hand to close the latch when he developed back pain. Petitioner complained of pain in the lower back that radiated to the right leg, that pain shot from the right buttock to the calf and foot, and that he had numbness and tingling as well. Petitioner reported that he was taking two pain pills at bedtime due to the discomfort, that he had difficulties lying on his back with the numbness present, and that he had been to 2-3 sessions of physical therapy with no relief. It was noted that Petitioner was currently using a cane for fear of falling as the leg had given way on several occasions, and that Petitioner stated that he pulled a muscle in his back 20 years ago but denied other injury to the back. Dr. Butler testified that he reviewed medical records of Dr. Ethiraj and Dr. Fabrique as well as Accelerated Physical Therapy. (RX6).

Dr. Butler testified that Petitioner appeared to be miserable, that he was limping as he came into the room, that he was leaning on a cane with both hands and that he had a very slow kind of unsteady gait. Dr. Butler testified that Petitioner's neurologic exam showed that he had some weakness of his plantar flexion on the right side and a loss of sensation in the L5 dermatome. Petitioner had no reflexes on his right lower extremity, no tenderness to palpation in the low back and he was able to flex 70 degrees but could not extend the spine at all. Dr. Butler testified that Petitioner could just barely stand straight up. (RX6).

Dr. Butler testified that the Oswestry Disability Index was basically a patient's perspective on how their pain interfered with basic activities of daily living, and that the index was used frequently in peer reviewed medical literature. He testified that Petitioner reported that in terms of walking, he scored a Level 4, that the scoring was between 0 and 5, that the higher the score the worse the function, and that he reported that he could only walk using a stick or crutches. (RX6).

Dr. Butler testified that he reviewed the scan for the MRI of the lumbar spine from February 17, 2015, and that the scan revealed a spondylolisthesis at L5-S1 with approximately 11 mm of subluxation of L5 on S1, that he had severe foraminal stenosis bilaterally, and that there was also a compensatory retrolisthesis of 7.5 mm at L4/5 with severe foraminal stenosis. He testified that Petitioner also had some central canal stenosis due to the degenerative findings present in the facets, and that the L3/4 level had some degeneration but no stenosis and L2/3 and proximal were all normal. He testified that stenosis was narrowing of a structure, and referred to a reduction in the size of the lumen. Dr. Butler testified that spondylolisthesis was a translation anteriorly of one vertebra upon the other and was graded based on the percentage of subluxation, and that Grade 1 was 25% up to Grade 2, which was 50%. (RX6).

Dr. Butler testified that the February 17, 2015 findings all predated January 21, 2015 as they were all degenerative findings that took years to develop. He testified that he did not see any evidence on the MRI scan of February 17, 2015 of any acute injury. He testified that his diagnoses were that of lumbar degenerative disc disease with spondylolisthesis and spinal stenosis primarily affecting L4/5 and L5/S1 levels. He testified that he opined that Petitioner's medical care and treatment to the date of the examination was reasonable and necessary, that Petitioner could work at a sedentary capacity with a 10-lb. lifting restriction, that he should be allowed to sit and stand as tolerated, and that there should be limited twisting and stooping. Dr. Butler testified that at that point in time he opined that he believed that there was a causal connection to the work incident by way of aggravation of a preexisting degenerative

condition, and that the condition was not caused by the injury as it was pre-existing. He testified that the primary basis for his opinion was that of the reliability of the history. (RX6).

Dr. Butler testified that he performed a second IME on June 5, 2015, at which time Petitioner completed another IME Medical History form. Dr. Butler testified that Mr. Maciorowski wrote a May 27, 2015 letter asking certain questions to be considered at the time of the exam. He testified that he generated the report dated June 5, 2015 as a result of the examination performed. He testified that there were additional medical records that were considered at the time of the examination, including a February 11, 2015 note with Sheehy, PA and Dr. Rahman. Petitioner reported that he had been working three days a week since his last evaluation, that he had been unable to complete a full week of work due to the back pain and that he had recently been taken off work by St. Mary's physicians. (RX6).

Dr. Butler testified that Petitioner was using a cane in his right hand, and that Petitioner noted that he had undergone an emergency appendectomy the past Saturday. Petitioner continued to have poor tolerance for most activities of daily living, and that at rest he was 3/10 but with activity it went up to 8-9/10. He testified that Petitioner presented with a cane, and that he again presented with a limp. He testified that the physical examination findings were consistent with the last examination where he was limping, using a cane with both hands, and walking very slowly with a labored effort. Petitioner had persistent weakness in his calf, numbness in the outer aspect of the calf and dorsum of the foot, and no reflexes on the right side. Petitioner had more tenderness to palpation over his back this time, and his flexibility had been worse with flexion of only hands to the knees. Petitioner again completed the Oswestry Disability Index, indicating that he could only walk with a stick or crutches. He testified that he reviewed no additional diagnostic testing, and that his diagnosis remained the same as did his opinion regarding Petitioner's ability to work. He testified that he felt that Petitioner needed to strongly consider a smoking cessation program as he was apparently not doing well with conservative treatment, and that in order for him to be a reasonable candidate for any surgery he would have to stop smoking. He testified that Petitioner would also need to have medical clearance as he likely had some underlying comorbidities that had not yet been diagnosed given his overall lack of physical fitness, obesity and many-year smoking history. He testified that from a treatment standpoint, it appeared that he was likely to require surgery in the form of a laminectomy and fusion. (RX6).

Dr. Butler testified that in his report of June 5, 2015 there was no review made by him of any surveillance as he did not have any surveillance as of that date. He testified that he eventually reviewed undated video that showed Petitioner entering a Wal-Mart store with a shopping cart walking at a brisk pace without an assistive device, walking with a normal gait and displaying no pain behavior. He testified that there was surveillance from July 18, 2015 which showed Petitioner walking in the yard with two bags in his left hand at a normal pace without any pain behavior, and that he stood tall and walked without a limp. He testified that the video further showed Petitioner carrying a bucket and dumping the contents over a railing. He testified that Petitioner was then seen driving a motor vehicle and stopped at a store. Petitioner pushed a shopping cart and was seen standing at a pharmacy check-out counter without difficulty, and he was standing and bearing weight equally and independently with the shopping cart in front of him. He testified that on July 24th, the video showed Petitioner using a cane, that he drove, parked and walked toward a hospital or medical clinic, and that his gait was slower and more deliberate as he approached the building. Petitioner was later seen smoking, sitting on a porch with a cane on his lap and the video showed him smoking multiple cigarettes with two younger people over the course of about 20 minutes. (RX6).

Dr. Butler testified that the video that he saw of Petitioner walking into the medical facility showed that as he left his car, his gait changed and he started to lean on the cane a little bit more. He testified that Petitioner's presentation at Wal-Mart and at home was markedly different than the presentation that Petitioner exhibited to him. He testified that after the surveillance video, he changed his

opinion as to causal connection and the need for surgery. He testified that based on Petitioner's subjective symptomatology ambulating with both hands on a cane, his significant pain complaints and his difficulty with limited ambulation, it seemed as though Petitioner had aggravated his underlying degenerative condition. He testified that the video showed an obvious disconnect between Petitioner's demonstrated pain behavior in the office and that as demonstrated on the video. He testified that the Facebook post where it appeared that he had been fishing with his son-in-law was completely inconsistent with what he had observed in the office, and also having been informed that he needed a golf cart to pick him up from his vehicle to take him to the place where he would work. Also, the video demonstrated a significant abuse of nicotine that would make Petitioner an extremely poor risk for a spinal fusion surgery, independent of any of the causation issues. He testified that his opinion was in part also based on the fact that there were no acute findings on the MRI. (RX6).

As to the payment from Exam Works, Dr. Butler testified that "Tony" in his office tended to handle all collection issues, and that the issue of distribution of medical reports was within the knowledge of either "Tony" or "Lisa." (RX6).

On cross-examination, Dr. Butler agreed that with respect to the Visual Analog Pain Scale Assessment completed by Petitioner on March 6, 2015, Petitioner gave a range of his pain level with "4" being the best and "9" being the worst and that it was a fair statement that Petitioner's pain was better on some days and worse on others. With respect to his notes from the March 6th evaluation, Dr. Butler agreed that Petitioner provided a history that 20 years prior he had some sort of aggravation or injury to his back and that he believed that Petitioner was honest with him about that. He agreed that Petitioner did not note any sort of chronic low back pain prior to the January 21, 2015 accident. (RX6).

On cross-examination, Dr. Butler testified that 70 degrees for flexion was pretty close to normal for an individual with an abdomen like Petitioner's and his overall physical fitness, and that it was better than he expected based on the way Petitioner ambulated. He testified that the records referenced in his report were those that were provided to him and that there were only 13 pages of records. He agreed that the February 17, 2015 MRI showed degenerative findings, and that his opinion at that time was that Petitioner aggravated the pre-existing degenerative condition. He agreed that the fact that the MRI did not show any new acute findings was consistent with his causal connection opinion rendered at that time. He agreed that he was in agreement with the treatment for the injury at that point in time, and that Petitioner was able to at least do some lifting up to 10 pounds. He agreed that Petitioner was not someone who he indicated should do nothing, and that he encouraged Petitioner to at least try to do a little bit of exercise and movement. He agreed that he noted that Petitioner did not describe any pre-existing medical conditions that may have contributed to his current condition, and that as far as he was aware Petitioner was honest about some injury to his back some 20 years ago. (RX6).

On cross-examination, Dr. Butler testified that in the April 22, 2015 addendum he was asked to opine what the course of care might be for Petitioner, and that he had recommended physical therapy as well as epidural injections and ongoing home exercises as a course of conservative treatment. He agreed that if the conservative treatment was unsuccessful, then he recommended a spinal decompression and fusion from L4 to S1. (RX6).

On cross-examination, Dr. Butler testified that once the IME report was finalized and signed, his staff was involved with distribution. He testified that Lisa, the office manager, supervised the whole process and made sure that the reports were sent out, that Jill, the IME coordinator, sent out probably the vast majority of the reports, and that they communicated with Tony to make sure that the financial component had been taken care of in order to release the reports. (RX6).

On cross-examination, Dr. Butler testified that with respect to the April 22nd addendum, he thought it was generated based on a phone call from one of the Exam Works representatives wanting further summary of the prospective care to be offered and that they had suggested that he should have done so with the initial IME report and did not answer all of their questions to their satisfaction. He testified that the electronic medical records system did not allow for modifications after it was signed, so if anything was added/deleted/edited it was entitled an "Addendum" to indicate that it was entered at a later date. (RX6).

On cross-examination, Dr. Butler testified that the cover letter from Mr. Maciorowski for the June 5, 2015 IME was dated May 27, 2015 and he did not believe that he saw it until the date of the evaluation. He agreed that Mr. Maciorowski's letter indicated that when Petitioner was at work he ambulated with the use of a cane but the video of him shopping in Wal-Mart presented a different picture. He testified that the Wal-Mart video was not provided along with Mr. Maciorowski's letter. (RX6).

On cross-examination, Dr. Butler agreed that at the time of the June 5th IME, he had Petitioner complete another IME Medical History form, and that Petitioner again noted that he was a pack-a-day smoker. Dr. Butler agreed that as to the Visual Analog Scale Pain Assessment, Petitioner noted at best a 3 and at worst a 10 so he had a wider range of good days and bad days. With respect to his notes from the June 5th evaluation, Dr. Butler testified that he had been given authorization to obtain x-rays if needed but he did not order them because they had an accurate MRI scan that demonstrated the instability and, given Petitioner's pain responses at the time in the office, he did not feel it was necessary to answer the questions that he needed to answer. He agreed that Petitioner was headed in the direction of an L4/S1 laminectomy and fusion at that time. (RX6).

On cross-examination, Dr. Butler testified that the lumbar spine flexion of 45 degrees was significant in that Petitioner's mobility was worse despite what he noted as an improved pain score. He testified that Petitioner's Disability Index was essentially the same as it was before, and that Petitioner came into the office using the cane with both hands, had a very slow, cautious gait and was limping. Petitioner did not have the physical appearance, at least subjectively, that he was doing better and if anything, he looked worse. He testified that range of motion was subjective on the part of the patient. He testified that he did not specifically ask Petitioner about his walking capabilities as he was able to observe him using the cane while he was in the office. He indicated that when Petitioner came in to sit down on the sofa outside the exam room and then hen going into the exam room, he looked miserable. He testified that he did not ask Petitioner whether there were any instances in which he was able to walk without using a stick or crutches, and that he did not do so because Petitioner indicated that he could only use a stick or crutches and took his word on the issue. (RX6).

On cross-examination, Dr. Butler agreed that in the June 5, 2015 report he indicated that Petitioner would be a reasonable candidate for additional medical care and treatment, and that a two-level decompressive laminectomy and spinal fusion would be the most appropriate treatment to remedy the condition. He testified that he recommended such treatment because Petitioner had high pain scores, significant limitations in his activities of daily living and a very high Oswestry Disability Index, and that he had neurologic impairment on his physical exam. Furthermore, Petitioner had attempted physical therapy with no success, was two-handing a cane limping into the office and appeared miserable, and that he had objective pathology on the MRI that seemed to correlate with his complaints. He testified that Petitioner was not happy with him when he suggested that Petitioner could continue to work in a sedentary capacity. He agreed that he recommended medical clearance and smoking cessation. (RX6).

On cross-examination, Dr. Butler testified that the office records reflect that the report was sent to Exam Works on June 26, 2015, and that his report was finalized on June 26, 2015 at 8:43 a.m. and was probably sent out later that day. (RX6).

With respect to the June 11, 2015 letter from Mr. Maciorowski, Dr. Butler testified that he had enclosed the CT of January 22, 2015, that he reviewed the CT and that it showed similar findings as the MRI. With respect to the June 26, 2015 letter from Mr. Maciorowski, he provided subpoenaed records from Accelerated Rehab and St. Mary's along with the MRI and CT. Dr. Butler testified that the July 14, 2015 addendum essentially had one or two extra pieces of information from Dr. Fabrique, and that the July 29th addendum had additional medical records and the surveillance. He testified that this was when he had the actual surveillance footage to review, but that he did not know when he received it but it was a fair statement that it was at some point after June 26, 2015. (RX6).

On cross-examination, Dr. Butler agreed that the Wal-Mart video was undated, and that he did not have an opinion as to when it was obtained because there was no date. As to the other surveillance video, the July 17th video was basically footage of his house. Dr. Butler agreed that he had provided weight restrictions of 10 pounds, but that Petitioner was seen carrying a five-gallon bucket, that he had two of them in his hands and he appeared to be leaning to the one side. Dr. Butler testified that you could see Petitioner with bags of groceries that he was carrying in his left hand that looked like they weighed in the range of 5-10 pounds, and he further agreed that they were under the 10-pound weight limit he had provided. Dr. Butler agreed that Petitioner had openly admitted that he smoked a pack per day, and that he was unable to testify whether he smoked them all at once or whether he smoked them throughout the day. (RX6).

As to the IME Medical Histories wherein Petitioner gave ranges of 4-9 and 3-10 on the pain scale, Dr. Butler agreed on cross-examination that it meant that Petitioner had good and bad days. When asked if it was fair to say that there may be days where Petitioner was able to walk a little better, Dr. Butler testified that it seemed inconsistent with what he had indicated at the two IMEs. He testified that when Petitioner showed up for the IMEs, he was two-handing a cane, had tremendous pain behavior and looked miserable. Petitioner reported at those times – in the office -- his pain scores were a 4 and a 3, and that at those levels he was still two-handing a cane. He testified that if Petitioner needed to two-hand a cane for a pain score of a 3-4, what he saw on the video was completely inconsistent with what Petitioner told him. (RX6).

On cross-examination, Dr. Butler agreed that pain varied and that Petitioner indicated that the pain varied, but stated that Petitioner completely misrepresented his pain in the office. He testified that if that was a 3 or 4, then what he saw on the video was a "negative 6." He agreed that he did not know when Petitioner had taken his pain medication prior to the video having been recorded, and he agreed that the entire day was not recorded and that these were limited points in a day. He agreed that some of the shots showed that he parked right in front of the building, and that there were videos showing Petitioner using a cane. He testified that he did not agree that the videos showed Petitioner "relying on" the shopping cart, that he had seen people who walk and rely on the shopping cart and Petitioner did not have that type of gait when seen using the cart. He agreed that Petitioner was seen using a cane when he was at a medical clinic, but not otherwise. He agreed that a shopping cart could be used as an assistive device. (RX6).

On cross-examination, Dr. Butler agreed that there were various points in the video where Petitioner used a cane outside of just walking into a medical facility such as that when he was shown with family members arising from a chair outside of a residence using a cane to get himself up after smoking. He testified that the footage showing him walking through the yard was the most extensive walking he had seen Petitioner do, but that generally speaking these were short distances. He agreed that the videos were given to him after the IMEs had been performed and that he was unable to ask Petitioner about the footage. He testified that he was not sure who provided the videos. (RX6).

With respect to an undated interoffice memorandum authored between July 1 and July 6, Dr. Butler testified on cross-examination that he believed that a no-charge addendum report was requested by Exam Works. He testified that he was on vacation during that time so he was unable to participate in any of the conversations. He testified that he completed the July 29, 2015 report on August 5, 2015. (RX6).

On cross-examination, Dr. Butler testified that in addition to the surveillance video, he was also given a Facebook entry to review. He testified that he believed Robert Weilmuenster was Petitioner's son-in-law based on Mr. Maciorowsi, and it was his understanding that the father-in-law referenced in the posting was that of Petitioner again based on Mr. Maciorowski. He testified that it was his understanding that Petitioner was divorced, but he did not know whether Petitioner's wife had remarried. (RX6).

With respect Petitioner's appendectomy, Dr. Butler testified on cross-examination that he did not have the operative report so as to indicate the date on which the surgery was performed. He testified that when he had his appendix out, he was driving a tractor and working in the fields on the day of his surgical procedure. He testified that Petitioner's CT of the abdomen and pelvis from May 30th was performed at 3:18 p.m., which gave him several hours in the day prior to that to "hit the lake" and go fishing. He testified that even if the evidence were to show that Petitioner was not fishing it would not change his opinion, as the video "in and of itself is enough to change my opinion." He testified that the video showed a marked discrepancy in Petitioner's observed behavior and that which he showed during his office evaluations. He testified that the video was not necessarily ironclad, but "when you have different days of behavior that I observed and you see such a tremendous discrepancy in behavior, it raises questions to the validity of their history which is essentially the basis for your causal connection opinion." (RX6).

On cross-examination, Dr. Butler testified that it was no longer his opinion that the January 21, 2015 workplace injury aggravated Petitioner's underlying condition because the establishment of that mechanism of injury as a causal connection relied on the validity of the historical account. Dr. Butler testified that if Petitioner was deemed an unreliable historian and/or was inaccurate in how he presented himself, then it raised questions regarding the validity of that mechanism of injury. He testified that the establishment of causation was based on the reliability of Petitioner's history, and that Petitioner had underlying conditions that could be aggravated by tying his shoes, getting in and out of bed, or stooping to do the dishes. He testified that Petitioner's underlying degenerative disease was so severe that blowing his nose could cause his right leg to hurt and have an aggravation, as could be closing a trailer door. He testified that when you found the history may be less than reliable, the establishment of causation was difficult to state to a reasonable degree of medical and surgical certainty. (RX6).

On cross-examination, Dr. Butler agreed that he recommended surgery following both the March and June IMEs with the knowledge that Petitioner smoked a pack a day. He agreed that he indicated that Petitioner was not a good surgical candidate. Dr. Butler testified that there was a difference between needing surgery and being a good surgical candidate. When asked if it was his opinion that Petitioner still needed the surgery that he proposed, Dr. Butler testified that Petitioner had objective findings on his imaging studies that had been there for years and that Petitioner had functioned well. He testified that there was a disconnect between what he had seen clinically in the office and what he had seen on the video, and that he did not now know whether Petitioner needed surgery. Dr. Butler testified that the indications for surgery were based on a combination of the subjective and the objective. (RX6).

On cross-examination, Dr. Butler agreed that it was fair that his July 29, 2015 addendum was based solely on surveillance videos and the Facebook entry of May 30, 2015. He testified that the changes in his opinions -- even if the Facebook posting was not referring to Petitioner – were based on the surveillance video that he saw. Dr. Butler confirmed that he did not have the videos during the June 5, 2015 IME. (RX6).

When asked on cross-examination how much he spent with Petitioner on March 6, 2015, Dr. Butler testified that he did not know specifically but that the appointments were scheduled for 30 minutes. He testified that if all 30 minutes were not spent directly in the room with the patient, it was spent reviewing studies, talking to the patient and preparing the report. Dr. Butler further testified that he did not know specifically how much time was spent with Petitioner at the time of the June 2015 IME, but it would be the same. (RX6).

On cross-examination, Dr. Butler testified that 25% of his practice was spent performing IMEs and that over 90% were performed at the request of the respondent. He testified that he performed 500-600 IMEs per year, and that a fairly small number were performed for Zurich per year such as 10. Dr. Butler testified that he believed that he performed 12 or fewer IMEs per year in which the Respondent's attorneys were Maciorowski, Sackmann & Ulrich. He testified that he charged $1500 per IME, and that included review of medical records. He testified that the addendum cost varied depending on how long it took to complete it and that it was billed in 15-minute increments. (RX6).

On redirect, Dr. Butler agreed that given Petitioner's preexisting condition any activity could aggravate the condition. He further agreed that based on his physical exam and the diagnostic studies, there was no objective evidence that the activity that Petitioner complained about actually aggravated the condition. (RX6).

Respondent's *Response to Petitioner's Revised Petition for Penalties and Motion to Strike July 29, 2015 Addendum and Certain Opinions of Dr. Jesse Butler* was entered into evidence at the time of arbitration as Respondent's Exhibit 7.

The Robison Group report pertaining to surveillance performed during the timeframe of July 17, 2015 and July 24, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

CONCLUSIONS OF LAW

In regard to Petitioner's *Motion to Strike July 29, 2015 Addendum and Certain Opinions of Dr. Jesse Butler Regarding the July 29, 2015 Addendum*, the Arbitrator finds that Petitioner has failed to allege a valid statutory or factual basis on which to strike the July 29, 2015 Addendum and any reference to it in Dr. Jesse Butler's evidence deposition.

The Arbitrator further finds that Petitioner has failed to prove that Respondent in any way tampered with, altered or modified the July 29, 2015 report prepared by Dr. Butler, nor has Petitioner proven that Respondent engaged in fraudulent concealment of either the June 5, 2015 or July 14, 2015 reports issued by Dr. Butler. The Arbitrator notes that had Petitioner desired to proceed to 19(b) hearing during the July 2015 Springfield docket, Petitioner could certainly have done so based upon the reference to the work accident in the medical records of Petitioner's treating physician, Dr. Rahman, as well as the prior IME report and Addendum prepared by Dr. Butler dated March 6, 2015 and April 22, 2015, respectively.

As such, the Arbitrator holds that the entirety of Dr. Butler's testimony and opinions are to be properly considered and weighed as part of the evidence in this case. As a result of the foregoing, Petitioner's *Motion to Strike July 29, 2015 Addendum and Certain Opinions of Dr. Jesse Butler Regarding the July 29, 2015 Addendum* is hereby denied.

In regard to disputed issues (C) and (F), given the common evidence and facts relative to both issues, the Arbitrator addresses them jointly.

The Arbitrator finds Petitioner not to be a credible witness, as he did not appear to be candid in his testimony and demeanor at Arbitration. Petitioner testified at the time of arbitration that his back was hurting, yet the Arbitrator notes that Petitioner was able to sit on an unpadded chair in the hearing room for more than five hours straight -- with only one very brief recess taken at the insistence of the Arbitrator – with no visible or oral indication made at any point in time by Petitioner of his being in any way, shape or form uncomfortable. The Arbitrator notes that Petitioner made no indication of any need to get up from his chair or to stretch, nor did he make any indication of any need to walk around the room or that he was in any type of discomfort. The Arbitrator finds it to be nearly incomprehensible that Petitioner would be able to sit for such an extended period of time without making *some* kind of outward indication of pain.

Furthermore, the Arbitrator admittedly finds it difficult to reconcile the fact that that Petitioner cancelled an appointment with Dr. Rahman -- whom he had not seen since April -- that had been scheduled for the day of arbitration, in light of the notations made in Dr. Holder's record of October 21, 2015, wherein she noted that literally only eight days prior to arbitration he could barely walk because of pain and that he was unable to sleep due to his pain. (PX18). Additionally, the Arbitrator also finds to be incredulous the fact that there was even any discussion of Petitioner going fishing with Mr. Nausley and Mr. Weimunster after the arbitration hearing concluded as testified to by Ms. Weilmuenster, as the Arbitrator would have expected that the basis for Petitioner's declining such a suggestion to be based on his purported condition of ill-being rather than his lack of a valid fishing license. Finding it to be troubling the fact that Petitioner's Application for Adjustment of Claim was signed by Petitioner on February 9th which before he even completed his treatment at St. Mary's Occupational Health and Wellness, the Arbitrator places no evidentiary weight on his testimony as it pertains to the alleged accident of January 21, 2015.

The Arbitrator finds that the surveillance video which showed Petitioner on multiple occasions to be ambulating without difficulty and without any type of assistive device to be significant in this matter and places great weight on this evidence. The Arbitrator finds it to be incredible that over the brief amount of time that surveillance was performed by the Robison Group the investigators were able to obtain multiple video clips showing Petitioner to be ambulating without difficulty and without the use of his cane or any type of assistive device, yet Petitioner at the time of arbitration testified that he estimated that he used his cane approximately 90% of the time and did not use his cane approximately 10% of the time. Petitioner testified at the arbitration hearing that he "leaned" on Wal-Mart shopping carts, but the video taken by his co-worker, Mr. Binkley, suggested otherwise, as did the Wal-Mart store footage secured by the Robinson Group investigators. The Arbitrator further points out that Petitioner testified that for distances 50 feet and closer, he sometimes tried not to use his cane but noted it was "rare." The Arbitrator finds it hard to believe that the video taken on July 18th showing him walking to his daughter's residence without the use of his cane or any type of assistive device in such a fluid and upright manner was one such "rare" instance. The Arbitrator finds Petitioner's testimony regarding his use of his cane to be self-serving in light of the surveillance performed, and notes that even his family members -- Ms. Weilmuenster, Mr. Weilmuenster, and Mr. Nausley -- testified that they typically saw Petitioner ambulating with his cane, and yet there were multiple instances of surveillance footage that clearly indicated otherwise.

The Arbitrator notes that Petitioner's testimony at the time of arbitration about his use of the cane on a 90/10 basis was also wholly contradictory to his assertions to Dr. Butler, to whom he indicated on more than one occasion that he could not ambulate without the use of a stick or crutches. The Arbitrator notes that Dr. Butler examined Petitioner more frequently than Dr. Rahman, and Dr. Butler at the time of

his deposition testified as to Petitioner's noted "miserable" presentation at each of the IMEs. (RX6). Finding Dr. Butler to ultimately have had a greater basis on which to render his opinion on the issue of causation given the frequency with which he examined and observed Petitioner, the Arbitrator gives greater weight to the opinions of Dr. Butler in this case.

The Arbitrator notes that Dr. Butler testified that he eventually reviewed undated video that showed Petitioner entering a Wal-Mart store with a shopping cart walking at a brisk pace without an assistive device, walking with a normal gait and displaying no pain behavior. (RX6). He testified that there was surveillance from July 18, 2015 which showed Petitioner walking in the yard with two bags in his left hand at a normal pace without any pain behavior, and that he stood tall and walked without a limp. (RX6). He testified that the video further showed Petitioner carrying a bucket and dumping the contents over a railing. (RX6). He testified that Petitioner was then seen driving a motor vehicle and stopped at a store. (RX6). He testified that Petitioner pushed a shopping cart and was seen standing at a pharmacy check-out counter without difficulty, and that he was standing and bearing weight equally and independently with the shopping cart in front of him. (RX6). He testified that on July 24th, the video showed Petitioner using a cane, that he drove, parked and walked toward a hospital or medical clinic, and that his gait was slower and more deliberate as he approached the building. (RX6). The Arbitrator takes note of the fact that prior to reviewing the surveillance at issue, Dr. Butler opined that he believed that Petitioner's alleged work accident had aggravated the pre-existing condition in his lumbar spine to the point at which he went so far as to recommend that Petitioner undergo surgery. Dr. Butler's opinions vastly changed after viewing the video, however, and he testified to an "obvious disconnect" between Petitioner's demonstrated pain behavior in the office and that as demonstrated on the video. Additionally, the Arbitrator notes that even Dr. Rahman agreed that his opinion that there was an aggravation of the pre-existing condition was based on his believing the history that Petitioner gave was correct, and that given the facts that there was a degenerative condition and there were no acute findings the sole basis for giving an opinion on causal connection was believing the veracity and accuracy of the patient. (PX12) As such, the Arbitrator notes that even Dr. Rahman, Petitioner's own treating physician, conceded that he based his causation opinion on the credibility of Petitioner.

Furthermore, the Arbitrator finds to be intriguing that Petitioner denied that Dr. Butler cautioned him on cigarette smoking and the affect that would have on the recovery of his surgery, and that Petitioner in fact denied that *any* doctor ever cautioned him on the effect of cigarette smoking and surgery to his back. Both Drs. Rahman and Butler testified, however, that they counseled Petitioner regarding his need to stop smoking, and their respective medical records included reference to same. (PX7; PX12; RX6). As such, the Arbitrator finds Petitioner's testimony on this particular issue to be incredulous and further supportive of the finding that Petitioner's testimony was not credible at the time of arbitration.

The Arbitrator finds that the May 30, 2015 Facebook posting that was entered into evidence at the time of Arbitration as Respondent's Exhibit 4 to be irrelevant given the evidence proffered at the time of arbitration by multiple witnesses called by Petitioner that established that he was not the father-in-law being referenced in the Facebook posting, and the further support of the medical record gfvs from both DMH Medical Group (PX15) and St. Mary's Hospital (PX3) that demonstrated that Petitioner had sought emergency medical treatment for appendicitis on the very date of the posting. As such, the Arbitrator places no weight on Respondent's Exhibit 4.

As a result of the foregoing, the Arbitrator finds that Petitioner's appearance and demeanor at the time of the arbitration hearing was consistent with his presentation on the surveillance video entered into evidence at the time of arbitration, and finds that Petitioner has failed to prove that he sustained an accident that arose out of and in the course of his employment with Respondent on January 21, 2015. All benefits are denied. The Arbitrator finds that the remaining issues of medical bills, temporary total

disability benefits, prospective medical treatment, and penalties and attorney's fees are moot, and the Arbitrator accordingly makes no conclusions as to those issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martin Melanie,
Petitioner,
vs.

NO: 15 WC 29983

At&t aka At&t Services Inc ,
Respondent,

16IWCC0609

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 and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2016, is hereby affirmed and adopted.

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

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

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

DATED: SEP 2 2 2016
o022516
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

MARTIN, MELANIE
Employee/Petitioner

Case# **15WC029983**

AT&T AKA AT&T SERVICES INC
Employer/Respondent

16IWCC0609

On 2/25/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2904 HENNESSY & ROACH PC
PAUL BERARD
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MELANIE MARTIN,
Employee/Petitioner

v.

AT&T aka AT&T SERVICES, INC.,
Employer/Respondent

Case # **15** WC **29983**

Consolidated cases: _____

16IWCC0609

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **1/29/16**. 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, **1/6/15**, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned **$59,836.24**; the average weekly wage was **$1,150.70**.

On the date of accident, Petitioner was **61** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**. Respondent shall be given credit for STD benefits paid from 7/24/15 through 11/12/15.

Respondent is entitled to a credit of **$7,864.27** under Section 8(j) of the Act.

ORDER

Having found the petitioner did not sustain an accidental injury that arose out of and in the course of her employment by respondent on 1/6/15, the Arbitrator finds the petitioner's claim for compensation 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

2/14/16
Date

ICArbDec19(b)

FEB 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 61 year old customer service agent, alleges she sustained an accidental injury to her low back that arose out of and in the course of her employment by respondent on 1/6/15. Petitioner was hired by respondent on 11/3/03. On the date of the alleged accident petitioner was working on the 2nd floor in the credit and collections center. Petitioner transverses 2 staircases when she comes to work and when she leaves for the day. Petitioner also has the option of taking the elevator. On 1/6/15 petitioner was wearing flat snow boots that lace up.

Prior to this incident petitioner testified that she had received treatment for her low back and accompanying left leg pain about 4 years ago. She testified that she had no restrictions related to this treatment.

On 1/6/15 petitioner's shift was 9:30am-6:00pm. Once her shift was completed, petitioner left her office and began walking down the 2 staircases in order to get to the ground floor and exit the building to get to her car. Petitioner was only carry her purse. She was not carrying anything related to her work, and she was not rushing.

After she had reached the ground floor she realized she left her personal phone at her desk. Petitioner then turned around and began walking back up the stairs to retrieve her personal cell phone. She testified that as she got to about the 5th or 6th step from the ground her left foot got caught on a portion of a nonslip strip on the stair that was missing. The stair was not wet, and there was no debris. She stated that she slipped on the area where a portion of the nonslip strip was missing. Petitioner fell forward and grabbed the railing in an attempt to prevent herself from falling on her face. Petitioner felt a pull in her low back. She sat down on the step and cried for a while. She then got up, continued up the stairs, retrieved her personal cell phone, and then took the elevator down, and went home.

When she arrived at work the next day, she emailed her supervisor Dawn Haynes, and Richard Stoneburner her union rep and the building's Safety Rep, reporting the incident. She reported that she caught her boot on loose tread edge about 4-5 steps up from the bottom of the first floor. Stoneburner responded and indicated that he reported the issue "to have looked at/repaired." He told petitioner "Please let your manager know so she can file a "Wait and see" for you." No one from respondent's business ever discussed the incident with petitioner, or investigated the area with her, asking her where she actually tripped.

Petitioner testified that the nonslip strip on the step was 1/8 inch. The part where she claims she tripped had chipped away. Petitioner claims that her foot caught on the part of the strip were it was chipped away.

Approximately 2 days after the incident petitioner went to the area of the stairwell where she fell and took pictures of the step she fell on, as well as pictures of other stairs in the stairwell where the strip was raised. Petitioner then took additional pictures of the same stairwell 2 months ago. She noted that these photos showed that the non-slip strip had been removed from the step she tripped on.

On 1/15/15, Haynes called Worker's Compensation and filed a claim with respect to petitioner's injury.

Petitioner tried self treatment until July of 2015. When she had not realized any real improvement by then, she made an appointment with Dr. Bruns, a chiropractor. Petitioner presented to Dr. Bruns on or about 7/1/15. Between 7/1/15 and 9/22/15 petitioner saw Dr. Bruns at least 40 times, with petitioner's last 20 or so appointments showing no discernible improvement. During this period, petitioner's discomfort was noticeable 60% of the time, and her discomfort was no better than 6 out of 10, and on a couple visits was 7 out of 10.

On 8/8/15 petitioner presented to Dr. Bruns. He authorized her off work from 7/24/15 through 11/12/15. Dr. Bruns referred petitioner to Dr. Sureka at Midwest Orthopedics. Dr. Sureka ordered physical therapy. No physical therapy records were offered.

Two right sided L4-L5 transforaminal epidural steroid injections were performed by Dr. Sureka on 8/18/15 and 9/9/15. Petitioner's complaints were related to her right low back that at times goes into her thigh. Petitioner reported that she had epidural injections in the past with good benefit. Dr. Bell performed a third injection on 10/8/15. On 10/23/15 petitioner followed-up with Dr. Bell. She reported that the injection helped her pain by about 75%, but she was starting to get some recurrence of her pain. Petitioner complained of pain in her right low back with some occasional radiation down her right leg, but not usually past the right knee. She reported no pain on the left.

On 11/11/15 petitioner underwent an MRI of the lumbar spine. The L5-S1 disc showed severe loss of height and desiccation. No significant dorsal annular bulging was noted. Mild bilateral foraminal stenosis greater on the LEFT related to spondylitic spurring, mild bilateral facet arthritis, and patent central canal was also noted. The paraspinal soft tissues were within normal limits. The visualized sacrum was within normal limits. The nerve roots were free within the confines of the thecal sac. Mild

central canal stenosis was present at L2-L3, L3-L4, L4-L5 related to disc bulging. Hypertrophy of the ligmenta flava was also noted.

Petitioner followed up with Dr. Bell on 11/12/15. Petitioner testified that she received limited benefit from the epidural steroid injections. She reported that her pain was 85% improved. She told Dr. Bell that her pain was currently at a 2/10. She reported that she had been more active but felt like she had not been completely back to her baseline level of activity due to a fear of getting a recurrence of her pain. She continued to complain of pain in her right low back with some occasional radiation down her right leg, but not usually past the right knee. She reported no pain on the left.

In his office note, Dr. Bell noted that he had ordered a repeat MRI to determine if petitioner had a surgical lesion. Dr. Bell reviewed the MRI performed 11/11/15 that revealed a broad based right paracentral annular disc bulge at L2-L3 that extends into the inferior aspect of the right neuroforamen; multilevel degenerative disc disease at L3-L4, L4-L5, and L5-S1, with facet joint arthropathy at L5-S1 with some facer fluid, and motor changes particularly at L4-L5 per petitioner; and, severe degenerative disc disease with loss of disc height at L5-S1, with no disc herniation noted. The results also referenced that petitioner had undergone an MRI of her lumbar spine in 2013 that showed multilevel degenerative disc disease and spondylosis, as well as broad-based disc bulge at the L3-L4 level and L4-L5 level that leads to the right sided neuroforaminal narrowing; eccentric disc prolapse at the L5-S1 level that seemed to impinge her left L5-S1 neuroforamina, that was not clinical at that time. Also noted was facet joint arthropathy at L3-L4, L4-L5, and L5-S1. Dr. Bell referred petitioner to Dr. O'Leary for a surgical consultation.

Dr. Bell's assessment on 11/12/15 was localized primary osteoarthritis of lumbar vertebrae and lumbar intervertebral disc disorder with displacement. He referred petitioner to Dr. O'Leary for a surgical evaluation because petitioner testified that she was not interested in a short term fix. She stated that she wanted surgery if there was any chance that it would take away all the pain, even though her overall pain had improved, even by as much as 85% since her last injection with him. Dr. Bell was of the opinion that if she was not felt to be a surgical candidate, she might benefit from MBBs to determine if her pain is due to a facet etiology. He continued her NSAIDs and Norco.

On 9/17/15 petitioner's Application for Adjustment of Claim was filed. She reported that on 1/6/15 she fell going up stairs and injured her person as a whole.

On 11/23/15 petitioner underwent a Section 12 examination performed by Dr. Edward Goldberg, at the request of the respondent. She provided a consistent history of the accident. Petitioner reported some lumbar problems 4 years ago for which she underwent 2 epidurals. She stated that she was asymptomatic after these epidurals until 1/6/15. Dr. Goldberg reviewed the records of Dr. Bruns, which included reports from Dr. Sureka and Dr. Bell, and performed a physical examination. Dr. Goldberg diagnosed an aggravation of asymptomatic lumbar stenosis at L2-L3 and L3-L4 from the work related accident. He was of the opinion that he could not comment upon whether it was permanently aggravated if she was not done treating. Dr. Goldberg opined that the therapy and chiropractic care had been appropriate. However, he recommended no additional chiropractic care. He opined that she could be maintained on a home exercise program. He recommended a right L3-L4 transforaminal epidural injection for her radicular pain that was in the L3 distribution stopping at the knee. If this did not provide relief he said she might benefit from a right L2-L3 and L3-L4 decompression. He opined that she could continue working her normal job. He opined that she had not yet reached MMI.

Following the Section 12 examination by Dr. Goldberg, respondent would not authorize a visit to Dr. O'Leary. As a result, petitioner continued to treated with Dr. Bruns through 1/22/16, and underwent over 40 additional chiropractic treatments. No treatment reports from Dr. Bruns after 9/23/16 are included in Dr. Bruns records, despite the fact that these treatments are identified in his medical bill.

Dr. Bruns drafted a letter dated 1/27/16 to Damon Young, petitioner's attorney. He noted that he was currently treating petitioner 2 times a week. This treatment includes chiropractic adjustments along with myofascial release, as well as lower cross exercises. Dr. Bruns noted that he had referred petitioner to Midwest Orthopedics, and due to the lack of authorization to schedule a surgical evaluation, her orthopedic treatment was placed on hold. He opined that her current care was reasonable and necessary and still related to the injury on 1/6/15. He further opined that her treatment had been prolonged due to the inability of the petitioner to receive the orthopedic treatment and evaluation that were recommended.

Petitioner testified that she is currently working her regular duty job.

Dawn Haynes, petitioner's supervisor on 1/6/15, was called as a witness on behalf of respondent. Haynes testified that she is responsible for investigating accidents. She testified that she has known petitioner for 12-13 years, and did receive an email regarding the incident on 1/7/15. Haynes admitted that she did not actually talk to petitioner about the incident. She stated that this was because Richard Stoneburner stepped in and she talked to him. Haynes testified that 2-3 days after the accident she and

Stoneburner went and inspected the flights of stairs. However, prior to the inspection, Stoneburner had clipped areas of the non-slip strips that were raised.

While examining the stairwell, Haynes took pictures of the stairwell. However, she did not take pictures of the stairwell where petitioner fell. Haynes testified that although she did not take pictures of the stairwell where petitioner fell, she did inspect it and did not believe the area of missing strip where petitioner claims she tripped was a defect in the step. Haynes admitted that she took no pictures before Stoneburn inspected and fixed the non-slip strip where areas were raised.

Haynes testified that an initial wait and see form was completed, and no accident report was made until a later date, which she could not recall. Haynes did not talk to petitioner when she was completing the report.

Petitioner offered into evidence photographs of the stairwell and step where she fell. (PX5) Some of these pictures are of bent up and chipped strips on some of the stairs on the stairwell where she fell. (PX5-1a, 2a, 2b, and 3b). Petitioner included pictures of the step she claimed she fell on. (PX5-3a,5b,6a). These pictures show that a small section of the non-slip strip was missing on the step she tripped on. Petitioner also showed pictures of some stairs where the non-slip strip had been removed. (PX5-5a, 6a).

Respondent's Exhibit 2 identifies the bills of Dr. Bruns that respondent has paid. These payments include payments for dates of service from 7/8/15 through 12/11/15.

Respondent also offered into evidence photos of a stairwell taken by Haynes. However, Haynes testified that none of these photos were taken in the stairwell where petitioner fell.

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

The court in *Martin v Kralis Poultry Co.,* 12 Ill.App.3d 453, 297 N.E.2d 610 (5th Dist. 1973) held that the injury was not covered by the Worker's Compensation Act, stating:

> **[E]ven though an accident happens on the employer's premises, if it occurs while the employee is doing something there for his own personal benefit, it does not arise out of his employment.** 297 N.E.2d at 616.

In the case at bar, petitioner had already completed her work for respondent and had signed out. She got dressed in her coat and boots and descended the stairs from the second floor to the first floor. The only thing she was carrying was her purse. When petitioner reached the first floor landing, instead of exiting the building and walking to her car, she realized she had forgotten her personal phone at her desk and turned around to retrieve it. She began walking up the same stairs she had descended, and somewhere

on the 4th, 5th, or 6th step, she claims her foot got caught where a small piece of the 1/8" non-slip strip was and she fell forward. She testified that she grabbed the railing as she was falling and pulled her back. She did not completely fall. Petitioner then continued walking up the stairs to the second floor and retrieved her phone. She then took the elevator down to the first floor. Petitioner always had the option of taking either the stairs or the elevator when going from the first to the second floor. Petitioner never testified that these stairs were only for employees use. She also testified that she only went up and down them once a day.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner did not sustain an accidental injury that arose out of and in the course of her employment by respondent on 1/6/15. The arbitrator finds it significant that the petitioner had already signed out of work, had already walked down the final stairway and was just about out the door when she realized she had forgotten her personal cell phone. Petitioner was not carrying anything other than her purse. The arbitrator finds the petitioner's decision to walk back up the stairs was solely for her own personal benefit. The arbitrator also finds it significant that petitioner never testified that the stairwell was not accessible to the general public. She also clearly testified that she had other access to and from the ground floor and the second floor where she worked, that being an elevator. Petitioner was not instructed by her employer to use the elevator or the stairwell. The choice was hers.

Additionally, the arbitrator notes that the step on which petitioner alleged she fell did have a small section of the nonslip strip missing. However, the picture shows that the strip was not raised or buckled, and in fact even where the piece was missing, the height of the strip was exactly the same as that around the perimeter of the strip, namely 1/8".

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 1/6/15.

J. WERE THE 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?

Having found the petitioner did not sustain an accidental injury that arose out of and in the course of her employment by respondent on 1/6/15, the arbitrator finds these remaining issues moot.

IBIACC0805

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dominick Ferazzo,

Petitioner,

vs.

No. 90 WC 55894

Jetco, Ltd.,

16IWCC0618

Respondent.

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

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

On July 31, 1997, the Commission filed a corrected decision and opinion on review awarding temporary total disability, medical and wage differential benefits. Regarding the nature and extent of the injury, the Commission found that on September 22, 1990, Petitioner sustained a twisting injury to the low back. On June 4, 1993, Petitioner underwent a laser disc decompression surgery. In July of 1995, Petitioner's treating surgeon, Dr. Stamelos, diagnosed a failed back syndrome.

On December 11, 2014, Petitioner filed a petition under section 8(a), as well as a petition for penalties and attorney fees. Petitioner seeks payment of medical bills for doctor's visits, as well as past and future bills for physical therapy, prescription medications and a gym membership. Petitioner also seeks penalties and attorney fees. Respondent argues that Petitioner had exceeded his two choices of medical providers. Further, Respondent argues that it properly denied medical benefits pursuant to utilization reviews.

16IWCC0618

On July 2, 2015, Commissioner Joshua Luskin held a hearing in the matter. Petitioner, who was 49 years old at the time of the hearing, testified that in 1996 he moved to Florida and began treating with Dr. Hale, an orthopedic surgeon. Since moving to Florida, Petitioner has been working on light duty. Petitioner generally saw Dr. Hale quarterly. In 2009, Dr. Hale prescribed a gym membership. Petitioner stated he needed to go to the gym to stay fit and improve his low back condition. Petitioner has been paying for the gym membership himself. Petitioner also underwent some physical therapy until Respondent stopped paying for it. Petitioner stated the physical therapy helped "in some areas." The physical therapists have instructed Petitioner on home exercises. Petitioner performs home exercises and attends the gym. Petitioner continues to receive the wage differential benefits.

Petitioner further testified that he suffers from constant low back pain. Petitioner had been taking Soma for his injury for a long time. In 2013, Dr. Hale prescribed Flexeril instead of Soma because Petitioner developed some undesirable side effects to Soma. Petitioner explained that he tried five or six different medications before deciding that Flexeril worked the best for him. Dr. Hale also prescribed flurbiprofen. Respondent denied payment for either medication. Petitioner maintains that his pain levels go up and his functioning deteriorates without these medications. Petitioner incurred out-of-pocket expenses when he paid for Curad tape to attach Flector patches. He also paid out-of-pocket for some pain medications. Recently, Petitioner has been seeing Dr. Hale every other month or every month because of worsening pain.

Petitioner acknowledged that after injuring his low back in 1990, he treated with Dr. Milos and then Dr. Stamelos. When asked how he found Dr. Stamelos, Petitioner responded: "I don't know if I used a referral from him and my father brought him into it, my dad did," adding: "So I don't know if we went through the doctor or not." When Petitioner moved to Florida, he began treating with Dr. Hale. Until recently, Respondent has been paying the bills from Dr. Hale.

Petitioner introduced into evidence voluminous medical records and prescriptions from Dr. Hale, the medical bills from Dr. Hale and for physical therapy, the record of out-of-pocket pharmacy expenses, and gym membership bills.

The medical records from Dr. Hale go back to December of 2002 and document a history of persistent back pain with or without radiation to the legs and with fairly benign physical examination findings. Dr. Hale managed Petitioner's condition with various medications. In 2008, Petitioner underwent five sessions of physical therapy and was instructed on home exercises. Petitioner reported the physical therapy helped "somewhat." In 2011, Petitioner underwent six sessions of physical therapy and was again instructed on home exercises. Petitioner reported the physical therapy helped. In July of 2012, Dr. Hale switched Petitioner from Soma to Flexeril because Petitioner complained of some side effects from Soma. In December of 2012, Dr. Hale switched Petitioner from Motrin to Ansaid (flurbiprofen) and prescribed another course of physical therapy. The insurance carrier denied authorization for the physical therapy. In January of 2013, Petitioner reported his symptoms worsened after he stopped physical therapy. In February of 2013, Dr. Hale noted: "The patient has had four PT sessions that appear to have helped," and requested additional physical therapy. In March of

2013, Dr. Hale noted that Petitioner attended another four physical therapy sessions, which helped. Petitioner was instructed on home exercises and discharged from physical therapy. Petitioner told Dr. Hale he needed to exercise in the gym in order to maintain or improve his function. Dr. Hale supported Petitioner in his request that the workers' compensation carrier pay for the gym membership. Further, Dr. Hale added Flector patches to Petitioner's medication regimen. For the remainder of 2013 and during 2014, Petitioner's condition remained essentially unchanged.

In June of 2014, Dr. Hale noted that the workers' compensation carrier denied coverage for Flexeril and Ansaid. Dr. Hale maintained both medications were medically necessary and indicated. Dr. Hale noted that when Petitioner tried to make do without Flexeril and/or Ansaid, his pain increased and his function decreased.

In March of 2015, Petitioner complained of worsening symptoms and increased difficulty sitting for any length of time. Dr. Hale prescribed physical therapy "to see if we can improve his sitting tolerance." On April 13, 2015, Dr. Hale noted no improvement. Dr. Hale reiterated his recommendation for physical therapy.

On May 12, 2015, Dr. Hale noted, in pertinent part: "Still with pain in the back. Still with right buttock pain. Worse with cough and sneeze without intervening trauma or change in activity. He notes he has increased difficulty sitting for any length of time. After sitting for approximately two hours, he has to lie down for the rest of the day. ¶ Current medications are helping him function. He continues with home exercise program instructed by therapy. He continues going to the gym three times a week in order to continue to exercise and function. If he does not go to the gym he finds his function declines and he has difficulty getting through the day." Petitioner reported Flexeril and Flector patches worked well. On physical examination, Dr. Hale noted a mild paraspinal spasm, increased tenderness in the left paralumbar region, and a mildly restricted range of motion. Dr. Hale stated Petitioner "should have access to full gym facilities in order to maintain his condition and work on improving it." Dr. Hale continued to prescribe physical therapy "to see if we can improve his sitting tolerance."

Also on May 12, 2015, Dr. Hale issued a "to whom it may concern" letter, stating:

> "Please be advised that [Petitioner] is a patient under my care receiving treatment for injuries sustained to his low back on 9/21/90. He is currently using analgesic medication, anti-inflammatory medication, and muscle relaxant medication; a combination which allows him to function. I have requested additional therapy for treatment of sitting intolerance which has developed recently which has been declined by the carrier. He has tried to go without the anti-inflammatory and/or muscle relaxant and finds his condition worsens when he stops taking them. Additionally, he is personally paying for access to a gym in order to work out as well as stretch and strengthen which, at the very least, must be provided to him in order to maintain his wellbeing and avoid additional flares of pain in the back.
>
> All the treatment as outlined above is considered medically necessary at

this time and is well within the providence of acceptable treatment for this type of condition."

Respondent introduced into evidence utilization review reports. A utilization review report dated March 31, 2011, denied physical therapy as not medically necessary per the ODG guidelines.[1]

A utilization review report dated January 21, 2013, denied payment for a gym membership as not medically necessary. The reviewer, an occupational medicine specialist, stated that instead "temporary transitional exercise programs may be appropriate for patients who need more supervision." A utilization review report dated August 5, 2013, denied payment for a gym membership as not supported by the records provided. The reviewer, a family practice physician, stated that treatment needed to be monitored and administered by medical professionals.

A retrospective utilization review report dated May 2, 2014, denied payment for flurbiprofen (Ansaid) and cyclobenzaprine (Flexeril). The reviewer, a physical medicine and rehabilitation specialist, explained that ODG guidelines support only short term use for either medication. A prospective utilization review report dated May 12, 2014, denied payment for flurbiprofen (Ansaid) and cyclobenzaprine (Flexeril) as not medically necessary. The reviewer was an orthopedic surgeon.

A utilization review report dated April 14, 2015, denied physical therapy. The utilization review was performed by a family practice physician and denied physical therapy because "[d]etails regarding previous physical therapy for the lumbar spine was [*sic*] not provided, such as, number of sessions completed to date and objective functional gains made. The documentation failed to provide current objective functional deficits of the lumbar spine to warrant the need for therapy and the request as submitted exceeds the guideline recommendations of 10 visits."

Respondent asks the Commission to adopt the opinions of the utilization reviewers. Further, Respondent argues that it is not responsible for the medical services provided by Dr. Hale because Dr. Hale is Petitioner's third choice of medical providers.

The Commission notes that even if Dr. Hale is Petitioner's third choice of medical providers, Petitioner has been treating with Dr. Hale for close to 20 years and Respondent has not objected until now. Under these circumstances, the doctrine of *laches* applies. See, *e.g.*, Marshall v. Metropolitan Water Reclamation District Retirement Fund, 298 Ill. App. 3d 66, 74 (1998); Williams v. Interstate Cleaning Corp., 14 IWCC 0615. The Commission awards outstanding medical bills from Dr. Hale, pursuant to sections 8(a) and 8.2 of the Act.

With respect to the utilization reviews, the Commission notes that Dr. Hale is an orthopedic surgeon. Only one utilization review was performed by an orthopedic surgeon. Furthermore, the utilization review denials of physical therapy and a gym membership are inconsistent, as the denial of a gym membership contemplated a supervised exercise program

[1] It appears Respondent ultimately paid for the physical therapy Petitioner underwent in 2011.

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instead. The Commission notes the short term courses of physical therapy Petitioner underwent in 2008, 2011 and 2013 proved to be beneficial in keeping his condition stable. The Commission awards another short term course of physical therapy, but not a gym membership.

As to the costs of Flexeril and Ansaid, the Commission defers to the opinions of Dr. Hale, who has kept Petitioner's condition stable for many years, and awards the costs of these medications. Further, the Commission awards the out-of-pocket expenses for medical supplies.

Lastly, the Commission finds that penalties and attorney fees are not warranted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §8(a) petition is granted, except for the gym membership, in accordance with §§8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $6,500.00. 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: SEP 27 2016
o-08/25/2016
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Stephen Mathis

Mario Basurto

David L. Gore