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

Otto Bush,

Petitioner,

15IWCC0084

vs.

NO: 12 WC 01191

Navistar,
International Truck & Engine Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, OTHER-any other issues presented in the transcript of evidence, and permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 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.

15IWCC0084

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $-0-. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 - 2015
o-12/4/14
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0084

BUSH, OTTO
Employee/Petitioner

Case# **12WC001191**

11WC026510
12WC001190
09WC002119
13WC041147

INTERNATIONAL TRUCK & ENGINE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DEIDRE A CHRISTENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0084

OTTO BUSH,
Employee/Petitioner

Case # **12 WC 01191**

v.

Consolidated cases: **09 WC 02119**
11 WC 26510
12 WC 01190
13 WC 41147

INTERNATIONAL TRUCK & ENGINE CORPORATION,
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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on January 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

FINDINGS

On **4/22/2010**, 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 $61,954.06; the average weekly wage was $1,346.94.

On the date of accident, Petitioner was 51 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.

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 has not proven, by a preponderance of the evidence that his current condition of ill-being is related to his accident of April 22, 2010, therefore no permanent partial benefits are awarded, pursuant to the Act.

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

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

15IWCC0084

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISIONS

09WC02119
11WC26510
12WC02290
12WC01191
13WC41147
SIGNATURE PAGE

L. Thompson Smith
Signature of Arbitrator

April 2, 2014
Date of Decision

APR 3 - 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 [Choose reason]	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify [Choose direction]	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Otto Bush,

Petitioner,

15IWCC0085

vs.

NO: 12 WC 01190

Navistar,
International Truck & Engine Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, medical expenses, prospective medical care, OTHER-any other issues presented in the transcript of evidence, and permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $-0-. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 - 2015
o-12/4/14
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0085

BUSH, OTTO
Employee/Petitioner

Case# **12WC001190**

11WC026510
09WC002119
12WC001191
13WC041147

INTERNATIONAL TRUCK & ENGINE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DEIDRE A CHRISTENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

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

OTTO BUSH,
Employee/Petitioner

v.

INTERNATIONAL TRUCK & ENGINE CORPORATION,
Employer/Respondent

Case # **12 WC 01190**

15IWCC0085

Consolidated cases: **09 WC 02119**
11 WC 26510
12 WC 01191
13 WC 41147

An *Application for Adjustment 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 January 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [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

Credits
Respondent shall be given credit for $12,765.22 for short-term disability benefits paid 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.

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

15IWCC0085

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISIONS
09WC02119
11WC26510
12WC02290
12WC01191
13WC41147
SIGNATURE PAGE

Signature of Arbitrator

April 2, 2014
Date of Decision

APR 3 - 2014

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Otto G. Bush,

Petitioner,

15IWCC0086

vs.

NO: 11 WC 26510

Navistar,
International Truck & Engine Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, temporary total disability, medical expenses, prospective medical care, OTHER-any other issues presented in the transcript of evidence, and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is an employee of Respondent, who described his job as a machinist/machine operator. Petitioner began working at Respondent's Melrose Park location in June 2004; prior to that time Petitioner had worked for Respondent in their Springfield Ohio plant from June 1997 and he had transferred to the Melrose Park location June 2004. When Petitioner worked for the Springfield, Ohio plant he had no problems with his back. Petitioner did have two work accidents at that plant; one while spot welding, some flash penetrated his glove and metal inserted in his right index finger and the other a forklift backed over Petitioner's left leg. Petitioner stated basically he was knocked to the ground

and an ambulance picked him up and he had a broken foot, ankle, and he stated from that his leg was broken in two places.

- When Petitioner was transferred to the Melrose Park plant they did not require him to pass a physical examination; he just transferred in. Petitioner started there as a machinist/machine operator and the heaviest weight he lifted there was with a hoist, about 50 pounds. Petitioner testified in that position he was on his feet about 70% of the time. Petitioner testified that job required him to twist and bend about 30% of the time. Petitioner had remained as a machinist from June 2004 to November 2008. Petitioner testified that in 2007 he had an incident where he was off work for his back for a short period of time; he stated he had twisted when he was on the cam line at Respondent. Petitioner did not file a workers' compensation claim regarding that incident.

- Petitioner testified that on **August 24, 2010-(11 WC 26510)**, as he was mounting a sprocket or flywheel-(about 35 pounds) onto an engine, it has about 12 bolts he had to screw into that. Petitioner stated that his back started up all over again and he stated it kicked in even more. Petitioner had the flywheel in his left hand and the drill in his right hand to drill it. Petitioner indicated the height again was at about 4 feet. Petitioner testified at that point the pain started going down his buttocks and that occasion it went down his legs and that was when he could not take it anymore. Petitioner saw Dr. Ehni a couple days later at Respondent plant medical. The doctor again recommended some physical therapy. Petitioner agreed, per the records, shortly after seeing Dr. McGivney a couple times, the doctor began taking Petitioner off work beginning September 25, 2010. Petitioner testified Dr. Ehni was going to recommend Petitioner to an orthopedic doctor, but Petitioner declined that to return to see Dr. McGivney. He saw Dr. McGivney in October 2010 and the doctor tried to return Petitioner to work on light duty; prior to that on October 6, 2010, the doctor had recommended another MRI of his lower back and also recommended Petitioner to see a pain management doctor, Dr. Bathina. Beginning in about early January 2011, Petitioner began a series of injections to his lower back. On January 27, 2011, Dr. Bathina performed bilateral lumbar medial branch blocks. Petitioner stated the first shot helped him for about three hours. Petitioner had returned to Dr. Bathina who recommended a second injection and he had the 2nd in that series on February 10, 2011. Petitioner testified he had relief from that injection for about ten minutes. Petitioner returned to Dr. Bathina who continued to attempt to manage Petitioner's pain. On March 17, 2011 the doctor performed a lumbar L4-5 epidural injection and Petitioner stated that did not work at all. Petitioner had a second ESI March 31, 2011 and that one did not work either. Petitioner indicated at that point Dr. Bathina said after that second series that there was nothing he could really do and surgery would be the next step so he referred Petitioner back to Dr. McGivney. Petitioner testified that from May 6, 2010 to about March 2011 he could not work to the degree that he used to work before. Petitioner stated he is a workaholic and that had all stopped. Petitioner stated that he is limited to what he can do and his lifestyle has changed. Petitioner does continue to treat.

- Petitioner had seen Dr. Andersson at Respondent's request and that doctor had returned Petitioner to a light duty job; he did not recall exactly when that happened. Petitioner

testified that his workers' compensation benefits were paid through June 23, 2011 and at that point there was some communication issue as o whether or not he should have returned to work. He believed it was sometime in July 2011 that he had returned to light duty work and Respondent had accommodated that restriction on each occasion that Petitioner had been released to light duty. Petitioner had then returned to see Dr. McGivney. Petitioner testified during the July-August 2011 period his lower back pain had increased and the pain had radiated down into his buttocks and his legs and eventually to his feet and at that point he stated that he was very scared. Petitioner stated that at that point Dr. McGivney recommended surgery. Petitioner had worked through about August 29, 2011 and then he was taken off of work and he had the surgery-(fusion and decompression surgery) August 31, 2011. During the following several months Petitioner continued seeing Dr. McGivney and the doctor recommended therapy and eventually returned Petitioner to work, about March 15, 2012, with restrictions of no lifting over 50 pounds. Petitioner agreed from August 30, 2011 through March 14, 2012 he had been paid short term disability through Respondent. He did not recall after he returned to work in March 2012 if he experienced some continuing difficulties. Petitioner did continue to see Dr. McGivney post surgery. About December 21, 2012, Petitioner saw the doctor and Petitioner requested the doctor to change the restrictions, so Petitioner could lift up to 70 pounds. Petitioner testified that the reason he did that was he was trying to get back in his old machining job. Petitioner stated at that point the job had opened back there and he felt like he could do it and safety said he could not unless he had the restrictions changed and that was why he contacted the doctor to change them. Petitioner did not get back into that job position. Petitioner believed from December 2010 through 2013 he believed he worked in the harness job, which was different that the other jobs. Petitioner stated that position is a lot lighter. Petitioner stated when he began that job there was a lot of twisting and bending and he felt he could not do that in the area they had him because there was a platform there and with his height, again he had to bend down a great deal and twist in order to do that job.

The Commission finds, as to the issues of accident and causal connection, Petitioner testified that on August 24, 2010-(11 WC 26510), as he was mounting a sprocket or flywheel-(about 35 pounds) onto an engine, it has about 12 bolts he had to screw into that. Petitioner stated that his back started up all over again and he stated it kicked in even more. Petitioner had the flywheel in his left hand and the drill in his right hand to drill it. Petitioner indicated the height again was at about 4 feet. Petitioner testified at that point the pain started going down his buttocks and that occasion it went down his legs and that was when he could not take it anymore. Petitioner saw Dr. Ehni a couple days later at Respondent plant medical. The doctor again recommended some physical therapy. Petitioner agreed, per the records, shortly after seeing Dr. McGivney a couple times, the doctor began taking Petitioner off work beginning September 25, 2010. Petitioner testified Dr. Ehni was going to recommend Petitioner to an orthopedic doctor, but Petitioner declined that to return to see Dr. McGivney. He saw Dr. McGivney in October 2010 and the doctor tried to return Petitioner to work on light duty; prior to that on October 6, 2010, the doctor had recommended another MRI of his lower back and also recommended Petitioner to see a pain management doctor, Dr. Bathina. Beginning in about early January 2011, Petitioner began a series of injections to his lower back. On January 27, 2011, Dr. Bathina performed bilateral

lumbar medial branch blocks. Petitioner stated the first shot helped him for about three hours. Petitioner had returned to Dr. Bathina who recommended a second injection and he had the 2nd in that series on February 10, 2011. Petitioner testified he had relief from that injection for about ten minutes. Petitioner returned to Dr. Bathina who continued to attempt to manage Petitioner's pain. On March 17, 2011 the doctor performed a lumbar L4-5 epidural injection and Petitioner stated that did not work at all. Petitioner had a second ESI March 31, 2011 and that one did not work either. Petitioner indicated at that point Dr. Bathina said after that second series that there was nothing he could really do and surgery would be the next step so he referred Petitioner back to Dr. McGivney. Petitioner testified that from May 6, 2010 to about March 2011 he could not work to the degree that he used to work before. Petitioner stated he is a workaholic and that had all stopped. Petitioner stated that he is limited to what he can do and his lifestyle has changed. Petitioner does continue to treat. The Commission finds Petitioner's testimony is unrebutted here. The evidence in this record with the treating medical noted the consistent history of a mechanism of injury as per Petitioner's testimony. Petitioner testified of his current condition of ill-being and he does have permanent restrictions and even Respondent's examining doctor agreed he needed restrictions. Petitioner's examining doctor opined the restrictions and his permanent condition of ill-being. The Commission considering the evidence and unrebutted testimony presented here finds that Petitioner met the burden of proving accident that arose out of and in the course of employment and further proved a causal relationship to his condition of ill-being. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding of accident, and affirms and adopts the Arbitrator's finding as to causal connection.

The Commission finds, as to the issue of notice, that notice was not really argued by either party on any case so the issue is considered as waived. Regardless, the Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding of timely notice.

The Commission finds, as to the issue of Other-any other issue presented in the transcript of evidence, that the issue was not really argued by either party on any case so the issue is considered as waived. Regardless, the Commission finds the decision and findings, regarding 'any other issues'-(other than the below modification) made by the Arbitrator, as not contrary to the weight of the evidence or otherwise in error, and herein, affirms and adopts the Arbitrator's findings.

The Commission finds, as to the issue of temporary total disability, that with the findings above for Petitioner further finds Petitioner's testimony of lost time supported in the records by the restrictions/off work records to find Petitioner met the burden of proving entitlement to the benefits as awarded. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding as to total temporary disability.

The Commission finds, as to the issue of medical expenses/prospective medical care, that with the findings above for Petitioner further finds Petitioner's testimony of lost time supported in the records by the restrictions/off work records and Petitioner's medical treatment and multi-level fusion, decompression, surgery with instrumentation to find Petitioner met the burden of proving entitlement to the benefits as awarded. Either the workers' compensation carrier or the group health insurance carrier paid all but co-pay and deductibles on medical bills and Respondent would be entitled to the credit for bills paid. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and herein, affirms and adopts the Arbitrator's finding as to medical expenses/prospective medical care.

The Commission finds, as to the issue of permanent partial disability-(PPD), that with the finding above for Petitioner further finds Petitioner's testimony of lost time supported in the records by the restrictions/off work records and Petitioner's medical treatment and multi-level fusion, decompression, surgery with instrumentation to find Petitioner met the burden of proving entitlement to support a permanent partial disability award of at least that awarded by the Arbitrator. Given the multilevel surgery and permanent restrictions and testimony of his ongoing condition and permanent restrictions, all consistent, the Commission finds the evidence and testimony supports an increase of the permanent partial disability award to 20% loss to Petitioner's person as a whole. The Commission finds the decision of the Arbitrator, while not totally contrary to the weight of the evidence, does not adequately address Petitioner's permanent partial disability, and the Commission finds the increase more consistent with prior cases of similar nature and result. The Commission, therefore, herein, increases the PPD award to find Petitioner has suffered a loss of **20% loss of use of his person** as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $897.96 per week for a period of 67-3/7 total weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 100 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of **20%** loss of Petitioner's person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $3,686.88 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.

15IWCC0086

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: FEB 2 - 2015
o-12/4/14
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0086

BUSH, OTTO
Employee/Petitioner

Case# **11WC026510**

09WC002119
12WC001190
12WC001191
13WC041147

INTERNATIONAL TRUCK & ENGINE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DEIDRE A CHRISTENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

OTTO BUSH,
Employee/Petitioner

Case # **11 WC 26510**

15IWCC0086

v.

Consolidated cases: **09 WC 02119**
12 WC 01190
12 WC 01191
13 WC 41147

INTERNATIONAL TRUCK & ENGINE CORPORATION,
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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on January 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **8/24/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $61,959.06; the average weekly wage was $1,346.94.

On the date of accident, Petitioner was 51 years of age, married with no dependent children.

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

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

Respondent shall be given a credit of $35, 277.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $35,277.00.

Respondent is entitled to a credit of $12,765.22 under Section 8(j) of the Act.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $897.96 per week for 39 2/7 weeks, commencing September 24, 2010 through June 23, 2011; and from August 30, 2011 through March 14, 2012, for 28 1/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $35,277.00 for temporary total disability benefits that have been paid, as provided in Section 8(b) of the Act.

Medical benefits
Respondent shall to Petitioner the following outstanding medical bills in the amount of: 1) 226.80 as exhibited in PX10; 2) $360.00 as exhibited in PX11; 3) $148.08 as exhibited in PX12; and 4) $2,952.00 as exhibited in PX13, for reasonable and necessary medical services, as provided in Sections 8(a) and 8.2of the Act.

Permanent Partial Disability
Respondent shall pay Petitioner $669.64 per week for 50 weeks as Petitioner has sustained an injury causing 10% loss of use of a person as a whole.

15IWCC0086

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISIONS

09WC02119
11WC26510
12WC02290
12WC01191
13WC41147
SIGNATURE PAGE

[signature]
Signature of Arbitrator

April 2, 2014
Date of Decision

APR 3 - 2014

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Otto Bush,

Petitioner,

15IWCC0087

vs.

NO: 09 WC 02119

Navistar,
International Truck & Engine Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $-0-. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 - 2015
o-12/4/14
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0087

BUSH, OTTO
Employee/Petitioner

Case# **09WC002119**

11WC026510
12WC001190
12WC001191
13WC041147

INTERNATIONAL TRUCK & ENGINE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DEIDRE A CHRISTENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

OTTO BUSH,
Employee/Petitioner

v.

INTERNATIONAL TRUCK & ENGINE CORPORATION,
Employer/Respondent

Case # **09 WC 02119**

15IWCC0087

Consolidated cases: **11 WC 26510**
12 WC 01190
12 WC 01191
13 WC 41147

An *Application for Adjustment 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 January 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] 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. [x] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **11/15/2008**, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of this incident **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 $**69,180.74**; the average weekly wage was $**1,503.93**.

On the date of accident, Petitioner was **49** 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.

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 $3,285.84 under Section 8(j) of the Act.

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 with Respondent therefore, no benefits are awarded, pursuant to the Act.

Credits

Respondent shall be given a credit for $3,285.84 for short-term disability benefits paid 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.

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

15IWCC0087

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISIONS

09WC02119
11WC26510
12WC02290
12WC01191
13WC41147
SIGNATURE PAGE

L. Thompson Smith
Signature of Arbitrator

April 2, 2014
Date of Decision

APR 3 - 2014

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Otto Bush,

Petitioner,

15IWCC0088

vs.

NO: 13 WC 41147

Navistar,
International Truck & Engine Corp.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, temporary total disability, medical expenses, prospective medical care, OTHER-any other issues presented in the transcript of evidence, and permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 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.

15IWCC0088

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $-0-. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 - 2015
o-12/4/14
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0088

BUSH, OTTO
Employee/Petitioner

Case# **13WC041147**

11WC026510
12WC001190
12WC001191
09WC002119

INTERNATIONAL TRUCK & ENGINE CORPORATION
Employer/Respondent

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0293 KATZ FRIEDMAN EAGLE ET AL
RICHARD K JOHNSON
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DEIDRE A CHRISTENSON
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

Otto Bush
09 WC 2119, 11 WC 26510
12 WC 1190, 12 WC 1191
13 WC 41147

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

OTTO BUSH,
Employee/Petitioner

v.

INTERNATIONAL TRUCK & ENGINE CORPORATION,
Employer/Respondent

Case # **13 WC 41147**
15IWCC0088
Consolidated cases: **09 WC 02119**
11 WC 26510
12 WC 01190
12 WC 01191

An *Application for Adjustment 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 January 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☐ Other

FINDINGS

On **5/6/2010**, 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 $61,959.06; the average weekly wage was $1,346.94.

On the date of accident, Petitioner was 51 years of age, married with no dependent children.

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

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

Respondent shall be given a credit of $3,976.68.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,976.68.00.

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

ORDER

Petitioner has not proven, by a preponderance of the evidence that his current condition of ill-being is related to his accident of May 6, 2010, therefore no permanent partial benefits are awarded, pursuant to the Act.

Respondent shall pay Petitioner $540.00 in reimbursement, pursuant to Section 8(a) of the Act.

Credits

Respondent shall be given a credit of $3,976.68 for temporary total disability, paid to Petitioner.

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

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

FINDINGS

On **1/14/2013**, 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 not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $61,959.06; the average weekly wage was $1,346.94.

On the date of accident, Petitioner was 54 years of age, married with 0 dependent children.

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

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

Respondent shall be given a credit of $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 $696.55 for short-term disability benefits paid under Section 8(j) of the Act.

ORDER

The Petitioner has not proven, by a preponderance of the evidence that an accident occurred, which arose out of and in the course of his employment with Respondent therefore, no benefits are awarded, pursuant to the Act.

Credits

Respondent shall be given credit for $696.55 for benefits paid 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.

FINDINGS OF FACT

Otto Bush, ("Petitioner") filed five Applications for Adjustment of Claim against International Truck & Engine Corporation ("Respondent"), which were consolidated and heard before the Arbitrator on January 21, 2014 Petitioner began working for Respondent, Navistar, at the Melrose Park location in June of 2004. Petitioner testified that prior to his employment in Illinois; he worked for Navistar at the Springfield, Ohio plant beginning in June, 1997. Petitioner testified that while employed in Springfield, Ohio he had no problems with his low back. Petitioner admitted that he had an injury to his right index finger and his left leg while in the employ of Navistar at the Springfield, Ohio facility.

Initially, Petitioner began work at the Melrose Park location as a machinist/machine operator. He would lift approximately seventy (70) pounds, using a hoist. He testified that he would be on his feet 70% of the day and his job required him to perform work activities, which required a bending and twisting motion. He testified he would be bending and twisting 30% of the day. He worked as a machinist from June 2004 until 2008, when he began working as a machine operator.

09 WC 2119

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability; and 6) the nature and extent of the petitioner's injuries. AX1.

Petitioner claimed an accidental injury on November 15, 2008. He testified that in 2007, he twisted his back on the cam line while working for Respondent, but did not file a claim for workers' compensation benefits. No medical evidence was presented showing the nature of the treatment or diagnosis of the condition.

Petitioner testified that when he went to work on November 15, 2008, a Saturday, he did not notice or observe any problems. He was hoisting a crank, weighing approximately 200 to 235 pounds, off the line and the momentum of the crank moved it under a ladder. Petitioner reached out, grabbed the crank to stop its momentum and felt something pop in his lower back. Petitioner testified this was at approximately 1:00 p.m. and that he continued working that day.

Petitioner further testified that at 2:00 p.m. on November 15, 2008, he approached his supervisor, Bill Hommrich, and advised him that he had "done something to his back" and he wanted to go home. Petitioner testified that he was scheduled to work the following day, Sunday, and that he called off work. He also testified that he was scheduled to work on Monday, November 17, 2008, and that he did not work.

Respondent's witness, Mr. Hommrich, testified that he was Petitioner's supervisor on November 15, 2008 and that Mr. Bush approached him on November 17, 2008 not November 15, 2008 and asked to go home, as he was not feeling well. Mr. Hommrich further testified Mr. Bush advised him he had hurt himself at home over the weekend. Mr. Hommrich also identified Respondent's Exhibit 1 as an email from the plant nurse, Iris Becker, to himself, with his response. The Arbitrator notes that Respondent's medical department wrote a note on November 17, 2008, which states that employee Otto Bush is going home because of an illness and was advised to see his own physician. There are three choices on this note as to why the petitioner would be going home. The other two (2) choices were an (i) industrial accident and (ii) non-industrial accident; illness was chosen as the reason for Petitioner leaving. PX1.

Mr. Hommrich testified he wears hearing aids at this time, and further testified that he saw Mr. Bush and his wife leave the plant together on November 15, 2008. Mrs. Bush testified she did not work the same shift as her husband on November 15, 2008.

Petitioner testified that on November 18, 2008, he was evaluated by Dr. Tehmina Bajwa, who recorded a history of the patient complaining of back pain for four to five days, i.e. lower back pain radiating down the right leg, midday November 15, 2008 with lifting. Dr. Bajwa completed several attending physician statements for Navistar. In most statements, Dr. Bajwa noted that the patient had no previous treatment for low back pain/radiculopathy/bulging lumbar discs. In most incidences, Dr. Bajwa indicated that the back pain was radiating down both legs. On most forms when answering the question "Is this condition related to an accident?" the doctor wrote "no" and her November 18, 2008 medical note also indicates that Petitioner complained of lower back pain for four to five (4-5) days. She also noted that he had difficulty walking, sitting, lying down and had pain on November 15, 2008; and that he called off Sunday and tried to work on Monday but left early. PX1, PX2.

An employee status report dated November 18, 2008, lists a date of injury of November 15, 2008 and states that Petitioner's diagnosis was a herniated lumbar disc and paraspinal spasms and that the petitioner was able to work with restrictions. Dr. Bajwa took an x-ray on November 18, 2008, which revealed mild spurring which was compatible with degenerative disc disease; with no change since May 15, 2007. PX1.

An MRI performed November 22, 2008, at Provena Mercy Medical Center, was read to demonstrate: multi-level degenerative disc disease, multi-factorial moderate to severe central stenosis at L2-3 and L3-4, with moderate central stenosis at L4-5; and moderate to severe right sided neuroforaminal narrowing at L4-5 secondary to a right lateral component of disc bulge; as well as right sided mild facet hypertrophy.

Petitioner testified Dr. Bajwa referred him to Dr. Thomas McGivney who evaluated him December 16, 2008. The records of Dr. McGivney reflect that Petitioner complained of low back pain, denied any radiating pain, except to the upper posterior buttock and thigh area. Dr. McGivney noted the pain had been persistent since the injury at work, which was denied. Examination showed significant muscle spasm, minimal motion with extension and flexion. Dr. McGivney recommended therapy and took Petitioner off work. The doctor noted, by way of history of the incident, that Petitioner stated that he was off-loading cranks when the line got away from him. He pulled it and started having pain. "He states that he did not feel good that day. The next day he did report it to medical and stated that he was just having more pain. He tried to go back to work on Monday and he could not..." PX1.

Dr. McGivney evaluated Petitioner on January 23, 2009. Petitioner presented with less spasm in the back and Dr. McGivney recommended additional physical therapy, possible pain management and a return to work on light duty. Dr. McGivney opined that Petitioner was not a surgical candidate at this time. Petitioner testified he returned to work light duty on January 23, 2009. He saw Dr. McGivney on February 23, 2009 and the examination showed no pain with extension and flexion of the back, straight leg raising was negative and Dr. McGivney returned him to work effective February 24, 2009 without restrictions. PX1, PX2, PX3.

The records of Dr. Bajwa show that on May 14, 2009, Petitioner complained of back spasms and back pain. Petitioner was seen by Dr. Bajwa on August 4, 2009, August 11, 2009 and September 3, 2009 for unrelated complaints. On October 9, 2009, Petitioner complained of back spasms starting at 4:00 a.m. and Petitioner indicated that he had not gone to work secondary to pain and medications. Petitioner was seen on November 10, 2009, January 14, 2010, January 22, 2010, and February 4, 2010, for unrelated issues. PX2.

12 WC 1190

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; and 5) the nature and extent of Petitioner's injuries. AX2.

Petitioner testified that he moved from the machinist job to a job in piston subassembly in April 2010. Petitioner testified on April 22, 2010, while off-loading pistons, he "turned the wrong way" and his back pain flared up. He was holding one piston weighing fifteen (15) pounds in his hand. Petitioner testified that he saw Dr. Ehni. In an entry in the plant medical records dated April 23, 2010, Dr. Ehni recorded a history that Petitioner started to develop low back pain gradually the day before, but that the pain became mid-back pain overnight. Dr. Ehni recommended that Petitioner return to the clinic on May 3, 2010 after his vacation. PX1.

12 WC 1191

The disputed issues in this matter are: 1) causal connection; 2) medical bills; and 3) the nature and extent of Petitioner's injuries. AX3.

Petitioner testified that he returned to work May 3, 2010. Petitioner testified that on May 6, 2010, he moved to a different job performing work on the haldex. This job requires him to affix a plastic unit to the engine as it is going down a line, with his body in either a twisted or bent position in order to perform the work. The plastic part weighs approximately twenty (20) pounds and Petitioner testified that he held that with one hand and in the other hand held a three or four pound drill.

Medical records from Advanced Occupational Medicine Specialists indicate an examination date of May 6, 2010, with the petitioner complaining of low back pain, on the left. AP and lateral views of the lumbar spine were read to show no evidence of acute fracture, collapse or slippage; a moderate loss of disc space at L5-S1, L2-L4; and osteroarthritic degenerative changes bilaterally, at L5-S1. The conclusion was multi-level degenerative disc disease, greatest at L5-S1, with probable left nephrolithasis. PX1.

Petitioner testified he saw Dr. Ehni at the plant medical department on May 7, 2010. Dr. Ehni noted that Petitioner reported he had worsening low back pain and noted this could be an exacerbation possibly secondary to spondylosis. Dr. Ehni recommended therapy. On May 10, 2010, the therapy records noted marked pain, muscle spasm and guarding with significant spinal mobility motion restriction. The history provided to the therapist is consistent with Petitioner's testimony and Petitioner complained of radiating pain into the left buttocks. Petitioner was evaluated by Dr. Ehni on May 19, 2010. Dr. Ehni opined Petitioner's low back pain was slowly resolving with therapy.

Petitioner followed up with Dr. Ehni on May 26, 2010 and complained of low back pain that increases with forward bending. Dr. Ehni recommended Petitioner continue the physical therapy. Petitioner was discharged from physical therapy on June 9, 2010 and he was evaluated by Dr. Ehni on June 10, 2010. Dr. Ehni's impression was "resolved low back pain" and he recommended that Petitioner return to work without restrictions. Respondent paid temporary total disability benefits from May 10, 2010 through June 9, 2010. AX3, PX1.

Petitioner testified that he bid off the job when Respondent was not able to make it easier for him to install the pipe. He transferred to the engine test area. Petitioner testified he continued to experience problems from the May 6, 2010 accidental injury.

11 WC 26510

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) medical bills; 5) temporary total disability liability; and 6) the nature and extent of Petitioner's injuries. *See*, AX4.

Petitioner testified that on August 24, 2010, he was mounting a sprocket onto an engine and he felt low back pain into his buttocks and legs. Petitioner testified he was evaluated by Dr. Ehni on August 26, 2010. During that evaluation, Petitioner gave a history of low back pain starting two days earlier, while working. He denied pain, tingling or numbness down either leg. The doctor noted this was the "third or fourth time" during the year Petitioner had the same problem. Dr. Ehni noted Petitioner was being more cautious with lifting but working full duty. Dr. Ehni diagnosed a strain and recommended physical therapy. Petitioner was re-evaluated by Dr. Ehni on September 10, 2010. At that time, Petitioner complained of moderately severe low back pain predominately on the left side and Dr. Ehni noted diminished lordotic curve, tenderness to palpation, increased muscle tone but not palpable muscle spasm. Range of motion was diminished with flexion, extension, lateral rotation and lateral bending to approximately one-third of normal. Dr. Ehni assessed the petitioner as having lumbar strain and recommended continued therapy. Petitioner again presented to Dr. Ehni on September 15, 2010, with complaints of moderate to severe low back pain. The plan was to refer him to Dr. Zaffer, an orthopedic specialist however, a hand-written note on the September 16, 2010 statement, indicates that the petitioner wanted to see his own doctor. PX1.

Petitioner testified that he returned to see Dr. McGivney. Petitioner was evaluated by Dr. McGivney on October 4, 2010. Petitioner complained of lower back pain and indicated in a handwritten note that the pain went into his buttocks down both legs. Dr. McGivney wrote a letter to "Connie" stating, "Otto Bush presents back to me today. He is a little vague on his injury time. I saw him back in 2009. At that time, he had denied a workman's compensation injury but now has a lawyer. He states that he injured his back several months ago, but is fairly vague on the timing". The doctor's impression was chronic back pain. Dr. McGivney noted paraspinal spasm, pain with extension and flexion of the low back and opined Petitioner had "acute chronic back pain". Dr. McGivney indicated he was not sure if the issue was a continuation of the previous injury or a recurrence of his chronic injury but stated that"definitely he seems to have re-exacerbated with work." An MRI was ordered. PX1.

The MRI dated October 6, 2010 demonstrated a small right subarticular and right foraminal disc herniation with moderate to severe impingement on the right neural foramen at the L4-5 level. There was mild to moderate central canal stenosis at that level secondary to bulging of the remainder of the disc materials and mild thickening of the ligamentum flavum. Petitioner was re-evaluated by Dr. McGivney on October 15, 2010. At that time, he restricted Petitioner to no lifting over ten (10) pounds, no repetitive bending, scooping, twisting or jerking and standing was limited to one hour

continuously for a four-hour period. Dr. McGivney stated "I discussed with Otto that this looks like a pre-existing condition that he has exacerbated." Dr. McGivney stated "I don't think he was ever normal from the previous time I saw him." Dr. McGivney referred Petitioner to Dr. Bathina. PX2, PX3.

Petitioner saw Dr. Bathina at the Aurora Pain Clinic. Dr. Bathina's records confirm that Petitioner complained of bilateral lumbar pain, buttocks pain with radiation into both lower extremities, down to his knees. Dr. Bathina recommended two medial branch block procedures, which were done on January 27, 2011 and February 10, 2011, respectively. Petitioner experienced brief pain relief with the first branch block and negligible relief after the second branch block. Subsequently, Dr. Bathina recommended an epidural steroid injection at level L4-5. The first injection was performed on March 17, 2011, the second injection on March 31, 2011. Dr. Bathina opined that the MRI showed an L4-5 right-sided foraminal disc protrusion, causing foraminal narrowing. The epidural steroid injections were noted to give Petitioner good pain relief but lasted only three to four days. On April 14, 2011, Dr. Bathina stated that even after two injections Petitioner did not make real progress and the pain had become as bad as before. PX1, PX3 @ p. 54.

Dr. Bathina referred Petitioner back to Dr. McGivney indicating that if Dr. McGivney would not do surgery, Dr. Bathina would see him again. PX2, PX3.

On April 19, 2011, Dr. McGivney noted that Petitioner complained of having numbness, tingling and pain in his legs. The stenosis was noted to be a degenerative disc at L4-5. He indicated that the plan was to proceed with surgery, decompressing L4 and most likely using instrumentation from L1 to L3 in an attempt to alleviate his back pain. His surgery was discussed but the doctor wanted an MRI for confirmation. Dr. McGivney believed Petitioner had no other choice but to proceed with surgery. The MRI was performed on April 21, 2011. The radiologist noted that the bulging of disc material was unchanged or slightly greater when compared to the previous study. PX3.

At Respondent's request, Petitioner was evaluated, pursuant to Section 12 of the Workers' Compensation Act, by Dr. Gunner Andersson on June 7, 2011. Dr. Andersson assumed a date of injury of November 15, 2008. He stated that he had limited information about what happened to the patient during the period January, 2009 until August 26, 2010. Dr. Andersson opined that the MRI scans of October 6, 2010 and April 21, 2011 show degenerative disc changes at L2-3, L3-4, L4-5 and L5-1. At L4-5, there was moderate to severe stenosis, which had progressed, according to the more recent film dated April 21, 2011. The stenosis and the foramina was now fairly severe. Dr. Andersson opined that Petitioner's condition of ill-being was not causally related to the accident of November 15, 2008. The doctor further opined that the condition was a long-standing development of degenerative changes, which accelerated from October of 2010 to April of 2011 without any intervening incident.

Dr. Andersson stated the treatment had been reasonable and necessary but unrelated to any work incident. Petitioner had surgery on August 31, 2011. The procedure consisted of a decompressive laminectomy, partial facetectomy, foraminotomy at L3-4, L4-5 with posterior instrument fusion at L3-4, L4-5, L5-S1 with an arthrodesis at L3-4, L4-5, and L5-S1. RX2.

Petitioner continued under the care of Dr. McGivney postoperatively. Dr. McGivney returned Petitioner to work on March 15, 2012. He returned to work with a restriction of no lifting over 50 pounds. Petitioner testified that after he returned to work with the restriction, he contacted Dr. McGivney to ask that the weight limitation be increased to seventy (70) pounds lifting, in order to transfer jobs.

Petitioner was evaluated, at his attorney's request, by Dr. Jeffrey Coe, on June 19, 2012. Dr. Coe reviewed medical records and recorded a history of each accident described by Petitioner. Dr. Coe opined there was a causal connection between each accident and that the August 24, 2010 injury "further aggravated the degenerative change in his lumbar spine and caused additional breakdown at L4-L5 with chronic lower back pain and lumbar radiculopathy symptoms. PX9.

13 WC 41147

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) temporary total disability liability; nature and extent of Petitioner's injuries. AX5.

Petitioner continued working until January 14, 2013, when he was working on a platform, installing a harness. He was bending and twisting when he experienced low back pain. Petitioner testified that he also went to his family physician. He testified that the restriction of no bending and twisting, no stooping and a fifty (50) pound weight limitation was imposed, subsequent to the episode on January 14, 2013.

On January 16, 2013, a letter was written from Dreyer Medical Clinic, stating that Petitioner's diagnoses were lumbago with sciatica on the right side, chronic back pain and a history of a laminectomy. Petitioner was returned to work with restrictions. PX1.

At the time of the hearing, Petitioner testified that his back continued to give him problems. He said that it "acts up" during the day and especially at night and he has difficulty sleeping. He takes a muscle relaxer to sleep. He notes that this acting up is muscle spasm. Petitioner testified that prior to his work accidents, he worked considerable overtime. However, he does not work overtime presently as it is not offered to him because of his restrictions. Petitioner testified he has difficulty bending down to tie his shoe because of a limitation of range of motion and that four out of seven days of the

week, he takes pain pills or muscle relaxers. He takes Motrin three times a week. He testified that he has not re-injured his lower back since January of 2013.

Dr. Andersson again evaluated petitioner, at Respondent's request. This examination took place August 20, 2013. Dr. Andersson opined the November 15, 2008 accident did not cause multilevel degenerative changes and spinal stenosis but did say it could potentially cause a temporary aggravation. RX3.

Dr. Andersson reviewed the report of Dr. Coe. He noted that the January 2013 accident, reported by Petitioner, was only a temporary aggravation. RX3.

15IWCC0088

CONCLUSIONS OF LAW

09 WC 2119

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

A claimant has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. It is the function of the Commission to judge the credibility of the witnesses and resolve conflicts in medical evidence. *See, O'Dette v. Industrial Comm'n*, 79 Ill. 2d. 249, 253, 403 N.E.2d 221, 223 (1980). In deciding questions of fact, it is the function of the Commission to resolve conflicting medical evidence, judge the credibility of the witnesses and assign weight to the witnesses' testimony. *See, R & D Thiel*, 398 Ill. App.3d at 868; *See also, Hosteny v. Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 674 (2009).

For an employee's workplace injury to be compensable to be compensable under the Workers' Compensation Act, he must establish the fact that the injury is due to a cause connected with the employment such that it arose out of said employment. *See, Hansel & Gretel Day Care Center v. Industrial Comm'n*, 215 Ill. App.3d. 284, 574 N.E.2d 1244 (1991). It is not enough that Petitioner is working when accident injuries are realized; Petitioner must show that the injury was due to some cause connected with employment. *See, Board of Trustees of the University of Illinois v. Industrial Comm'n*, 44 Ill.2d 207 at 214, 254 N.E.2d 522 (1969).

Petitioner testified that when he went to work on November 15, 2008, a Saturday, he did not notice or observe any problems. He was hoisting a crank, weighing approximately 200 to 235 pounds, off the line and the momentum of the crank moved it under a ladder. Petitioner reached out, grabbed the crank to stop its momentum and felt something pop in his lower back. Petitioner testified this was at approximately 1:00 p.m. and that he continued working that day.

Petitioner testified that at 2:00 p.m. on November 15, 2008, he approached his supervisor, Bill Hommrich, and advised him that he had "done something to his back" and he wanted to go home. Petitioner testified that he was scheduled to work the following day, Sunday, and that he called off work. He also testified that he was scheduled to work on Monday, November 17, 2008, and that he did not work.

Respondent's witness, Mr. Hommrich, testified that he was Petitioner's supervisor on November 15, 2008 and that Mr. Bush did not approach him at all, on November 15, 2008 however, did approach him on November 17, 2008 and asked to go home, as he was not feeling well, as he had hurt himself over the weekend.

Dr. Bajwa noted, by way of history of the incident, that Petitioner stated that he was off-loading cranks when the line got away from him. He pulled it and started having pain. "He states that he did not feel good that day. The next day he did report it to medical and stated that he was just having more pain. He tried to go back to work on Monday and he could not..." The Arbitrator notes that Mr. Hommrich's testimony and Dr. Bajwa's medical notes contradict the petitioner's testimony; and that the doctor's medical notes support Mr. Hommrich's testimony. Therefore, the Arbitrator concludes that the petitioner has not proven, by a preponderance of the evidence that an accident occurred that arose out of and in the course of his employment by Respondent on November 15, 2008 therefore, no benefits will be awarded, pursuant to the Illinois Workers' Compensation Act (the "Act"). As the Arbitrator has found that no accident has been proven, the remaining issues are moot and will not be addressed.

12 WC 1190

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

Petitioner testified that he moved from the machinist job to a job in piston subassembly, in April 2010. Petitioner testified on April 22, 2010, while off-loading pistons, he "turned the wrong way" and his back pain flared up. He was holding one piston weighing fifteen (15) pounds in his hand. Petitioner testified that he presented to Dr. Ehni and in an entry in the plant medical records, dated April 23, 2010, Dr. Ehni recorded a history that Petitioner started to develop low back pain gradually the day before and a day off was recommended as well as possible future treatment. The Arbitrator concludes that an accident did occur, arising out of petitioner's employment as documented by the Respondent's medical staff.

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

Respondent had sufficient notice of the accident on April 23, 2010, when the petitioner reported to its medical staff.

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

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n*, 283 Ill. App. 3d 607, 610 (1998).

15IWCC0088

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. 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. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

The medical records indicate that Petitioner had previous back issues in 2007. While he testified that the problem was work related, he did not produce any evidence to support that contention. The medical records also document the petitioner as having a moderate to severe spinal, degenerative disease condition and as such, the Arbitrator concludes that the petitioner aggravated a pre-existing condition when he turned the wrong way causing his back pain to flare up. Therefore, while this may be a temporary exacerbation of his back condition, it assuredly did not cause the petitioner's present condition of ill-being.

K. What temporary benefits are in dispute?

Petitioner is claiming one day of temporary total disability. The Arbitrator finds that no benefits are due and owing, pursuant to the Act.

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

The Arbitrator finds that there is no permanent, partially disability associated with this accidental injury.

12 WC 1191

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

Petitioner testified that he returned to work May 3, 2010. Petitioner testified that on May 6, 2010, he moved to a different job performing work on the haldex. This job requires him to affix a plastic unit to

the engine as it is going down a line with his body in either a twisted or bent position, in order to perform the work. The plastic part weighs approximately twenty (20) pounds and Petitioner testified that he held that with one hand and in the other hand held a three or four pound drill.

Medical records form Advanced Occupational Medicine Specialists indicate an examination date of May 6, 2010, with the petitioner complaining of low back pain, on the left. AP and lateral views of the lumbar spine were read to show no evidence of acute fracture, collapse or slippage; a moderate loss of disc space at L5-S1, L2-L4; and osteroarthritic degenerative changes bilaterally, at L5-S1. The conclusion was multi-level degenerative disc disease, greatest at L5-S1, with probable left nephrolithasis.

The Arbitrators finds that this may be a temporary exacerbation of Petitioner's back condition; and it did not cause the petitioner's present condition of ill-being.

J. Were 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 the parties have agreed that an accident did occur and that Petitioner was owed temporary total disability for 4 3/7 weeks; Petitioner is also claiming reimbursement of $540.00 for payment to Dr. McGivney. Respondent shall pay Petitioner $540.00 in reimbursement, pursuant to Section 8(a) of the Act.

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

The Arbitrator finds that there is no permanent, partially disability associated with this accidental injury.

11 WC 26510

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

Petitioner testified that on August 24, 2010, he was mounting a sprocket onto an engine and he felt low back pain into his buttocks and legs. Petitioner testified he was evaluated by Dr. Ehni on August 26, 2010. During that evaluation, Petitioner gave a history of low back pain starting two days earlier, while working. He denied pain, tingling or numbness down either leg. The doctor noted this was the "third or fourth time" during the year that Petitioner had the same problem. Dr. Ehni noted Petitioner was being more cautious with lifting but working full duty. Dr. Ehni diagnosed a strain and

recommended physical therapy. Petitioner was re-evaluated by Dr. Ehni on September 10, 2010. At that time, Petitioner complained of moderately, severe low back pain predominately on the left side and Dr. Ehni noted diminished lordotic curve, tenderness to palpation, increased muscle tone but not palpable muscle spasm. Range of motion was diminished with flexion, extension, lateral rotation and lateral bending to approximately one-third of normal. Dr. Ehni assessed the petitioner as having lumbar strain and recommended continued therapy. Petitioner again presented to Dr. Ehni on September 15, 2010, with complaints of moderate to severe low back pain. The plan was to refer him to Dr. Zaffer, an orthopedic specialist however, a hand-written note on the September 16, 2010 statement, indicates that the petitioner wanted to see his own doctor.

The doctor's impression was chronic back pain. Dr. McGivney noted paraspinal spasm, pain with extension and flexion of the low back and opined Petitioner had acute and chronic back pain. Dr. McGivney indicated he was not sure if the issue was a continuation of the previous injury or a recurrence of his chronic injury, but stated that Petitioner definitely seemed to have re-exacerbated his condition by working.

The MRI dated October 6, 2010 demonstrated a small right subarticular and right foraminal disc herniation with moderate to severe impingement on the right neural foramen at the L4-5 level. There was mild to moderate central canal stenosis at that level, secondary to bulging of the remainder of the disc materials and mild thickening of the ligamentum flavum. Petitioner was re-evaluated by Dr. McGivney on October 15, 2010. At that time, he restricted Petitioner to no lifting over ten (10) pounds, no repetitive bending, scooping, twisting or jerking and standing was limited to one hour continuously for a four-hour period. Dr. McGivney stated "I discussed with Otto that this looks like a pre-existing condition that he has exacerbated."

The Arbitrator finds from the Petitioner testimony and his medical records that both he and Dr. McGivney indicated that he definitely seems to have re-exacerbated his chronic back. The doctor was not sure if the issue was a continuation of the previous injury or a recurrence of his chronic injury ,but it was aggravated by working. Therefore, the Arbitrator finds that the Petitioner has proven, by a preponderance of the evidence that an accident occurred, which arose out of and in the course of his employment with Respondent.

The Arbitrator finds that that Petitioner has proven, by a preponderance of the evidence, that his condition was exacerbated to the point that surgery was necessary and that an accident occurred which arose out of and was in the course of his employment by Respondent.

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

Respondent had sufficient notice of the accident on August 26, 2010, when the petitioner reported to its medical staff.

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

The Arbitrator finds that by continuing to work in a full duty capacity, the Petitioner did exacerbate his chronic, pre-existing back condition, to the point that surgery was necessary, therefore, the Arbitrator finds that the petitioner's current condition of ill-being, is 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?

Respondent shall to Petitioner the following outstanding medical bills, 1) 226.80 as exhibited in PX10; 2) $360.00 as exhibited in PX11; 3) $148.08 as exhibited in PX12; and 4) $2,952.00 as exhibited in PX13.

K. What temporary benefits are in dispute?

Petitioner is claiming benefits from September 24, 2010 through June 23, 2011 and then again from August 30, 2011 through March 14, 2012. Respondent had paid benefits from September 24, 2010 through June 23, 2011 but denies that Petitioner is owed benefits from the second period. The Arbitrator finds that the Respondent shall pay petitioner temporary total disability benefits from August 30, 2011 through March 14, 2012; a period of 28 1/7 weeks.

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

The Arbitrator finds that Respondent shall pay Petitioner $669.64 per week for 50 weeks as Petitioner has sustained an injury causing 10% loss of use of a person as a whole.

13 WC 41147

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

Petitioner continued working until January 14, 2013, when he was working on a platform, installing a harness. He was bending and twisting when he experienced low back pain. Petitioner testified that he

also went to his family physician and that the restrictions of no bending, twisting, no stooping; and a fifty (50) pound weight limitation was imposed, subsequent to the episode on January 14, 2013.

On January 16, 2013, a letter was written from Dreyer Medical Clinic, stating that Petitioner's diagnoses were lumbago with sciatica on the right side, chronic back pain and a history of a laminectomy. Petitioner was returned to work, with restrictions.

The Arbitrator concludes that the petitioner has not proven, by a preponderance of the evidence that an accident occurred that arose out of and in the course of his employment by Respondent therefore, no benefits will be awarded, pursuant to the Act. As the Arbitrator has found that no accident has been proven, the remaining issues are moot and will not be addressed.

15IWCC0088

ILLINOIS WORKERS' COMPENSATION COMMISSION ARBITRATION DECISIONS
09WC02119
11WC26510
12WC02290
12WC01191
13WC41147
SIGNATURE PAGE

Signature of Arbitrator

April 2, 2014
Date of Decision

APR 3 - 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

David Anthony Moore, Sr.,
Petitioner,

vs. NO: 12WC 30052

15IWCC0089

City Colleges of Chicago,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 14, 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.

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

DATED: FEB 3 - 2015

o011315
CJD/jrc
049

Daniel R. Donohoo

Ruth W. White

DISSENT

I must respectfully dissent from the majority's finding that the Arbitrator's award of 30% loss of use of the right arm should be affirmed and adopted.

The Petitioner testified that he had never had any problems with his right arm or wrist prior to his accident on August 6, 2012. Based on the criteria and factors required by Section 8.1b (ii), (iii), (IV) and (v), the Petitioner proved that he was entitled to an award greater than 30% of the right arm.

Due to the physical requirements of his current job, which requires him to restrain inmates, Petitioner's disability will be larger than an individual who performs lighter work. It is also clear that because of Petitioner's age and the physical demands of his job, he will work less years than an individual that is required to do lighter work duties. If Petitioner was unable to perform the duties of a correctional officer his earning capacity would be greatly impacted.

Finally, when reviewing the treating records and Petitioner's range of motion, it is clear that Petitioner has a disability greater than what the Arbitrator awarded him.

I would have awarded the Petitioner 40% loss of use of the right arm.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MOORE SR, DAVID ANTHONY
Employee/Petitioner

Case# **12WC030052**

CITY COLLEGES OF CHICAGO
Employer/Respondent

15IWCC0089

On 4/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
JACOB SCHNEIDER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

David Anthony Moore, Sr.
Employee/Petitioner
v.
City Colleges of Chicago
Employer/Respondent

Case # **12** WC **30052**

An *Application for Adjustment 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 23, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **August 6, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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 $**90,896.00**; the average weekly wage was $**1,748.00**.

On the date of accident, Petitioner was **48** 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 $**13,817.36** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**13,817.36**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**712.55**/week for **75.9** weeks, because the injuries sustained caused the **30%** loss of the **right arm**, as provided in Section 8(e) of the Act.

Respondent shall be given a credit of $**13,817.36** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**13,817.36**.

Respondent shall be given credit for all benefits paid under 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

April 14, 2014
Date

APR 14 2014

FACTS

On August 6, 2012, Petitioner was employed by Respondent as a security guard. Petitioner has concurrent employment with Cook County, where he has worked as a correctional officer, which requires him to physically restrain and transport inmates and to lock and unlock jail doors during transfers. Petitioner testified that on the day of the accident, he fell and broke his right arm while chasing a suspect who was in the process of stealing a "bike". Petitioner underwent right forearm fasciotomy, open reduction and internal fixation of the right radius and ulna, and fluoroscopic localization of fracture performed by Dr Ivankovich at Loretto Hospital. Thereafter, he underwent physical therapy.

Petitioner testified that he never had problems with his right upper extremity before the accident. Petitioner has now returned to work full duty for both Respondent and Cook County. Petitioner testified that transferring inmates and is more difficult for him today than before the accident. Petitioner is responsible for opening and closing the doors in the holding cells and he notices pain with the turning of the keys to lock and unlock the cell doors. Petitioner testified that his activities of daily living are affected. Petitioner testified that he has decreased range of motion in his right wrist, loss of grip strength, and numbness.

Petitioner has scarring and disfigurement on his right upper extremity. On the medial aspect of the forearm there is a 5 inch in length scar that is 3/8 inch wide at the widest point. There is keloiding in the scar. On the lateral aspect of the forearm there is a 6 inch in length scar that is ¼ inch wide at the widest point. There is keloiding in the scar but less in comparison to the medial aspect scar. There are two 1 inch, oval shaped scars from where bone protruded from the skin. There are two scratches from where Petitioner fell on his forearm.

CAUSATION

Based upon the unrebutted testimony of Petitioner in this claim, regarding the history of the August 6, 2012 accident coupled with the medical records from the Petitioner's treatment at Loretto Hospital, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the August 6, 2012 workplace injury.

NATURE AND EXTENT

In determining the level of permanent partial disability, the Arbitrator bases his determination on the following factors:

(1) no impairment rating has been offered into evidence;

(2) the occupation of the injured employee is a security guard and correctional officer; the work is medium to heavy;

(3) the employee was 48 years old at the time of the injury; he is not a younger individual; due to the medium to heavy nature of his work, he can work less years than an individual required to perform lighter work duties;

(4) the employee's future earning capacity as a security guard and correctional officer appears to be diminished due to a substantial upper extremity injury;

(5) the evidence of disability is corroborated by the treating medical records.

No single enumerated factor is the sole determinant of disability.

Based upon the evidence in this matter, the Arbitrator finds that Petitioner has sustained a 30% loss of use of the right arm.

CREDIT

Respondent claims a credit for a TTD overpayment. This is an undisputed issue (AX1, #8). The parties have stipulated that Respondent has paid $13,817.36 in total TTD benefits to Petitioner (AX1, #9).

The Arbitrator finds that Respondent shall have a credit for all amounts paid to or on behalf of Petitioner on account of the accidental injuries of August 6, 2012.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

OFELIA RINCON,

Petitioner,

vs. NO: 08 WC 24861

VIE DE FRANCE YAMAZAKI, INC.,

15IWCC0090

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, temporary total disability, and nature and extent, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission finds that Petitioner had reached maximum medical improvement as of the March 24, 2010 visit with Dr. Slack. Petitioner testified that she underwent physical therapy/work hardening for nine months. The records indicate that her initial therapy evaluation was on October 1, 2009 and the last record is dated June 23, 2010.

Although Petitioner testified that the exercises helped her get stronger and that she improved after each one (T.23, 32), the therapy records do not support this. After several months, Petitioner's pain level remained fairly constant and her stamina, lifting ability, and range of motion varied; sometimes marginally better and other times marginally worse. (Px7). We find that this is particularly the case after the progress report of February 26, 2010. We note that on March 24, 2010, Dr. Slack instructed the therapist to, "Please make note when Pt has plateaued in her work conditioning program." (Px5). Based on a review of the records, we find that Petitioner had already plateaued by that time and the prolonged treatment and recommendation for continued work hardening after March 24, 2010 was excessive and not reasonable or necessary.

Although Petitioner had a couple more follow-up visits with Dr. Henriquez and Dr. Slack, and one visit with Dr. Fisher on July 9, 2010, she declined surgery and was released at maximum medical improvement with restrictions. Petitioner testified that, since that time, she

has not had any formal treatment but continues to exercise and does "a little bit of yoga," which helps her. (T.24). Petitioner testified that she began working on a production line at Encor Frozen Foods in November 2012 (T.25) but that she also had other jobs before that while working through a temporary agency (T.35-36). The August 18, 2010 record of Dr. Slack indicates that Petitioner had been working for a month, ten hours a day about 40 hours a week, and "seems to be tolerating this." (Px5).

We conclude that the record as a whole supports a finding that Petitioner's condition had stabilized by March 24, 2010, and she had reached maximum medical improvement at that time. We find that Petitioner's continued restrictions of being off work completely were not reasonable and that she is not entitled to temporary total disability after that date. We also find that Petitioner failed to prove that the medical expenses and formal work conditioning after this date were reasonable and necessary.

We hereby modify the decision to award medical expenses and temporary total disability only through March 24, 2010.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $336.04 per week for a period of 92-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $302.44 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% loss of use of Petitioner as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses incurred through March 24, 2010, for medical expenses under §8(a) of the Act subject to the medical fee schedule in §8.2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 4 - 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 1/14/15
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RINCON, OFELIA
Employee/Petitioner

Case# 08WC024861

15IWCC0090

VIE De FRANCE YAMAZAKI INC
Employer/Respondent

15IWCC0090

On 9/10/2013, 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 0.03% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0532 HOLECEK & ASSOCIATES
LAWRENCE SZYMANSKI
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

15IWCC0090

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

- [ ] 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

Ofalia Rincon
Employee/Petitioner

v.

Vie de France Yamazaki Inc.
Employer/Respondent

Case # 08 WC 24861

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Wheaton, Illinois**, on **July 12, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

15IWCC0090

FINDINGS

On **4/24/2008**, 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 $**26,211.64**; the average weekly wage was $**504.07**.

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

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

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

Respondent shall be given a credit of $**2,976.44** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**2.974.44**.

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 $ $336.04/week for 107-3/7 weeks, commencing 6/18/2008 through 7/9/2010, as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related conditions as stated in the DECISION pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

Respondent shall pay Petitioner permanent partial disability benefits of $ $302.44/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Carolyn Doherty   9/10/13

Signature of Arbitrator   Date

SEP 10 2013

FINDINGS OF FACT

The Arbitrator notes the parties stipulated to the issues of accident and proper notice. ARB EX 1. Petitioner testified that she began working for Respondent in 2004. The parties stipulated that on 4/24/08, Petitioner was cleaning a bread machine used to make bread sticks and was cleaning the machine alone. Petitioner lifted a tray full of flour from under the machine and noticed pain in her lower back and in both shoulders. The metal tray weighed about 10 pounds and measured 3 feet by 3 feet.

Petitioner worked the rest of her shift until 11:30. She reported her back injury to her supervisor and was taken by her supervisor to Alexian ER in Elk Grove Village. Petitioner reported pain in her lower back, neck and both arms. The medical records of Alexian Brothers indicate that Petitioner received treatment there on April 25, 2008. There, a history was taken of "pt is a 47 yo f here with lower back pain that rad up her back after trying to lift tray at work tonight." (PX 1, pg. 6). She was diagnosed with a back sprain, prescribed Vicodin and Ibuprofen and sent home. (PX 1, pg. 10, 22).

Petitioner followed up with Dr. Henriquez and underwent physical therapy in his clinic, Progressive Medical Center on May 2, 2008. (PX. 2). There, Dr. Henriquez noted that Petitioner had injured her back at work when she was "bending and pulling things at work". (PX. 2, pg. 29). He noted that she was experiencing back pain radiating to her arms. He diagnosed her with cervical thoracic and lumbar strains referred her to physical therapy and maintained the medication previously prescribed. (PX. 2, pg. 29). PX, 3. Dr. Henriquez monitored Petitioner's progress with physical therapy through June of 2008. (PX. 2). On May 12, 2008, Dr. Henriquez ordered cervical and lumbar MRIs. (PX. 2, pg. 30). He noted that work was not following the restrictions that he had previously placed on Petitioner. (PX. 2, pg. 30).

Petitioner underwent cervical and lumbar MRI's on June 14 2008. The cervical MRI revealed at C5-6 a "mild disc bulge and tiny spur with a paracentral disc extension into the central canal. There is indentation of the ventral thecal sac approximating the ventral cord contour." The impression was "paracentral C5-6 protruding disc herniation accompanying minor degenerative changes." At C6-7 there is a "mild leftward disc extension and small spur with mild abutment on the thecal sac and mild left foraminal encroachment." The impression was "a shallow left C6-7 protruding disc and small spur." PX 4. The lumbar spine MRI revealed a "tiny tear of the annulus fibrosis accompanies minor posterior bulging/protruding disc at L5-S1." PX 4.

On June 18, 2008, Dr. Henriquez reviewed the MRIs and referred Petitioner to Dr. Kondelis, a pain management specialist. He further maintained Petitioner's prescription for physical therapy and placed her with work restrictions. (PX. 2. pg. 33). Petitioner testified that she approached the Respondent with her work restrictions and the Respondent indicated it could not accommodate the same. She began receiving TTD benefits from the Respondent beginning June 18, 2008.

On July 1, 2008, Petitioner was evaluated by Dr. Nicholas Kondelis. Dr. Kondelis noted a history of "bending to clean the koho line machine, pulling out a tray ladened with flour from the bottom of the machine. She developed pain in her back and neck." (PX. 4, pg 24). He further noted that her pain was getting worse as she was going about her work activities since the accident and that she was recently she was placed off of work. After a physical examination, Dr. Kondelis diagnosed Petitioner with herniated

discs at the cervical and lumbar spine with signs of radiculopathy. He recommended that Petitioner undergo cervical and lumbar epidurals as well as an EMG afterward, if she did not respond well to physical therapy. (PX. 4, pg. 25).

Petitioner underwent a cervical epidural injection and trigger point injections on July 18, 2008. (PX. 4, pg 32). Petitioner underwent lumbar epidural injections on August 8, 2008 and again on September 12·2008 by Dr. Kondelis. (PX. 4, pg. 13-19). The operative reports of each injection indicate that the Petitioner felt relief from her pain. (PX. 4, pgs. 13-19 and 23). At trial, Petitioner clarified that the relief that she felt from the injections provided by Dr. Kondelis lasted for about 6 months.

Petitioner attended a Section 12 exam with Dr. Matz on July 30, 2008, at Respondent's request. RX 1. Dr. Matz opined that Petitioner did not suffer an injury on April 24, 2008. Dr. Matz read the 6/14/08 cervical spine MRI to show some mild bulging. He read the lumbar MRI to show age appropriate changes related to degenerative etiologies but no acute or post traumatic findings. RX 1. Dr. Matz examined Petitioner and determined that she had an objectively normal neurologic exam. He stated that no further injections or chiropractic treatment was necessary and would likely have the adverse effect "of increasing her self-assessed disability." He found Petitioner at MMI and determined she could return to work full duty. RX 1. Petitioner received notice of the Respondent's Section 12 examiners full duty release on August 18, 2008. Respondent terminated TTD benefits at that time.

Petitioner testified that she returned to Respondent and worked full duty as of 8/23/08 after receiving Dr. Matz' recommendation. The medical records reflect a return to work with general restrictions to prevent more exacerbation to her existing condition. PX 3, PX 2. However, Petitioner testified that she only worked 2 or 3 days before she was called to the office and told by "Gayle" from HR that she was not capable of doing the work and was fired. Petitioner left the premises. The medical records reflect that Petitioner was still treating at the time she returned to work including physical therapy and injections. PX 3, PX 4.

Petitioner testified that she applied for and ultimately received unemployment benefits after an appeal. Petitioner testified that during the time she was applying for and receiving unemployment, she was under restrictions from her treating physician certifying that she could work within the restrictions of her treating physician. The Arbitrator notes that on September 10, 2008, it appears that Dr. Henriquez was continuing to reference work restrictions and "follows restrictions" during his treatment of Petitioner. PX 2, p. 41.

Petitioner continued to undergo physical therapy with Progressive Rehab through October 29, 2008. PX 3. The record from 10/29/08, indicates that although Petitioner completed the physical therapy and her condition was considered to have reached a permanent status, she still had symptoms. PX 3, p. 23. The examining Chiro on that date indicated restrictions against heavy lifting, repetitive bending, stopping and prolonged standing, due to her neck and low back injuries. PX 3, p. 25. He further referenced Petitioner's attempt to return to work and the employer's failure to accommodate the restriction to "prevent more exacerbation to her existing condition."

Petitioner testified that the physical therapy provided to her by Progressive Rehab did help maintain her pain. On October 28, 2008, Petitioner was evaluated once again by Dr. Kondelis and he noted that the

"injections and transforaminals (September 12, 2008) were extremely beneficial." (PX. 4, pg. 12). Nonetheless, he noted that she was still feeling a pain level of at least 3/10 in her lower spine and recommended that she undergo an EMG/NCV to determine the source of her lumbar radicular pain. (PX. 4, pg. 12). The EMG was not authorized and Petitioner saw Dr. Kondelis again on November 11, 2008 who noted that her pain level was still at 3 and that she should undergo the EMG. (PX. 4, pg. 10).

On December 9, 2008, Petitioner was evaluated by Dr. Charles Slack, a spine surgeon with the Illinois Bone and Joint Institute upon the referral of her therapist at Progressive Rehabilitation. (PX. 5, pg. 11). Dr. Slack noted that although the injection she received from Dr. Kondelis provided her with some benefit, she was still having pain especially when she is walking more than 45 minutes or sitting for any length of time. Dr. Slack diagnosed her with persistent cervical derangement with recurrent disc protrusion and low back derangement with radiculopathy and some disc bulging as seen on the MRI scan. He concurred with the recommendation for an EMG but also recommended that she undergo new MRI scans of her lumbar and cervical spines. (PX. 5, pgs 43-44). Dr. Slack also took Petitioner off work on 12/9/08. PX 5, p. 45.

An EMG was performed by Health Benefits Pain Management on December 11, 2008 which revealed electrodiagnostic evidence of chronic left L4-L5 radiculopathy. PX 5. On February 9, 2009, Dr. Slack reviewed the EMG and maintained the need for new MRI scans. He maintained Petitioner's total disability from work. (PX. 5, pg. 37-39).

On March 4, 2009, repeat MRIs were performed of Petitioner's cervical and lumbar spine. The 3/4/09 lumbar spine MRI was compared to the lumbar MRI of 6/14/08. The impression was "unchanged lumbar spine from 6/14/08 with a small disc extrusion at the L5-S1 level without significant nerve root compression or stenosis and stable degenerative changes of the lower lumbar spine resulting in predominantly in left neural foraminal stenosis at the L5-S1 level." PX 8. The cervical MRI was also compared to the cervical MRI of 6/14/08 and noted was "unchanged right paracentral disc herniation at the C5-C6 level with an adjacent disc osteophyte complex in a right paracentral to foraminal location. The overall mass effect is unchanged, however. No new disc herniations are present. Also, noted was a "tiny left paracentral disc herniation at the C6-7 level without nerve root compression." PX 8.

On March 24 2009, Dr. Slack reviewed the MRIs and recommended that Petitioner undergo a new series of lumbar epidural steroid injections followed by a functional capacity evaluation. (PX. 5 pgs. 33-34). Petitioner was referred to Health Benefits pain management by Dr. Slack and was seen there by Dr. Daniel Cha who recommended Petitioner first undergo a cervical epidural steroid injection. A cervical epidural steroid injection was performed that day and a lumbar epidural steroid injection was performed on May 28, 2009 by Dr. Cha. (PX. 6, pgs. 25-27). On June 11, 2009, Dr. Cha noted that Petitioner was experiencing significant improvement with the injections. (PX. 6, pg. 28).

Following the injections, Petitioner did undergo a functional capacity evaluation at Premiere Physical Therapy on June 18, 2009. The FCE placed her at a light physical demand level and was noted to be valid. The recommendation was for work conditioning. PX 7, p. 222.

On September 3, 2009, Petitioner returned to Health Benefits Pain Management and was seen by Dr.

Simon Ho. Dr. Ho said that the injections to the Petitioner's cervical and lumbar spine had helped her in the past, but that her pain had resumed. He recommended that she undergo a new course of epidural injections. (PX. 6, pg. 29).

On October 10, 2009, Dr. Cha performed yet another epidural steroid injection but noted that she was not experiencing long term relief from that injection. On September 4, 2009, Dr. Slack reviewed the FCE and ordered that Petitioner undergo a course of work conditioning. (PX. 5, pg. 66). Petitioner began a course of work conditioning which commenced on October 9, 2009. (PX. 7, pg. 237). At the initial evaluation, the Petitioner was reporting a 3-4 out of 10 pain scale. By December 2, 2009, Petitioner was reporting a 2 out of 10 on the pain scale and noted that her spine was getting stronger. (PX. 7, pg. 239).

By February 26, 2010, the physical therapist noted that Petitioner's neck pain was 2 out of 10, strength is 4+ out of 5 but she continued to experience tingling in her leg. It was noted that she could carry 10 pounds consistently without pain and could walk on a treadmill for 30 minutes. (PX. 7, pg. 261). Dr. Slack continued physical therapy instructions through June 24, 2010. PX 7. On June 9, 2010, Dr. Slack noted that despite the aggressive course of physical therapy, Petitioner continued to have symptoms especially after standing for more than an hour. He reported bilateral leg numbness at that time. Dr. Slack thereafter referred her to his associate, Dr. Theodore Fischer at Illinois Bone and Joint. Petitioner's last day of physical therapy was on June 24, 2010. P X 7.

On July 9, 2010, Dr. Fisher examined the Petitioner. After performing the physical examination and having reviewed the MRI films, he opined that Petitioner would be a good candidate for a fusion at C5-C6. Petitioner indicated that she was not interested in surgical intervention. Dr. Fisher placed her at maximum medical improvement. (PX. 5, pg. 21, 19). On August 18, 2010, Dr. Slack concurred with the placement at MMI, but indicated that Petitioner could return to work with permanent restrictions of no lift more than 20 pounds. (PX. 5, pgs. 17-18).

Petitioner was off work from June 18, 2008 through July 9, 2010 when she was placed at MMI by Dr. Fisher. Petitioner was paid TTD from June 18, 2008 through August 18, 2008. ARB EX 1. Petitioner is currently working for Encore on the packing/production line. She began the job in November 2012 and testified that the job does not involve lifting or pulling. Petitioner testified that while working she has pain in her low back and she is fatigued. Petitioner continues to perform home exercises every other day. Petitioner further testified that she has sharp pain in her shoulders and neck after working a full shift.

Respondent offered into evidence a medical record review rendered by Dr. David Trotter. (RX. 2). Dr. Trotter concurred with Respondent's original Section 12 examiner, Dr. Matz, that Petitioner's injury was not severe and would have resolved itself without any active medical treatment. He determined that "at most", Petitioner sustained a thoracolumbar strain/sprain injury as a result of the 4/24/08 accident and determined that any other diagnosis, including radiculopathy and nerve root impingement, were not accurate or causally related to the accident. RX 2. Based on the "combination of subjective and objective findings and injury mechanisms," Dr. Trotter determined that Petitioner had been fully diagnosed and treated to complete resolution as of on or prior to Dr. Matz' exam of July 30, 2008. Further, he indicated that any treatment after that date, including the physical therapy provided to Petitioner at Progressive Rehab, was not reasonable or necessary. He concurred with Dr. Matz that Petitioner reached MMI on July 30, 2008 "if not dramatically earlier for that matter." Dr. Trotter indicated that he was basing his opinion on ODG Guidelines. RX 2.

Respondent also offered into evidence surveillance videos of Petitioner on May 5, 2010 and November 25, 2011. RX 4. The Arbitrator viewed the video footage. The video of May 5, 2010 shows Petitioner getting in and out of her car, walking with her purse on her shoulder and pumping gas into her car. The video of November 25, 2011 shows Petitioner taking out garbage to a dumpster, pushing the dumpster, and rolling it away from her car. Petitioner does not appear to strain while pushing the dumpster using both arms as well as kicking the dumpster with her foot. Petitioner is also seen lifting and moving plastic yard chairs and moving other small items from her car to her trunk. Although active, Petitioner is not seen lifting anything of great weight and is seen moving slowly. RX 4.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

F. Is Petitioner's condition of ill-being causally related to the injury? J. Were the medical services 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

The Arbitrator finds that given Petitioner's credible testimony regarding the absence of a preexisting condition, the immediate onset of pain following the April 24, 2008 accident, and the continuation of pain symptoms documented thereafter in the medical records through July 9, 2010, the chain of events supports a finding that Petitioner's current condition of ill-being is causally related to her accident of April 24, 2008.

Petitioner's treating physicians documented objective findings on the MRI's and the EMG testing to both Petitioner's cervical and lumbar areas. Based on those findings, treatment was rendered. Respondent's Section 12 examiners opined that Petitioner's condition should have stabilized by July 30, 2008 and that no treatment rendered to Petitioner was reasonable or necessary or causally related to the accident. The Arbitrator gives less weight to those opinions to the extent they minimize the objective findings on the EMG and MRI's taken before and after July 30, 2008. Furthermore, Petitioner testified that the therapy by Progressive Rehab Center, the injections performed by Health Benefits Pain Management and the work conditioning provided by Premier Physical Therapy provided her with significant relief from her pain further supporting a finding of necessity for the treatment received.

With regard to medical expenses, the Arbitrator finds the treatment rendered to the Petitioner consisting of the physical therapy from Progressive Rehab, the treatment provided by Dr. Charles Slack of Illinois Bone and Joint and all the diagnostics ordered therein, the injections provided by Health Benefits Pain Management and Dr. Kondelis and the physical therapy/work conditioning performed at Premier Physical Therapy, through June 24, 2010 were reasonable and necessary to cure and alleviate the Petitioner's condition. Again, Petitioner credibly testified that all the treatment rendered to her by these providers provided her with relief from her pain.

Again, Respondent's dispute on the issue of medical expenses was again based on liability and the opinions of Drs. Matz and Trotter. ARB EX 1. Given the Arbitrator's findings on the issue of causal

connection, the Arbitrator further finds Respondent is to pay Petitioner medical expenses incurred through July 9, 2010, pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any. The parties stipulated that no Section 8(j) credit is owed. ARB EX 1.

Respondent's dispute with regard to TTD was also based on liability. The Arbitrator notes that Petitioner was paid TTD from 6/18/08 through 8/18/08. ARB EX 1. The record reflects only Petitioner's testimony on the facts surrounding her return to work thereafter. Specifically, Petitioner testified that she returned to work for 2 to 3 days full duty per the instructions of Dr. Matz only to be "fired". Petitioner was under continued, although vague restrictions, as of 8/19/08 to return to work and to avoid exacerbation of the condition. This appears not to have been possible from Respondent's perspective. It should be noted that despite her return to work in August 2008, Petitioner also continued to treat and the continued restrictions are mentioned in these treatment records.

Accordingly, based on the evidence in the record and on the Arbitrator's findings on causal connection, the Arbitrator finds that Petitioner was temporarily totally disabled for a period of 107-3/7 weeks commencing 6/18/08 through 7/9/10. Respondent shall receive credit for payments made during this period. ARB EX 1.

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

Petitioner suffered injuries to her cervical and lumbar spine which resulted in unoperated cervical and lumbar disc herniations and protrusions. Petitioner underwent a series of both cervical epidural and lumbar epidural injections. She was off work while receiving the treatment and has since returned to work within her restrictions against living heavy weights. Petitioner does home exercises and rest as well as yoga to address her current pain.

The Arbitrator has reviewed the surveillance films which demonstrate that Petitioner is capable of lifting and carrying garbage as well as pushing a metal garbage dumpster on wheels. Accordingly, the Arbitrator finds that the Petitioner suffered an injury to her body equivalent to 5% loss of use of man as a whole pursuant to Section 8(d)(2) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Wright,
Petitioner,

vs.

NO: 11WC 21799
12WC 19279

Kreitner Construction, Co.,
Respondent,

15IWCC0091

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 3, 2014, is hereby affirmed and adopted.

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

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

Bond for 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: FEB 4 - 2015
o012815
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMAS, WRIGHT
Employee/Petitioner

Case# **11WC021799**
12WC019279

KREITNER CONSTRUCTION CO
Employer/Respondent

15IWCC0091

On 4/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

2593 GANAN & SHAPIRO PC
IAN M WHITE
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Thomas Wright Case # **11** WC **21799**

Employee/Petitioner

v. Consolidated cases: **12 WC 19279**

Kreitner Construction Co.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **January 31, 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. [x] Was timely notice of the accident given to Respondent? (Case #12 WC 19279)
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **11/3/10 and "late October of 2010"**, Respondent *was* operating under and subject to the provisions of the Act.

On those dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On 11/3/10, Petitioner ***did*** sustain an accident that arose out of and in the course of employment. On/in "late October of 2010" Petitioner ***did not*** sustain an accident that arose out of and in the course of employment and timely notice of the alleged accident ***was not*** given to Respondent.

Timely notice of the 11/3/10 accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$33,280.00**; the average weekly wage was **$640.00.**

On the date of accident, Petitioner was **45** years of age, ***single*** with 4 dependent children.

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

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

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

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

ORDER

Petitioner failed to prove he sustained an accident in "October of 2010" that arose out of and in the course of his employment, that timely notice of an "October of 2010" accident was given, and that Petitioner's current condition of ill-being is causally connected to the alleged accident. Petitioner's claim in 12 WC 19279 is denied and no benefits are awarded.

Petitioner failed to prove a causal connection between his current conditions of ill-being in his low back, right leg (sciatica), right knee, left knee, and neck and his November 3, 2010 accident. Petitioner did prove a causal connection between his accident of November 3, 2010 and his left knee but only through August 1, 2011.

Respondent shall pay reasonable and necessary medical services for treatment to Petitioner's left knee through August 1, 2011 as set forth in PX 9 and as provided in Section 8(a) of the Act. Respondent stipulated to reimburse Medicare for related payments.

Petitioner failed to prove he sustained any permanent partial disability with regard to his left knee 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

March 28, 2014
Date

APR 3 - 2014

Findings of Fact and Conclusions of Law

Petitioner has two claims pending against Respondent. The cases were consolidated for purposes of hearing and the parties requested one decision for both cases. The issues in both cases are accident, causal connection, medical expenses, temporary total disability, and the nature and extent of any injuries. In addition, Respondent disputes notice in 12 WC 19279. Three witnesses testified at the hearing: Petitioner; Cassidy Kreitner; and Jerome Kreitner.

The Arbitrator finds:

On February 2, 1996, Petitioner sought treatment with Dr. Stephen Horner of Belleville Orthopedic Surgeons for a work injury occurring on January 19, 1996 when he twisted his right knee while loading some ladders onto a truck. Petitioner was subsequently diagnosed and treated for an anterior cruciate ligament tear with a "questionable problem" in the anterior horn of the medial meniscus. Dr. Horner recommended physical therapy with a follow-up evaluation in 2-3 weeks. He further noted that an ACL reconstruction might be necessary. (RX9)

Medical records also indicate Petitioner treated at St. Elizabeth's Hospital on May 11, 2002 for complaints of pain in his face and neck stemming from an earlier "altercation." (RX 12)

Medical records further show that Petitioner was treated at Belleville Memorial Hospital's emergency room on September 27, 2002 for neck pain stemming from a near syncope episode. Cervical spine x-rays were taken and read as unremarkable. (RX 11)

An Emergency Room Record dated November 22, 2004 from Belleville Memorial Hospital indicates that Petitioner had fallen 13 feet from a ladder and presented with complaints of low back pain and carpal tunnel to both arms. X-rays were taken of the lumbar spine and cervical spine and Petitioner was diagnosed with a lumbar spine contusion as well as cervical radiculopathy. (RX 11)

Thereafter in 2005 Petitioner sought medical treatment with Dr. Donald Bassman for his right knee. (RX10) According to the doctor's notes Petitioner had fallen out of a truck injuring his right knee seven years earlier and then fell again on November 22, 2004 resulting in a "flare up" and worsening pain. (RX 10) A right knee MRI was performed on January 19, 2005. (RX 12) Petitioner was subsequently diagnosed with a torn anterior cruciate ligament and medial meniscus tear and underwent an arthroscopy of his right knee with partial medial meniscectomy and anterior cruciate ligament reconstruction using autograft on November 28, 2005. Petitioner later underwent an FCE and was given permanent restrictions of no lifting over 50 pounds, no kneeling, no squatting, and no repetitive climbing or ladders. Petitioner was released from care on February 22, 2006. Dr. Bassman's notes reflect occasional examinations of Petitioner's left knee for comparison purposes with Petitioner's left knee consistently being described as "normal." (RX 10)

Petitioner filed an application for adjustment of claim (05 WC 01588) on January 12, 2005 alleging a fall off a ladder on November 21, 2004 causing injury to both hands and a torn meniscus of the right knee. (RX1) On that same date Petitioner filed a second claim (05 WC 01587) alleging bilateral carpal tunnel syndrome (RX 2).

Petitioner went to the Belleville Hospital Emergency Room on May 17, 2005 regarding a fall earlier in the day while at work with resulting in knee pain. (RX 11)

Petitioner underwent a left knee MRI on June 6, 2007 which revealed a purely cartilaginous fracture of the weight bearing tibial plateau lateral compartment, a small amount of reactive joint effusion with a Baker's cyst and some "most likely" reactive changes from a crush injury within the medial facet of Petitioner's patella. (RX 12)

Petitioner subsequently filed an application for adjustment of claim (07 WC 29732) on July 3, 2007 alleging injury to his left knee caused by a fall on a treadmill while in physical therapy for the right knee. (RX3)

The above claims were settled and settlement contracts were approved by the Illinois Workers' Compensation Commission on July 18, 2007. (RX4)

Petitioner underwent cervical spine x-rays on April 2, 2009 after falling off a ladder in February. Petitioner had multiple back and neck complaints at that time. (RX 12)

Petitioner was diagnosed with a backache on November 1, 2009 when seen at St. Elizabeth's Emergency Department. A nursing assessment form indicated that Petitioner had been assaulted and kicked repeatedly on both sides and in the groin. A history of cocaine use on Friday October 30th was noted. (RX 12)

On January 14, 2010, Petitioner sought medical treatment with St. Elizabeth's Emergency Department complaining of bilateral foot/toe numbness and pain going down the back of his right leg of approximately one month's duration. (RX 12)

Petitioner sought medical treatment on April 30, 2010 at St. Elizabeth's Emergency Department with complaints of congestion, back pain, and headache. Petitioner primarily complained of low back pain. Nursing notes indicate "Patient released from county jail today and thinks he was exposed to black mold." (RX12) Petitioner was diagnosed with an acute respiratory infection and a lumbar sprain. (RX 12)

Petitioner presented to the emergency room at Memorial Hospital in Belleville, Illinois on November 3, 2010 at 4:15 p.m. reporting that he was working with paint that day and began experiencing shortness of breath, nausea, and a headache. Petitioner was diagnosed with an acute exacerbation of asthma, a cervical strain, and a knee contusion[1] and told to take off work for one to days and follow up with his primary care physician thereafter or return to the emergency room if his symptoms worsened. Petitioner advised the nurse he became dizzy while painting and fell off of a ladder with loss of consciousness. Petitioner also complained of neck, lower back, right ankle, and left knee pain in addition to his shortness of breath. At 9:35 p.m. Petitioner told the nurse, "I gotta go. This is ridiculous. I've been here since 4 p.m. My wife is sleeping in the car. I'll sign out...." Petitioner further advised he was leaving and "felt great." Petitioner was discharged with prescriptions at 9:40 p.m. Left knee x-rays taken that day showed no fracture, dislocation, joint effusion or other bony abnormality. Cervical spine x-rays taken that day (and compared with earlier ones taken on November 23, 2004) showed no fracture or dislocation, satisfactory vertebral body height and alignment, and no changes since November 23, 2004. A right ankle x-ray and chest x-ray were taken and read as normal. (PX 2, PX 3) A handwritten note on a Memorial Hospital Emergency Physician Record appears to indicate "Petitioner was seen at O'Fallon 2 weeks ago... [illegible]...yesterday or today." (PX 2, PX 8)

---

[1] Which knee was not designated; however, the Arbitrator presumes it was the left knee as records indicate Petitioner only complained about his left knee.

An office note from Dr. Morrison dated November 10, 2010 indicates a fall off a ladder on November 3, 2010. Petitioner complained of having pain in "the knee", lower back, and trouble with his sciatic nerve. Dr. Morrison ordered X-rays and an MRI. (PX 8)

Petitioner presented to Memorial Hospital in Belleville, Illinois on November 10, 2010 with an order from Dr. Morrison requesting a right knee series due to "worsening knee pain and range of motion after a fall." Petitioner's right knee x-ray showed post-surgical changes compatible with a prior ACL repair without evidence of loosening along with mild degenerative and enthesopathic changes. (PX 3)

Petitioner underwent a right knee MRI on November 11, 2010. It revealed a nondisplaced horizontal tear of the posterior horn of the right lateral meniscus with mild lateral femoral condyle chondrosis; changes of prior partial right knee medial meniscectomy with mild partial thickness medial femoral condyle chondrosis; intact right ACL reconstruction; mild to moderate right patellofemoral chondrosis with subchondral edema in the medial trochlea; small right knee joint effusion with a small Baker's cyst; and a chronic right fibular collateral ligament sprain. (PX 8)

A lumbar spine MRI taken on November 11, 2010 revealed bilateral pars defects at L5-S1 resulting in minimal anterolisthesis of L5 on S1 with no evidence of central canal or neuroforaminal narrowing at that level. (PX 8)

A left knee MRI taken on November 11, 2010 revealed moderate left knee tricompartmental chondrosis, most severe in the lateral compartment; severe left knee superficial infrapatellar bursitis; and a small left knee joint effusion with a small Baker's Cyst. (PX 8)

On November 15, 2010 Petitioner presented to Dr. Robert H. Brophy at the Orthopedic Department at Washington University with knee complaints. Petitioner completed a medical history form indicating he had been experiencing knee pain for about three weeks after sustaining a fall. Petitioner noted that his "knee pain" increased with work. In response to the question, "Did this problem start at work?" Petitioner responded, "Yes and no." (PX 4) Petitioner listed no current medications were being taken for his complaints and that he had undergone an MRI on November 9, 2010 at Barnes Hospital[2] and an x-ray at Belleville Memorial Hospital. Dr. Brophy and a resident examined Petitioner noting his previous history of an ACL reconstruction and complaints stemming from a fall off a 12 foot ladder approximately three weeks earlier. Petitioner advised both Dr. Brophy and the resident that he was unconscious after the fall and woke up with the ladder on top of him. He could not recall if he twisted his knee or not but his left knee was hurting more than his right knee. Petitioner's primary complaints were crepitus and popping with positive locking and catching episodes requiring manipulation in order to get the knees to move. Petitioner was also noted to have a history of asthma. Bilateral knee x-rays were taken and interpreted as showing bilateral mild lateral and patellofemoral compartment osteoarthritis. Based upon the doctor's examination and review of the diagnostic films, Dr. Brophy felt Petitioner was suffering from bilateral anterior knee pain with chondromalacia in the left knee. Given Petitioner's MRI showed no ligamentous injury, Dr. Brophy felt Petitioner's popping and locking was associated with his chondromalacia. Dr. Brophy recommended bilateral Synvisc injections when the drug becomes available. (PX 4)

Dr. Morrison reviewed the various MRIs on December 1, 2010 noting, "Lumbar back - good. Right knee- old repairs. Arthritis. Chronic tendinitis. Possible meniscus tear. Left knee - arthritis. Bad tendinitis and bursitis. No tears." (PX 8) According to the doctor's records the nurse tried calling Petitioner repeatedly to advise him of the results but was unsuccessful. (PX 8)

---

[2] Not in the record.

On December 3, 2010 Dr. Morrison met with Petitioner and they reviewed Petitioner's knee MRIs noting that they primarily showed chondrosis and inflammation. The records further indicate, "Would like to f/u with the surgeon who performed his original surgery on the right knee. Consult written." An exam was performed with Petitioner's gait being described as normal. Dr. Morrison also reviewed the recent MRI of Petitioner's lumbar spine and noted the appearance of some mild disc disease but no stenosis. Dr. Morrison recommended a pain management evaluation; however, the records state, "Patient wants to see Neurosurgeon instead, consult written." Petitioner was referred to Dr. Poulos. (PX 8)

Petitioner returned to Washington University on January 3, 2011 and received a right knee injection. (PX 4; PX 7)

Petitioner was first examined by Dr. Poulos for his lumbar spine complaints on January 14, 2011. (PX 7; RX13) Dr. Poulos noted two discrete injuries with the first one occurring in October of 2010 when Petitioner slipped on the floor and fell into a nine foot hole experiencing acute, sharp, lower lumbar spine pain for which he was evaluated that evening at the emergency room. Petitioner further stated he had returned to work but continued experiencing low back pain with only minimal improvement. Petitioner also described his accident on November 3, 2010 when he was on a 16-foot ladder painting a truck, became lightheaded and fell approximately 13 feet. Petitioner landed on his right side and not only did that accident aggravate his back pain but Petitioner "began to develop" right knee pain too. The records indicate that "Remarkably, no ambulance was called. The patient was quite frustrated with his employer and actually drove himself to an ER. Once again, workup revealed no fractures." (PX 7; RX 13) Dr. Poulos performed an examination and reviewed Petitioner's recent lumbar spine MRI. He noted that Petitioner had not fully recovered after his first work injury and he, therefore, suspected the second accident aggravated the earlier symptoms. At the present time Petitioner's chief complaint was lumbar axial spinal pain and his exam was consistent with sacroiliitis. Dr. Poulos could not clearly ascertain if Petitioner's pars defect was symptomatic or not. He recommended aggressive medical treatment in the form of intramuscular injections, a Medrol Dosepak, Mobic, Skelaxin, sacroiliac injections and physical therapy. Petitioner was to return in three weeks. (PX 7)

Petitioner began physical therapy for his lower back pain on January 27, 2011 at St. Elizabeth's Hospital in Belleville. (PX 5; RX12) A physical therapy certification form from January 27, 2011 indicates Petitioner was diagnosed with low back pain and was to undergo a home exercise program for 3 times a week for 3 weeks. A record entitled "Patient History" indicates Petitioner was experiencing back and knee pain as a result of a fall off a ladder and an "October 2010" incident where he was twisting to the right and his lumbar spine flexed forwarded slipping downward. (PX 5; RX 12)

A hospital "History and Physical" form completed on February 7, 2011 contains a history of Petitioner experiencing low back pain and right leg pain since a fall on November 3, 2010 when he fell approximately 13 feet from a ladder landing on his right side. Petitioner reported the fall aggravated his pain. Petitioner also gave a history of an accident in October of 2010 when he fell in a nine foot hole; however, his work-up thereafter was negative and he returned to work with minimal improvement prior to the November 3rd accident. Petitioner was currently unemployed and had been diagnosed with lumbar spondylolisthesis, lumbar facet arthropathy, sacroiliitis, and lumbar degenerative disc disease. Petitioner was getting ready to proceed with bilateral sacroiliac injections. (RX 12)

Petitioner underwent bilateral sacroiliac joint injections on February 8, 2011. (RX 12)

Petitioner returned to see Dr. Poulos on February 10, 2011 reporting he was just beginning to feel the injection was "impacting on his pain." He reported a new complaint of intermittent neck pain which he dated to his injuries; "emphasis on plural." (PX 7) Petitioner reported the Tramadol seemed to be making him aggressive and short-tempered. His mood improved when he stopped the Ultram. Lortab was started as an alternative. Petitioner was given Flector patches to be alternated between his sacroiliac joints and he was to return in 3 - 4 weeks. Dr. Poulos expressed hope that Petitioner's complaints were solely related to his sacroiliitis and that he would not require any surgical reconstruction for his pars defect. Some neck exercises were to be incorporated into Petitioner's therapy program. (PX 7)

On February 21, 2011 Petitioner again presented for physical therapy. According to the "Patient History," form Petitioner was experiencing a neck problem and references a November 3, 2010 fall from a ladder as well as an incident in 2010 where Petitioner indicated he hit his head on a steel beam. A handwritten note from the physical therapist on February 21, 2011 indicates that "Patient is a questionable historian regarding the onset of symptoms. Ultimately states neck pain started with fall from ladder 11-3-10." (PX 5; RX 12)

When Petitioner returned to see Dr. Brophy on February 21, 2011 he reported that he did not feel as though his knee was much better after the injection as he still had the same symptoms. A discussion was held regarding treatment options (including another injection, therapy, medication, and surgery) with Petitioner opting for "more aggressive" intervention in the form of surgery (a partial meniscectomy and debridement) which the doctor felt was a reasonable approach given Petitioner's mechanical symptoms and level of pain. Petitioner also wished to undergo a left knee Synvisc injection which was going to be arranged. (PX 4)

Petitioner was discharged from therapy for his back on March 7, 2011. During the time he underwent therapy Petitioner also received care for his neck. Therapy was discontinued due to lack of improvement /progress in Petitioner's condition. (PX 5)

Petitioner was re-examined by Dr. Poulos on March 7, 2011. While Petitioner had originally seemed to be responding to the injections, his condition was now described as "regressed." Petitioner brought the doctor up-to-date on his right knee treatment, including the prospect of surgery. Dr. Poulos believed Petitioner was probably going to need reconstructive spinal surgery but should proceed with the knee surgery first to see if that could improve his back complaints and do away with the need for back surgery. A CT discogram was ordered. (PX 7)

Petitioner underwent bilateral sacroiliac joint injections on March 31, 2011. (RX 12)

Petitioner underwent a left knee Synvisc injection and right knee partial medial meniscectomy, partial lateral meniscectomy, and patellar chondroplasty on April 8, 2011 at Barnes Jewish Hospital. (PX 4; PX 5)

Petitioner returned to see Dr. Poulos on April 18, 2011. Dr. Poulos noted that after two rounds of sacroiliac injections, Petitioner has a known grade I L5-S1 isthmic spondylolisthesis secondary to a pars defect and he was very suspicious that that was the cause of Petitioner's ongoing spinal pain. He still wanted the discogram performed. (PX 7)

Petitioner also saw Dr. Brophy on April 18, 2011 reporting constant pain after his surgery. Physical therapy was to be initiated. (PX 4)

Petitioner underwent a CT of his lumbar spine on May 4, 2011 that revealed: an L3-4 annular tear with a left central disc protrusion effacing the ventral thecal sac; L5-S1 Grade 1 spondylolisthesis with bilateral L5

spondylolysis; an L5-S1 annular tear with mild to moderate disc bulge encroaching upon the L5 nerve roots, and a small anterior annular tear at L4-5 with a mild disc bulge posteriorly. (RX 12)
Petitioner underwent a discogram on May 4, 2011. (RX 12)

As part of Petitioner's recovery process post right knee surgery Petitioner underwent physical therapy beginning on May 9, 2011. When Petitioner began knee therapy he remarked he was uncertain how much therapy he could tolerate due to his lower back pain. (PX 4; PX 5; RX 12)

Dr. Poulos dictated an office memo on May 18, 2011 based upon his review of Petitioner's file, including MRI studies and discogram. He believed Petitioner's relevant pain generators were at L4-5 and L5-S1 and he recommended a two level reconstruction with an anterior approach. (PX 7)

Petitioner signed his Application for Adjustment of Claim in Case # 11 WC 21799 on "June 2, 2010 [sic]"[3]. Petitioner alleges an accident on November 3, 2010 when he fell from a ladder when overcome by paint fumes. (AX 2)

On June 9, 2011, Petitioner again presented to Dr. Poulos. Dr. Poulos reviewed his recommended surgery with Petitioner and noted Petitioner must be smoke-free in the perioperative period or else he would risk pseudoarthrosis. Petitioner was asked about his insurance status near the end of the visit with the doctor noting that Petitioner "consistently has reiterated this is a worker's compensation case the entire time I've been treating him." Petitioner was asked to provide an appropriate claim number so the doctor's office could correctly file insurance claims; however, when asked, Petitioner became quite angry and defensive. Dr. Poulos noted that Petitioner's behavior was unexpected and surprising given the straightforward request. Dr. Poulos documented his providing Petitioner with an explanation as to why this was necessary and, again, noted Petitioner's agitation. He then stated, "...this is a mute [sic] point given [Petitioner's] acute asthma which absolutely obligates for medical safety reasons delaying his case by a few weeks." (PX 7)

Four days later on June 13, 2011, Dr. Poulos dictated another office memo. In it, he reviewed what had transpired a few days earlier (lack of workers' compensation billing information for services). He further noted he was discharging Petitioner from his care, stating in his notes that he would not tolerate abuse to his staff, and cancelled Petitioner's proposed surgery. "Since that visit on 06/09/2011, the patient has had several phone calls to the office with various staff. He has basically been very violent. The patient has been very angry. He has been screaming, using expletives, and threatening the staff. What is remarkable is that this very routine request for a worker's compensation claim number would result in this kind of behavior." (PX 7) Dr. Poulos indicated that this kind of psychological instability did not bode well for the type of commitment and proper rehabilitation required for a major reconstructive surgery. (PX 7)

Petitioner next presented to Dr. Morrison's office for "surgical clearance" on June 16, 2011. Petitioner advised he was scheduled for surgery but the doctor was no longer willing to perform it. According to the doctor's notes, "[Petitioner and Dr. Poulos' office] have different reasons why this occurred." Petitioner requested a referral to another surgeon and Petitioner was eventually scheduled for a visit with Dr. Zebela, an orthopedist. (PX 8)

On July 20, 2011 Petitioner presented to the Washington University Orthopedic Department in regard to a back injury with an onset date of "October,November 2010." Petitioner reported that the pain/problem had worsened in the past few months after a fall at work. Petitioner complained of a sharp, severe, and aching pain. Petitioner completed a detailed questionnaire regarding his back problem indicating that "most of the time" he was

[3] The claim was filed 6/7/11.

experiencing low back and/or buttock pain, numbness or tingling in his leg and/or foot, and weakness in his leg and/or foot. He described his low back pain as "extremely bothersome." (PX 4) Petitioner was examined by Dr. Zebala who recorded a more specific history of Petitioner having a fall at work in October and November of 2010 with 90 % back pain and 10% leg pain. Petitioner's work-up with Dr. Poulos was noted. Petitioner rated his back pain at a "7/10" and largely activity related. On examination Petitioner was noted to be ambulating with an antalgic gait and favoring his right leg. Petitioner displayed pain on lumbar flexion and "gentle rocking." Petitioner also displayed pain in his lower back when pressure was applied to his head and shoulders. Straight leg raise was negative bilaterally and strength was 5/5 bilaterally. Petitioner had globally decreased sensation to light touch in his right leg and tenderness to palpation over his lumbosacral junction and S1 joints. Lumbar spine x-rays taken that day showed mild L3-4 and moderate L4-5 degenerative disc disease with bilateral pars defects with a grade 1 anterolisthesis of L5 on S1. There was minimal anterolisthesis in the November 11, 2010 x-rays. Dr. Zebala's impression was Grade 1 isthmic spondylolisthesis of L5 on S1 with predominantly mechanical back pain and right leg dense numbness without evidence of foraminal or central stenosis on the November 2010 MRI but discogenic pain as evidenced by a positive discogram at levels L3-4 L4-5 and L5-S1. Dr. Zebala did not recommend any surgery but other treatment measures included a corset, medication, weight reduction, and physical therapy. Petitioner was advised he could work as tolerated and engage in activities as tolerated. (PX 4)

Petitioner returned to see Dr. Brophy on August 1, 2011 regarding his right knee complaining of ongoing pain in his knee since the surgery in April of 2011. Petitioner reported the pain was worse with stairs and walking for long periods of time and he occasionally notices a bit of popping. Dr. Brophy recommended additional therapy aimed at strengthening the knee and muscles. Petitioner's left knee felt "better." Synvisc injections were discussed but Petitioner wanted to focus on therapy and strengthening. Otherwise Petitioner was to return as needed. (PX 4)

Petitioner underwent knee therapy beginning on August 1, 2011. At his last therapy session on August 19, 2011 Petitioner noted no improvement in his right knee and he cancelled his remaining appointments preferring to continue his exercises on his own. Petitioner's right knee strength was noted to be within normal limits. (PX 5; RX 12)

A radiology report dated August 18, 2011 from St. Elizabeth's Hospital showed stable mild anterolisthesis at L5-S1, without evidence of ligamentous laxity. (RX 12)

Petitioner presented to Dr. Gregory Bailey on August 22, 2011 with complaints of back pain and middle back pain with numbness and tingling radiating down his right leg towards both knees which began after a fall at work in "Oct/Nov. 2010." Petitioner had undergone a discogram and injections with increased pain. On examination Petitioner was tender at his L5-S1 facet on the right. Flexion/extension films were ordered. Petitioner was given Voltaren and told to engage in aquatic therapy and stop smoking for his congenital spondylolisthesis. (PX 6)

Dr. Brophy re-examined Petitioner regarding his right knee on August 29, 2011 noting Petitioner was still experiencing pain in his right knee. Based upon his physical examination of Petitioner's right knee, Dr. Brophy believed Petitioner was suffering from some mild persistent right patellofemoral pain for which no immediate aggressive intervention was needed. However, the doctor did not rule out Synvisc in the future and noted some mild limitations in terms of stairs and climbing ladders or squatting. (PX 4)

Petitioner followed up with Dr. Bailey on September 2, 2011 at which time they reviewed the diagnostic films and Petitioner was advised they showed no "real change." Petitioner's diagnosis remained congenital

spondylolisthesis and he was told it would take time to heal. The doctor was going to contact his "rep" about getting Petitioner fitted with a brace. (PX 6)

Petitioner returned to see Dr. Gregory Bailey on November 15, 2011 after having last been seen in September. Petitioner was wearing a back brace but still having "ongoing issues." His examination was positive for neck and joint pain. Petitioner reported the inability to stand up without leaning forward and experiencing some tightness. His diagnosis was listed as congential spondylolisthesis and he was given Diazepam. If that did not help improve his condition he would try Elavil. (PX 6)

Petitioner next saw Dr. Gregory Bailey on March 5, 2012 advising him he was having trouble with the Elavil as it caused him to be irritable and lose his patience with people, his back brace was too small due to his use of steroid medications for asthma, and he was having some back pain and right leg pain. Dr. Bailey's diagnosis was congenital spondylolisthesis and he increased Petitioner's Voltaren, started Petitioner on Lyrica to help with the side effects of Elavil, and told Petitioner to use an inversion table. (PX 6)

Petitioner signed his Application for Adjustment of Claim in Case #12 WC 19279 on April 2, 2012. Petitioner alleged an accident in "late October 2010" when he fell while carrying a panel across a trench of a building footing. (AX 3)

Petitioner presented to Dr. Gregory Bailey on June 13, 2012 regarding right thigh and right leg pain below his knee. Petitioner stated his right leg would occasionally give out and he had been wearing a back brace as he couldn't lie flat and had to sleep in a recliner. Petitioner reported his valium "wasn't working." Dr. Bailey felt Petitioner was suffering from degeneration of a lumbar disc or lumbosacral intervertebral disc and advised him treatment could take six months to two years. Petitioner was also noted to not be doing everything that had been recommended to him such as smoking cessation and engaging in aquatic exercises. (PX 6)

Petitioner underwent a cervical spine MRI on July 5, 2012 which revealed minimal degenerative disc disease at C4-5. (RX 12)

At the request of one of his previous attorneys, Petitioner was examined by Dr. Shawn Berkin on November 19, 2012. (PX 1, dep. ex.) Dr. Berkin met with Petitioner, reviewed his history and available medical records and test results, conducted a physical examination, and then issued a written report. According to the report Petitioner injured his lower back and both knees in November of 2010 while working as a mechanic/driver for Respondent. On that day he was standing on a scaffold and painting a dump truck when he lost his balance and fell sixteen feet onto his side, twisting his lower back and injuring his knees. He was seen that day at Memorial Hospital in Belleville. Dr. Berkin's report includes a review and summary of various treatment records through the date of his examination. Petitioner's complaints when seen that day included pain and tenderness to his lower back, pain extending into his right leg with numbness to his toes, difficulty maintaining, his personal hygiene, and the inability to lie flat. Petitioner was wearing a back brace in order to relieve his symptoms. Petitioner also complained of pain and tenderness to his right knee, give away, difficulty with pain when ambulating up the stairs, and shrunken right leg muscles. Petitioner's medical history included bipolar disorder, asthma, and pulmonary symptoms. He had previously undergone bilateral carpal tunnel releases and ACL reconstruction of the right knee.

On examination Petitioner walked with an antalgic gait, lurching on his left leg. He displayed tenderness over the paraspinal muscles lateral to the lumbar column extending into the sacroiliac joints bilaterally. He had no trigger points or muscle spasms. The Patrick-Fabere test was positive on the right and sacroiliac provocative maneuvers were positive for pelvic rock and iliac springing. Petitioner had muscle atrophy of the right thigh and

lower leg. Range of motion was limited. Straight leg raising was positive for lower back pain at 70 degrees of elevation of the right leg and Yeoman's testing was positive bilaterally. Petitioner's right knee revealed mild quadriceps atrophy. He had tenderness over the medial and lateral joint surfaces and medial joint pain with lateral stressing. McMurray's test was positive. The anterior drawer test was slight positive for anterior translation of the tibia on the femur. Muscle strength testing revealed 4/5 quadriceps strength to resisted knee extension. Petitioner's left knee examination was fairly normal although Petitioner was unable to squat.

Dr. Berkin's diagnoses included the following: lumbosacral strain with right sided sciatic; bilateral sacroiliitis; spondylolisthesis of L5-S1, right knee sprain with tears of the medial and lateral menisci; left knee contusion/strain; and status post arthroscopy of the right knee with medial and lateral meniscectomies and chondroplasty of the patella. Dr. Berkin was of the opinion Petitioner had sustained lower back and bilateral knee injuries when he fell in November of 2010. More specifically, he believed Petitioner's accident was the "prevailing factor" in Petitioner's lumbosacral strain and sciatica, bilateral sacroiliitis, and spondylolisthesis and right knee medial and lateral menisci tears and left knee contusion. As a result he felt Petitioner had sustained "significant disabilities" to his lower back and knees and recommended ongoing medication for his pain, a home exercise program, avoidance of excessive squatting, kneeling, stooping, turning, twisting, lifting, and climbing. He also felt Petitioner's lifting should be limited to 20 to 25 lbs. occasionally and 15 lbs. repetitively. Regarding Petitioner's knees, Dr. Berkin believed Petitioner should avoid pivoting and lateral movements and avoid rapid acceleration and deceleration movements, be cautious when climbing ladders and stairs, working at heights above ground level, and walking on uneven surfaces. Petitioner should remain as active as possible but pace himself and take frequent breaks. Dr. Berkin also felt Petitioner might benefit from periodic examinations by a spine surgeon to monitor his low back and cessation of smoking to better improve his pulmonary status and overall health. (PX 1, dep. ex.)

Petitioner underwent a right knee MRI (as ordered by Dr. Horner) which was performed on December 18, 2012 and revealed a complex tear of Petitioner's medial meniscus with an oblique component extending to the inferior surface, increased signal/fluid within the medial collateral ligament suggesting bursitis and an area of narrowing cartilage in the weight bearing medial femoral condyle. (RX 11)

Dr. Berkin's deposition was taken on February 14, 2013. (PX 1) Dr. Berkin testified he is a family practitioner and performs about 25 independent medical examinations per week. Dr. Berkin opined that Petitioner's November 2010 accident caused a right-sided sciatica, bilateral sacroillitis, and spondylolisthesis of L5 on S1. Dr. Berkin also opined that the November 2010 injury was the prevailing factor in causing the tears of the medial and lateral menisci of Petitioner's right knee and a strain/contusion to Petitioner's left knee. While Petitioner told Dr. Berkin his right knee was previously injured in 2006 when he was dragged by a truck, Dr. Berkin did not receive any of Petitioner's pre-accident medical records or diagnostic studies. (PX 1)

An independent medical examination was performed by Dr. Richard Lehman on March 28, 2013. (RX7) Dr. Lehman examined Petitioner's right and left knee and his lumbar spine as these were the only areas of complaint that day. Petitioner denied any cervical spine pain. Petitioner provided a history to Dr. Lehman of working on scaffolding, passing out, and falling and landing on the ground, and getting up and driving himself to the emergency room. (RX 7, pp. 1-2)

Dr. Lehman performed an extensive physical examination and summarized Petitioner's main complaints as appearing to be right knee pain (primarily patellofemoral in nature and directly related to the patellofemoral joint). Petitioner's left knee evidenced mild patellofemoral complaints, but the doctor's examination was normal. Dr. Lehman found Petitioner's right knee to evidence mild laxity anteriorly with no breakdown as it related to

the joint surfaces. Petitioner's back showed significant L5-S1 spondylolisthesis of a long-term and chronic nature. X-rays were taken that day. (RX 7, pp. 2-4)

Dr. Lehman reviewed medical records and diagnostic films that both pre-dated and followed the alleged accidents. (RX 7, pp. 3-11) Dr. Lehman opined that Petitioner's spinal injuries as it relates to his injury of October of 2010 were none. Dr. Lehman opined that Petitioner's lumbar spine chronic changes at L5-S1 were long-term in nature and chronic and did not appear to have been in any way altered, exacerbated or otherwise changed by his fall. (RX 7, p. 11)

Dr. Lehman also opined that no acute processes in Petitioner's right and left knees could be found or related to his alleged accidents. (RX 7, pp. 11-12) Dr. Lehman reviewed all of Petitioner's MRIs, one by one, frame by frame, and indicated he found "absolutely no evidence in any one of these scans of an acute pathological process that one could attribute to the injury to date." Dr. Lehman also examined Petitioner's x-rays in conjunction with previous x-rays. He measured tibiofemoral angles and joint space openings and indicated that "clearly there has been absolutely no change and nothing that one could relate to an alteration from his pre-injury status to his post-injury status."

Dr. Lehman opined that Petitioner's problem was long term in nature, degenerative, and appeared to be directly related to his pre-existing pathology. (RX7, pp. 11-12) He believed Petitioner would have been at maximum medical improvement by November 29, 2010 when the MRIs of his knees and lumbar spine had been completed and showed no evidence of any acute pathology. (RX 7, pp. 12-13) Dr. Lehman indicated that after reviewing frame-by-frame diagnostics studies, that "there appears to be nothing to suggest in any of these objective examinations, and again, I have been through every one frame-by frame, that that there has been change that one can see pre-injury or post-injury. (RX 7, pp. 13-14)

Dr. Lehman was deposed on May 28, 2013. (RX 8) Dr. Lehman is board certified in orthopedic surgery with a subspecialty certification in sports medicine. Dr. Lehman testified consistent with his written report of March 28, 2013. (RX 7, pp. 6-23)

On cross-examination Dr. Lehman testified that Petitioner had a long history of back complaints prior to November 3, 2010 including treatment for a lumbar strain on April 30, 2010 and April 2, 2009 (RX 7, pp. 25-26) He acknowledged Petitioner had undergone no back surgery or injections prior to November 3, 2010 (RX 7, p. 26) He was also unaware of any treatment to Petitioner's right knee between 2005 and November of 2010 or to Petitioner's left knee between May of 2007 and November of 2010 (RX 7, p. 28) It was further the doctor's understanding that Petitioner was working full duty in November of 2010. (RX 7, p. 28) He also acknowledged that while he had stated in his written report that Petitioner's lumbar spine MRIs post and pre accident were identical there was no pre-accident lumbar spine MRI. Dr. Lehman testified that he performs approximately 21 IMEs per week and about 60-65% of them are for insurance companies and the rest are for injured workers. He charges $500.00 per hour. (RX 7, p. 30)

At the arbitration hearing Petitioner testified that he began working for Respondent in October of 2010 although he was uncertain as to the exact date.[4] was delivering and carrying a 10 foot tall panel onto a construction job site in "October of 2010" when he tripped over a footing that was cut out, dirt gave way, he twisted, and his leg and knee went down. Petitioner testified there was a 12-foot drop and that the only thing that kept him from going into the hole was a mound of dirt that caught the other panel. Petitioner testified he hit his right knee and he "kind of" limped on it for a couple of days but did not go to the doctor. Petitioner testified that he had

[4] According to RX 6, it was October 21, 2010.

previously undergone surgery in that knee and so he just thought he had "tweaked it." Petitioner continued working for Respondent.

Petitioner testified that the owner's brother was the supervisor and was present on the jobsite when the accident occurred. Petitioner testified that he never told anyone at work about it because he (the supervisor) witnessed it and when he got to the shop "it was a big joke to everyone."

Petitioner testified that he had a second accident on November 3, 2010 when he was painting, passed out from fumes, and fell from a ladder. Petitioner testified that he had made a scaffold by placing a board between two ladders. Petitioner testified he was painting a 13 to 14 foot tall dump-truck, became lightheaded, passed out, and fell to the floor. Petitioner testified he landed on his right side, twisted. Petitioner testified he was the only one working there except for the owner's sister who was around "off and on." Petitioner testified that he woke up on the floor with his body "twisted" -- ie., his upper body was going to the left and his lower body and hips were going to the right.

Petitioner testified that after he fell, he tried yelling for somebody for help. Petitioner testified that he crawled to the door where she was at and knocked on the door and nobody came out. Petitioner testified that he finally got outside, tried calling Jerry and several other people. Getting no response he drove himself to Memorial Hospital. Petitioner testified he just left the stuff in the garage.

On cross-examination Petitioner testified that the accident occurred between 10:30 and 12:00. He denied that the ladder(s) fell on top of him. He estimated 20 - 30 minutes transpired before he left for the hospital. When asked several questions about whether or not he went straight to the hospital, Petitioner was really unsure and didn't really remember. He might have gone home for a second or a couple of hours. He felt really out of it. He just really wasn't sure.

Petitioner testified that when he got to Belleville Memorial Hospital he complained of back and neck pain along with both knees. When asked if he knew why the hospital only x-rayed his left knee, Petitioner testified that he spoke to a technician and thought they "misinterpreted the records or something." In any event Petitioner thought he tweaked his left knee a little on November 3rd. On cross-examination Petitioner testified that he didn't think he left the hospital early.

Petitioner initially testified that the reason why he hurt his knee in 2004 was that he was carrying a triple dresser down the stairs and tore the ACL. Petitioner testified he did not file a workers' compensation claim relating to this incident. Petitioner testified that within a few days of the triple dresser incident, he also fell on a ladder when one of the rungs snapped while coming up the ladder. Petitioner testified he was not aware that he was issued permanent restrictions by Dr. Bassman in 2006 and thought the restrictions he was given were temporary.

Petitioner testified that he did not recall seeking medical treatment with St. Elizabeth's Hospital in April of 2009. Petitioner also did not remember falling from a ladder in February of 2009.

When asked if Petitioner ever sustained a back strain or sprain that necessitated medical treatment with St. Elizabeth's Hospital in 2010, Petitioner testified it was possible due to the type of work he performed -- ie., construction. Petitioner testified that it was also possible that he sought medical treatment with St. Elizabeth's Hospital emergency in 2009 with complaints of back pain.

Petitioner testified that he did not remember his treatment and diagnosis from Dr. Horner in 1996.

Petitioner testified on cross-examination that he did not recall and did not think he had toe numbness and pain down his right leg prior to November 3, 2010.

Petitioner testified that he has continued to experience problems and limitations with his low back including pain in the low back running down his sciatic nerve, down the right leg and into his right big toe. He experiences pain with any type of sudden bends or turns. He has constant pain in his low back that fluctuates depending on his level of activity. He described that he sleeps in a recliner because he is simply unable to lay flat.

Petitioner denied having any problems with his right knee immediately before his accident[5]. According to Petitioner he had undergone surgery in 2005-2006, went through physical therapy and then felt great with no limitation in his activities or his ability to work. In his words, he was "ready to go."

Since the accident Petitioner continues to experience weakness around his right knee and also described a loss of muscle mass in that area. Petitioner testified that he occasionally walks with a limp depending on the level of activity he has performed. He described difficulty with stairs indicating that he must lead with his left foot. He described that he cannot put pressure or direct force on his right knee. He continues to take pain medications for both the back and his right knee.

Petitioner has been on social security disability since 2002 or 2003 due to a bipolar disorder which he regulates with medication. When asked how he was able to work while on social security disability, he described that over the years he has been trying to get back into the work force on a permanent basis. Social Security allowed him to work so many months and hours within a year.

Respondent called Cassidy Kreitner to testify at the arbitration hearing. Ms. Kreitner testified that she does not work for Respondent but she is the sister of Jerry Kreitner, the owner of Respondent's business, and lived in close proximity to Respondent's shop and garage. Ms. Kreitner testified that on November 3, 2010, she saw Petitioner painting a truck and using ladders. She further testified that her apartment is in the basement and one must walk through the garage/shop to get to it. Ms. Kreitner testified that she briefly left the premises that day to go about 2.5 miles to Casey's for a soda and cigarettes. Ms. Kreitner testified that the trip took approximately 15 minutes altogether and when she returned to the shop, the shop was closed, the lights were off, and nobody, including Petitioner, was there. Ms. Kreitner testified that this occurred around noon that day.

Respondent called Jerome Kreitner, owner of Kreitner Construction, to testify at the arbitration hearing. Mr. Kreitner testified that Petitioner was hired as a mechanic/truck driver/laborer. He also testified that Respondent's garage had three stalls. The ceiling height of two of the stalls is 11 feet while the ceiling height of one stall is 13 feet. Mr. Kreitner estimated that the truck Petitioner was painting on was about 11 feet tall. A written statement signed by Mr. Kreitner (submitted as Respondent's Exhibit 6) indicated that Kreitner Construction only owned 6 foot and 8 foot ladders. 6-foot ladders were used in the shop itself while 8 foot ladders were used outside of the shop. (RX6) Mr. Kreitner acknowledged that Petitioner told him he had fallen off a ladder a couple of days after it occurred. He further testified that he went to the shop/garage on November 3, 2010 and noticed Petitioner wasn't there and began trying to reach him by telephone. He reached Petitioner a couple of days later. According to Mr. Kreitner, Petitioner came by to pick up his final pay check a couple of days later and he did not observe Petitioner limping.

---

[5] The Arbitrator recalls this questioning was somewhat confusing as Petitioner was initially asked if before "November/October 2010" he had any problems with his right knee and the question ended with reference to only one accident (but the date wasn't specified).

The Arbitrator concludes:

1. Case # 12 WC 19279 (D/A - "Late October 2010")

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

Petitioner failed to prove he sustained an accident arising out of and in the course of his employment with Respondent. This conclusion is based upon Petitioner's failure to testify regarding a specific date, place and time of his accident. Petitioner never identified a specific date, time, or place where his alleged accident occurred. He was not even sure when he began working for Respondent other than it was in October of 2010. The first mention of this alleged accident as found in the medical records is on January 14, 2011 when Petitioner was examined by Dr. Poulos for lumbar spine pain allegedly stemming from a fall in a hole in October of 2010. Even this history is completely at odds with Petitioner's testimony as Petitioner never testified to low back pain stemming from this alleged occurrence (rather, he claimed, at most a twisting or tweaking of his right knee). Petitioner never mentioned this alleged accident to Dr. Morrison, Dr. Brophy, Dr. Zebela, Dr. Bailey, or Dr. Berkin, his own examining physician. As Petitioner's testimony was not specific in details and was not corroborated by the medical records, Petitioner has failed to prove he sustained a compensable accident.

Additionally, Petitioner's testimony as to the giving of proper notice was unconvincing. Petitioner testified the owner's brother was present on the job when the alleged accident occurred and that the brother was his supervisor. However, Petitioner further testified that Mr. Kreitner's brother witnessed the alleged accident and he just "assumed" everyone knew about his accident so he figured he didn't have to explain what happened himself. At no time did Petitioner testify to a date and time when he gave proper notice of the alleged accident to Respondent.

Issue (F) -- Causal Connection.

Even assuming, arguendo, that Petitioner established he sustained an accident and provided timely notice of it to Respondent, Petitioner's claim must be denied as he failed to prove a causal connection between his accident in October of 2010 and his current condition of ill-being in his lumbar spine or right knee. The Arbitrator notes that Petitioner did not testify to any neck, left knee or low back injuries occurring at the time of this accident. At most, Petitioner thought he "tweaked" his right knee. He sought no medical treatment, lost no time from work, and continued working for Respondent until his second accident (case # 11 WC 21799) Dr. Berkin did not provide a causation opinion between this accident and any of Petitioner's medical conditions. Indeed, the doctor testified that he didn't think the first accident was much of anything. He testified, "I really don't think that that first incident was much of an incident, didn't have much treatment for it at all or anything. Didn't even bother to tell me about it." (PX 1, p. 13) While Dr. Poulos arguably provided something close to a causation opinion in his January 14, 2011 office note, that "opinion" was based upon incorrect information supplied by Petitioner in that he claimed a lumbar spine injury in conjunction with the October accident and also reported having undergone an emergency room evaluation that same day. Petitioner's arbitration testimony was completely contrary to that and no emergency room records were submitted into evidence. Petitioner failed to prove any of his problems in his knees, low back, or neck were/are causally connected to the October of 2010 alleged accident.

For the foregoing reasons, Petitioner's claim is denied. No benefits are awarded. All other issues connected to this claim are moot.

2. Case # 11 WC 21799 (D/A - 11/3/10)

Issue (C) - Accident.

Petitioner sustained an accident on November 3, 2010 that arose out of and in the course of his employment with Respondent. Petitioner's testimony concerning his job duties that day and how he became over come with fumes and fell were corroborated by the medical records. Notice was not disputed. Neither of Respondent's witnesses really rebutted that an accident occurred. While there were some discrepancies in some of the details of Petitioner's fall (such as the distance, Petitioner's consciousness, etc.) those discrepancies go more to the issue of Petitioner's credibility and causation rather than whether an accident occurred or not.

Issue (F) - Causal Connection.

At the outset the Arbitrator wishes to comment on Petitioner's credibility. As noted above, there were discrepancies in some of the details of Petitioner's testimony. Any discrepancies in the distance Petitioner fell are not alarming to the Arbitrator -- the point is he fell some distance. More significant are Petitioner's problems with recall (ie., his prior medical condition and treatment, whether he lost consciousness or not, whether he drove straight to the hospital or not[6]), his inability to recall/remember that he did leave the emergency room on the day of the accident (he did and he reported feeling "great") and his inconsistent histories as to the injuries he correlated with each of his alleged accidents. For example, he testified he only "tweaked" his right knee in the October of 2010 accident; however, he had previously told Dr. Poulos he injured his low back at that time and had undergone an emergency room visit thereafter. Even later, he presented with neck complaints claiming to Dr. Poulos that he also hurt his neck with both of his accidents. However, he had not really undergone any care to his neck prior to that assertion (except for the ER visit on the 3rd). There are problems with Petitioner's medical histories being inconsistent with his testimony as well as problems with the histories being consistent with one another. There is also the question of whether or not Petitioner injured one or both knees in the November accident. Petitioner testified he had complaints to both knees when examined at the hospital on the 3rd; however, the records don't corroborate his testimony. He testified that he thought he "tweaked" his left on the 3rd but that his right knee was more problematic. Yet, no mention of the right knee is made in the ER records. Petitioner's credibility is further suspect based upon his testimony regarding the condition of his right knee prior to October of 2010. Petitioner testified he had no problems with his right knee and that he was not limited by it in any way. This seems completely at odds, and contrary to, the permanent restrictions issued by Dr. Bassman and his office note of February 22, 2006 indicating Petitioner was experiencing "constant soreness" in his right knee and was, according to the FCE, not at his prior level of workability. (RX 10) All in all, this Arbitrator has difficulty wholly believing Petitioner and Petitioner's lack of credibility clouds the causation issue.

The Arbitrator notes that none of the treating physicians were deposed or provided causation opinions. While Dr. Poulos' office note of January 14, 2011 contains comments that might come close to being causation opinions, they are based upon a faulty history as provided by Petitioner. That leaves the opinions of two examining physicians -- Dr. Berkin, a family practitioner, and Dr. Lehman, a board certified orthopedic surgeon. Petitioner did not inform Dr. Berkin of injuring his right knee and back in falls from ladders in 2004 and 2009. Dr. Berkin did not examine any of Petitioner's pre-accident medical records. While Dr. Lehman indicated he reviewed both pre-accident medical records and diagnostic films studies, frame by frame, and compared these studies to post-accident diagnostic studies, he acknowledged during his cross-examination that there were no pre-accident lumbar spine MRIs , thereby making a comparison difficult. Thus, he, too, does not give an entirely

[6] The medical records show Petitioner presented at 4:15 p.m. Both parties agree the accident occurred no later than Noon.

persuasive opinion. Based upon qualifications and amount of material reviewed and studied as part of the examination process, the Arbitrator finds the opinions of Dr. Lehman to be more persuasive than those of Dr. Berkin; however, as stated previously, they are not entirely persuasive.

Thus, finding problems with Petitioner's credibility and problems with both examining physicians' reports and opinions the Arbitrator relies heavily on the objective medical records presented and concludes as follows:

1. Petitioner's right knee -- Petitioner failed to prove his current condition of ill-being in his right knee is causally connected to his accident of November 3, 2010. This is based upon the lack of documentation of any right knee complaints at Petitioner's initial emergency room visit on November 3, 2010, Petitioner's testimony that he may have injured his right knee in another earlier accident in "October of 2010", Petitioner's lack of a complete and accurate history to Dr. Morrison, Petitioner's inconsistent and incomplete history to Dr. Brophy when initially seen on November 15, 2010, and Petitioner's MRI of November 11, 2010 which Dr. Morrison summarized as showing old repairs, arthritis, chronic tendinitis, and a possible meniscus tear. No credible and persuasive evidence was presented establishing a causal connection between any of these findings and Petitioner's accident nor can causation be established herein by a chain of events.

2. Petitioner's left knee -- Petitioner's left knee condition is causally related to his accident of November 3, 2010 but only through August 1, 2011. This is based upon a chain of events. Petitioner failed to prove ongoing causation post August 1, 2011. Petitioner had no problems with his left knee prior to his November 3, 2010 accident. When seen at the hospital after his fall, Petitioner complained of left knee pain and he was diagnosed with a left knee contusion. Petitioner presented to Dr. Brophy on November 15, 2010, with left knee pain. Dr. Morrison interpreted the left knee MRI as showing arthritis, bad tendinitis and bursitis. He saw no tears. Dr. Brophy recommended, and Petitioner received, some Synvisc injections in his left knee. As of August 1, 2011, Petitioner's left knee felt better. Thereafter, Petitioner had no further treatment for his left knee and when examined by Dr. Lehman on March 28, 2013, Petitioner expressed no left knee complaints. Examination of his left knee was normal. Petitioner did not testify to any ongoing problems or limitations with his left knee.

3. Petitioner's low back and right leg sciatica. Petitioner failed to prove a causal connection between his low back and sciatic conditions and his accident of November 3, 2010. Petitioner had problems with his low back and right leg sciatica prior to his work accident. Petitioner needed an expert opinion to establish the requisite causal connection; however, the Arbitrator was not persuaded by the opinion of Dr. Berkin. No other causation opinions were tendered by Petitioner.

4. Petitioner's cervical condition. Petitioner failed to prove a causal connection between Petitioner's cervical condition and his accident of November 3, 2010. While Petitioner was diagnosed with a cervical strain at the emergency room he made no further reports or mention of neck pain until February 10, 2011 when he advised Dr. Poulos of a new complaint of intermittent neck pain which he dated to both of his accidents. That history was contrary to Petitioner's testimony as he associated no neck complaints with his alleged October of 2010 accident. When he began therapy in February of 2011 Petitioner reported experiencing a neck problem with a fall from a ladder and an earlier incident when he hit his head on a steel beam. Again, an incorrect history. When initially examined by Dr. Berkin Petitioner made no mention of any cervical injuries associated with his November 3, 2010 accident. Dr. Berkin did not diagnose any cervical condition nor did he render any causation opinion regarding Petitioner's alleged cervical condition. When examined by Dr. Lehman on March

28, 2013 Petitioner denied any cervical complaints. At arbitration Petitioner did not testify to any ongoing cervical complaints.

Issue J -- Medical Services.

The parties stipulated that in the event of a finding of liability and an award of medical bills, Respondent would reimburse Medicare and Medicaid for the medical bills paid by it and in the amounts paid by it. To that end Petitioner is awarded those bills set forth in PX 9 which are related to treatment Petitioner received for his left knee but only through August 1, 2011.

Issue K-- Temporary Total Disability (TTD) Benefits.

The parties stipulated that Petitioner was temporarily totally disabled from November 4, 2010 through July 20, 2012. (AX 1) However, Respondent disputed liability for TTD benefits. No evidence was presented establishing that Petitioner was off work during the aforementioned time period due to his left knee condition. Accordingly no temporary total disability benefits are awarded.

Issue L -- Nature and Extent.

Petitioner failed to prove he sustained any permanent partial disability to his left knee. He underwent two injections for minimal complaints. Petitioner did not testify to any ongoing left knee problems.

****

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

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert T. Liefer,

Petitioner,

vs. NO: 11WC 7038

Illinois Department of Natural Resources,

15IWCC0092

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability, notice, incurred and prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 23, 2014, is hereby affirmed and adopted.

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

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

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

DATED: FEB 4 - 2015
o012715
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

LIEFER, ROBERT T
Employee/Petitioner

Case# 11WC007038

IL DEPT OF NATURAL RESOURCES
Employer/Respondent

15IWCC0092

On 6/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

0384 NELSON & NELSON
NATHAN LANTER
420 N HIGH ST PO BOX Y
BELLEVILLE, IL 62222

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN 23 2014

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

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
19(B)

ROBERT T. LIEFER
Employee/Petitioner

Case # **11** WC **007038**

v.

Consolidated cases: N/A

ILLINOIS DEPT. OF NATURAL RESOURCES
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Belleville**, on **April 16, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other:

FINDINGS

On the date of accident, **October 27, 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 **$53,594.00**; the average weekly wage was **$1,030.65**.

On the date of accident, Petitioner was **40** years of age, *married* with **3** dependent children.

Respondent *has not* paid all temporary total disability benefits to which Petitioner is entitled.

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

Respondent shall receive credit for any medical bills paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent is to pay the medical bills 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 for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of services for which Respondent is receiving credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$687.10/week** for **31 weeks**, commencing **01/03/11** through **08/08/11**, as provided in Section 8(b) of the Act.

Respondent shall authorize and pay for the surgery recommended by Dr. Gornet.

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

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

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

Nancy Lindsay
Signature of Arbitrator

June 12, 2014
Date

JUN 23 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This claim involves an injury to Petitioner's cervical spine. At the time of trial the issues in dispute were: accident, causal connection, notice, liability for medical bills, temporary total disability, and prospective medical care. The parties agreed that this hearing only concerned Petitioner's alleged cervical injury and any related symptoms and conditions (i.e. tennis elbow or possible thoracic outlet syndrome) would not be addressed in this decision. Witnesses testifying before the Arbitrator were Petitioner, Joseph Mickey ("Mic") Middleton, and Paul Greatting.

The Arbitrator finds:

Pre-Arbitration Summary

According to the medical records, Petitioner was treating with Dr. Quentin Stenzel, a chiropractor, prior to his alleged accident of October 27, 2010. Petitioner presented to Dr. Stenzel on June 2, 2010. In conjunction with his initial examination he completed a medical questionnaire listing his chief complaints as the right shoulder and left lumbar spine. He denied any injury. A pain drawing reflected complaints of burning and aching in Petitioner's right shoulder and left lower back. A "symptom box" indicated Petitioner was experiencing numbness or pain in his arms/legs/hands and a stiff neck. Dr. Stenzel completed a physical examination noting Petitioner's chief complaint was right-sided neck and shoulder pain "into right arm" that started three days earlier and with no known injury. Another pain diagram was labeled consistent with Dr. Stenzel's noted complaints. Petitioner was given treatment and told to return in two days. (RX 2)

Petitioner returned to see Dr. Stenzel on June 5, 23010 reported his right shoulder was less painful. Dr. Stenzel again provided treatment noting right trapezial spasms. Petitioner was to return in two days. (RX 2)

At his follow-up visit on June 7, 2010 Petitioner was noted to have full cervical range of motion and he reported he was "much better." Petitioner was to call if he needed further care. (RX 2)

Petitioner returned to see Dr. Stenzel on September 27, 2010 reporting a "pinched nerve in his right arm again." Treatment was given and Petitioner was to return in two days which he did and he reported being "60%" better that day. He was treated and released to call, if needed. (RX 2)

Petitioner again returned to see Dr. Stenzel on November 3, 2010 reporting "same pain into right arm - felt better for 2 weeks after [treatment]." Petitioner's visit was labeled as "WC" in the doctor's office notes. Dr. Stenzel's examination notes indicate Petitioner's "chief complaint was severe right-sided neck pain with shooting pain into right arm after work injury on 10/27/10." Petitioner was noted to be in obvious pain and carried his right arm in a manner to reduce the strain. Rotation and flexion were restricted and painful. Pain prohibited some testing by the doctor. (PX. 1; RX 2) Petitioner was diagnosed with a cervical strain, thoracic strain and shoulder/upper arm strain. Dr. Stenzel told Petitioner he may have pinched a nerve. Dr. Stenzel provided chiropractic adjustments, and told Petitioner to apply ice. He did not take Petitioner off work; however, the doctor noted Petitioner was going to call his doctor if he had no improvement. As with the visit in June of 2010, there is a pain

drawing included with the doctor's notes and it suggests more shoulder and arm symptoms than in the June 2010 visit. (PX. 1)

On December 13, 2010 Petitioner saw his primary care physician, Dr. Walls, due to his continued problems and because he was now experiencing left arm complaints. Dr. Walls had Petitioner undergo a cervical MRI and a bilateral EMG/NCS. (PX. 4)

A cervical MRI was performed on December 17, 2010 and showed abnormal increased T2 weighted signal in Petitioner's inferior brain stem and junction of the brain stem and spinal cord. Further examination was recommended as a demyelinating disorder or other lesion was possible. Petitioner was also noted to have bulging discs at C5-6 and C6-7 with some mild neuroforaminal narrowing at both levels. (PX 4) The EMG dated December 17, 2010 suggested mild right carpal tunnel syndrome. Petitioner refused to undergo studies of his left upper extremity. (PX 4) An MRI of Petitioner's brain was taken on December 28, 2010 and reportedly normal. (PX 4)

On December 23, 2010 Dr. Walls reviewed the cervical MRI and other tests. The doctor's office note references a neurosurgical consultation was recommended. Petitioner was taken off work pending the consultation. (PX. 4, PX 13)

On December 23, 2010 an Illinois Form 45 was completed by Respondent regarding an alleged accident occurring on October 27, 2010 at approximately 9:30 a.m. The accident was described as "Worker was applying oak leaves and bush limbs to handicap line, and injured his neck." (RX 1)

On December 28, 2010 Petitioner completed an Employee's Notice of Injury. (PX. 13) He stated that he was dragging brush to use for cover and was dragging the brush/limbs down a ramp when he turned and felt a sharp pain shoot in his neck and down his right arm. He thought he had pulled a muscle and continued working on the stand. Petitioner further stated he went to the office and was talking to "Mic and he asked me what was wrong with my neck. I told him that I pulled a muscle in my neck and it was not getting better so I went to Dr. Quentin Stenzel on 11/3/10 and he told me I might have pinched a nerve. I told Mic the next day that it might be a pinched nerve. I have been on vacation since 12/4/10 maintaining a trap house. My neck was not getting better so I went to Dr. David A. Wells on 12/13/10. He ordered a MRI which I did on 12/17/10. On 12/23/10 I found out that my C5, C6, C7 vertebrae having bulging disks." (PX 13)

On January 18, 2011 Petitioner signed his Application for Adjustment of Claim. (AX 2)

On February 10, 2011 Petitioner saw Dr. Todd Stewart, a neurosurgeon. The history in the February 10, 2011 office note indicates Petitioner had been experiencing intermittent neck pain for one year and had been treating it with chiropractic visits which helped for several days. On October 27, 2010 Petitioner was dragging brush "at home" and developed severe pain with constant neck and arm pain since. Petitioner had been off work for 2 1/2 months. Petitioner also complained of headaches and dizziness. (PX 5) Based upon his exam and review of Petitioner's MRI and films, Dr. Stewart's impression was right C6 and C7 radiculopathy and some C7 radiculopathy on the left. He further suspected a herniated disc on the right and recommended a CT myelogram which was performed on February 16, 2011 and revealed soft tissue density in the right C6-7 foramina, suggestive of a herniation, mild right C6-7 foraminal stenosis and lymph node/tonsil concerns. (PX. 5)

On April 1, 2011 Dr. Stewart performed surgery at C5-6 and C6-7. The operative report is not in the record but Petitioner apparently underwent a C5-6 and C6-7 ACDF following up with Dr. Stewart on May 12, 2011. Petitioner reported relief of his shooting arm pain and numbness, along with elbow pain but significant neck pain on the right side (described by the doctor as axial back pain) persisted. Petitioner was having difficulty swallowing but reporting some improvement. (PX. 5 & 6)

Petitioner returned on June 30, 2011 reporting ongoing problems with neck pain and headaches and elbow complaints. Dr. Stewart reviewed x-rays noting a solid arthrodesis from C5- C7. Dr. Stewart believed Petitioner still had some axial neck pain and right epicondylitis, and recommended physical therapy for both along with a full duty return to work in one month. (PX 5)

Petitioner underwent post-surgical physical therapy.

On October 13, 2011 he returned to Dr. Stewart for a post-op check up. At that time his elbow complaints had improved with physical therapy but it was "minimally symptomatic." He was also noted to have symptoms of thoracic outlet syndrome but he didn't wish to pursue further revaluation. According to the doctor's note, the ACDF had relieved Petitioner's radiculopathy. Petitioner was asked to return in six months. (PX. 5)

As instructed, Petitioner returned to see Dr. Stewart on April 12, 2012. Petitioner reported elbow pain and neck pain being aggravated by driving a bobcat while at work, and arm pain when he worked with his arms above his head. Petitioner specifically mentioned that the vibrations and bumps involved with operating the bobcat were aggravating his neck. X-rays showed a solid arthrodesis.Dr. Stewart believed the neck pain was muscular in nature and prescribed Zanaflex. Petitioner's other symptoms of thoracic outlet syndrome and right epicondylitis remained but Petitioner seemed pleased with his surgical results and happy he underwent the surgery. Petitioner was asked to return in one year. (PX. 5)

On November 29, 2012 Petitioner underwent a CT scan of his cervical spine. (PX 8)

On February 7, 2013 Petitioner saw Dr. Matthew Gornet. He reviewed Dr. Stenzel's records before and after October 27, 2010, Dr. Walls' notes, and Dr. Stewart's notes. Based on these notes and the information he obtained, Dr. Gornet believed Petitioner's symptoms were causally connected at least in their magnitude and severity to the October 2010 event and were at minimum an aggravation of a preexisting condition. (PX. 8) Dr. Gornet noted Petitioner did see Dr. Volarich[1] for an IME and Dr. Volarich did feel Petitioner's symptoms were causally connected and Petitioner had not yet reached maximum medical improvement (MMI) due to the failed fusion at C6-7. (PX. 8) Dr. Gornet took cervical x-rays that confirmed the November 29, 2012 cervical CT scan showing a nonunion at C6-7. (PX 8) He recommended a MRI to evaluate C4-5. Dr. Gornet agreed with Dr. Volarich that Petitioner was not at maximum medical improvement (MMI). Dr. Gornet recommended a revision surgery at C6-7. (PX. 8)

On February 22, 2013 Petitioner returned to see Dr. Walls who noted that Petitioner was still waiting for his C6-7 injury to be "fixed" and Petitioner was reporting some tingling in his right hand but, otherwise, displaying no new findings. (PX 4)

---

[1] This IME report is not a part of the record.

Petitioner again returned to see Dr. Walls on March 15, 2013 to review a CT scan which had been performed on November 29, 2012 and was reportedly abnormal. Petitioner's complaints of ongoing cervical radiculopathy, disc disease, and neck pain were noted. Petitioner was to return to see the doctor after his visit with Dr. Stewart. (PX 4)

On April 10, 2013 Petitioner returned to Dr. Stewart. The report states the numbness and weakness in Petitioner's arm had improved after the surgery, but Petitioner continued to have neck pain and headaches. (PX. 5) The report also notes Petitioner having some tingling into his hands bilaterally. (PX. 5) Dr. Stewart reviewed a cervical CT scan performed on November 29, 2012. The CT scan showed a solid arthrodesis at C5-6 and an incomplete arthrodesis at C6-7. Dr. Stewart said the neck symptoms and headaches might be attributable to the incomplete fusion at C6-7. (PX. 5) He recommended cervical injections. Dr. Stewart believed Petitioner's getting a second opinion from Dr. Gornet "to be very reasonable." (PX. 5)

Petitioner returned to see Dr. Walls on July 5, 2013 having undergone a left shoulder sonogram on July 1, 2013 stemming from a recent injury. (PX 4) In a noted dated July 15, 2013 Dr. Walls stated Petitioner was still awaiting an appointment with Dr. Gornet. (PX 4)

On November 14, 2013 Petitioner returned to Dr. Gornet, who noted Petitioner having continued pain and symptoms in his neck, headaches, pain in both trapezius and both shoulders, with tingling in his arms, right worse than left. (PX. 8) He noted Petitioner continued to work full duty but the pain and symptoms were affecting his quality of life and most aspects of his life. (PX. 8) In an addendum to his November 14, 2013 report Dr. Gornet reviewed the cervical MRI and said the adjacent discs at C4-5 and C7-T1 looked pristine, so the failed fusion as the source of Petitioner's problems had been confirmed. (PX. 8)

Dr. Gornet was deposed on January 23, 2014. Dr. Gornet's testimony is consistent with the information contained in his medical records. He opined Petitioner's current diagnosis and symptom generator is a failed fusion at C6-7. (PX. 15, p. 14-15) Petitioner's diagnosis before Dr. Stewart's surgery was disc pathology at C5-6 and C6-7 with radiculopathy. (PX. 15, p. 15) In regard to causality, Dr. Gornet opined the October 27, 2010 work event was a cause of or aggravated the preexisting condition of Petitioner's cervical spine, made it symptomatic, and caused the need for Dr. Stewart's surgery. (PX. 15, p. 15-16) Dr. Gornet recommends a revision surgery with either an AP fusion at C6-7 versus removal of hardware, revision cervical surgery and potential disc replacement at C6-7. (PX. 8) He opined the October 27, 2010 work injury was a cause for the need for the surgery he recommends. (PX. 15, p. 16) He opined the medical care and treatment provided to Petitioner was reasonable and necessary. (PX. 15, p. 16-17) He doesn't believe Petitioner has reached MMI. (PX. 15, p. 17) Dr. Gornet believed if Petitioner does not have the surgery he recommends Petitioner's condition will progressively get worse. (PX. 15, p. 17) On cross-examination, Dr. Gornet based his causal opinion on Petitioner having neck pain and some right-sided pain before the October 27, 2010 work-event and then after the October 27, 2010 work-event Petitioner experienced a dramatic change in symptoms as indicated in the contemporaneous medical records. (PX. 15, p. 23) He did not question Petitioner's veracity. (PX. 15, p. 26) He did not believe Petitioner to be a malingerer. (PX. 15, p. 27)

On February 13, 2014 Petitioner saw Dr. Gornet, who noted Petitioner was continuing to have neck and radicular symptoms. Dr. Gornet again recommended a revision surgery at C6-7. He mentioned

his continued belief that Petitioner's symptoms for which he was treating Petitioner were causally connected to his work-related injury on October 27, 2010. (PX. 8)

Arbitration Hearing

Petitioner's case proceeded to arbitration on April 16, 2014. Petitioner testified that on October 27, 2010 he was 40 years old, married, with three dependent children. He started working for the Illinois Department of Natural Resources in 1990. Petitioner testified he was a "ranger." His job duties varied from doing paperwork in an office to working outside, planting crops, mowing grass, maintaining roads, and brushing (providing camouflage for) duck hunting blinds/platforms. As a ranger, Petitioner was required to carry up to 50 lbs. and be able to walk over rough terrain. Brushing blinds required Petitioner to cut limbs and haul them to the platform. This required Petitioner to load the limbs onto a truck, drive to a location, unload them and then haul the limbs (lift and drag, with each arm, stacks of tree limbs weighing up to 40 lbs. each) to the platform. The limbs could be oak or willow and they would be placed on the platforms to hide hunters from the ducks. Petitioner identified Petitioner's Exhibit 14 as an accurate depiction of his job duties as a ranger.

Petitioner acknowledged that prior to October 27, 2010 he had seen a chiropractor, Dr. Quintin Stenzel, a few times for "dull" neck and shoulder pain. During these visits, Dr. Stenzel did not restrict Petitioner's work activities or take Petitioner off work. Dr. Stenzel did not recommend any diagnostic tests. Petitioner was able to fully perform his job duties. Petitioner denied experiencing any numbness in his hands or fingers prior to October 27, 2010. Petitioner did not injure his neck at home or at work before October 27, 2010.

Petitioner testified that he saw Dr. Stenzel on June 2, 2010. At that time Petitioner was experiencing a dull ache in his neck and his shoulder. Petitioner described it as a dull pain that would never go away. The pain was in the right side of his neck and right shoulder down into his arm. Petitioner rated the pain as a "2/10" and explained that Dr. Stenzel realigned his neck and back during the visit. Petitioner testified that he returned to see Dr. Stenzel on June 5th and June 7th. Petitioner testified that Dr. Stenzel's notes regarding Petitioner's complaints during those visits were correct.
Prior to October 27, 2010 Petitioner last saw Dr. Stenzel on September 27 and 29, 2010. According to Petitioner he had been working full duty throughout this time. Petitioner returned on the 27th due to a dull ache in his back and shoulder which the doctor realigned. By the 29th he was 60 percent better.

Petitioner testified that on October 27, 2010, around 9 a.m., Petitioner was working on the south handicap blind. Petitioner testified he was dragging 40 lbs. stacks of tree limbs to a duck blind. He felt an extremely painful sensation, like "a lightening bolt", from his neck to his right fingertips for a few seconds. He'd never experienced anything like this before. He rated the pain a 9 out of 10. His neck felt like it was "in a vise" for several minutes. He then had constant numbness in his right index and third finger. Petitioner continued to work and finished brushing the blind. Petitioner returned to the office and told his supervisor, Mr. Middleton, he had injured his neck while working "down there."

Petitioner testified over the following week his neck was very tight and it hurt to raise his right arm up all the way. He still had numbness in his right index and middle fingers but he was able to perform his job. On November 3, 2010 Petitioner saw Dr. Stenzel. Petitioner testified that on November 4, 2010 Dr. Stenzel once again re-aligned his back and neck and the doctor told Petitioner that he thought he had a pinched nerve.

Petitioner testified that he attended a daily morning meeting at work on November 4, 2011. Those attending the meeting included Mr. Middleton, Petitioner, and other workers. At the conclusion of the meeting, everyone disbursed and Petitioner approached Mr. Middleton in the break room and told him that Dr. Stenzel believed Petitioner had pinched a nerve, to which Mr. Middleton replied "okay."

Petitioner further testified that he usually takes the whole month of December off for a vacation. In 2010 he was scheduled to be off December 4, 2010 through January 3, 2011. Petitioner also acknowledged that he is passionate about hunting and trapping water fowl. Trapping season began November 11, 2010. Petitioner denied engaging in any water fowl hunting in late 2010. Petitioner usually traps by himself but, occasionally, he is joined by Jace Duncan, Chris Everding, and/or James Samson. Petitioner testified that in addition to trapping beavers, raccoons, and muskrats, he skins them, dries them, and sells them. Petitioner denied selling any furs to Zanders Fur Company in 2010.

Petitioner went on vacation from December 4, 2010 to January 2, 2011. This vacation had been scheduled prior to October 27, 2010. During this vacation, Petitioner trapped and skinned animals with the help of various persons, including his daughter's boyfriend, his best friend, and brother-in-law. Petitioner testified that he had constant numbness in his fingers and neck pain before he went on vacation and he continued to experience neck pain and numbness in his right hand and fingers while trapping but he noticed the numbness in his fingers wasn't getting any better.

Petitioner denied any new injuries between October 27, 2010 and December 13, 2010.

Petitioner testified that on December 13, 2010 he saw his primary care physician, Dr. Walls, due to his continued problems and because he was now experiencing numbness in his left hand. According to Petitioner Dr. Walls referred Petitioner for diagnostic testing, took him off work until he saw a neurosurgeon, and completed a disability form for Petitioner. The next day, December 14th, Petitioner had his friend, Chris Everding, pull the animal traps while Petitioner navigated the boat. After December 23, 2010 Petitioner stopped all trapping and skinning.

Petitioner testified that on December 28, 2010 he completed and turned in an Employee's Notice of Injury. According to Petitioner this was the first paper work he had received. (PX. 13) Petitioner testified Dr. Walls, his primary care physician, told him to call a supervisor so Petitioner called Mr. Middleton, who gave Petitioner the form and told him to complete it. (PX. 13)

Petitioner testified he did not return to work on January 3, 2011 as Dr. Walls had taken him off work.

On February 10, 2011 Petitioner saw Dr. Todd Stewart, a neurosurgeon. The history in the February 10, 2011 report is consistent with Petitioner's testimony, except for stating Petitioner had developed constant neck and right arm symptoms while dragging brush "at home." Petitioner testified he told Dr. Stewart this because Petitioner had been told by Dr. Walls' office that Dr. Stewart would not perform surgery if Petitioner mentioned workers' compensation.

According to Petitioner Dr. Stewart released him to return to work without restrictions on August 8, 2011. Petitioner testified he did not receive any temporary total disability benefits (TTD) benefits from January 3, 2011 through August 8, 2011.

Petitioner testified he returned to work initially as a ranger but in a light duty capacity. After a few weeks, he returned to full duty work. On October 13, 2011 he returned to Dr. Stewart for a post-op check up. Petitioner testified he was having "major headaches" and still experiencing neck pain. He had no numbness in either hand or any fingers.

Petitioner testified that on April 12, 2012 he returned to see Dr. Stewart. He followed up with Dr. Stewart one more time and was then referred to Dr. Gornet for a second opinion.

Petitioner testified he was promoted to Site Assistant Superintendent I on August 1, 2013 and he moved to Metropolis, Illinois. According to Petitioner, his new position is less strenuous than his job duties as a ranger. He is now a working supervisor and goes out in the field. He provides some assistance with job duties but refrains from the "major work."

Petitioner testified that Dr. Gornet has recommended a revision surgery at C6-7 and he wishes to undergo the surgery. Currently, he experiences constant pain, varying in intensity, between his shoulder blades. The neck pain put him in a fetal position two or three times. He gets headaches daily and usually takes Ibuprofen. When the headaches are severe he takes Tramadol. The condition of his neck, shoulder and arm has not gone back to where it was before October 27, 2010.

Petitioner testified the headaches start at the base of his neck and travel through the top of his head to his temples. Migraines, which he gets less now than when he was in high school, are different in that they start in his eyes and go out the other way.

Joseph Mickey Middleton testified on behalf of Respondent. For the past 8 ½ years, Mr. Middleton has been a site superintendent for Respondent. He was Petitioner's supervisor. He identified Respondent's Exhibit 3 as a January 4, 2011 letter he typed to Susan Benson, Respondent's workers' compensation coordinator, about Petitioner's workers' compensation claim. Mr. Middleton testified he never actually saw Petitioner out in the water trapping while Petitioner was on vacation in late 2010. He did see Petitioner working with fur and traps and moving items from his boat to a fur shed. He remembers Petitioner first telling him about a work injury at the end of December while he was out goose hunting. According to Mr. Middleton Petitioner called him to tell him he was going to have to undergo surgery to which Mr. Middleton told Petitioner to call Lisa at the Alton regional office for assistance. Mr. Middleton did not recall a conversation with Petitioner on October 27, 2010 during which Petitioner told him he had injured her neck. Furthermore Mr. Middleton did not recall Petitioner, on November 4, 2010, telling him Dr. Stenzel said Petitioner had a pinched nerve.

Mr. Middleton testified that he did not believe Petitioner had a work accident in October of 2010 because of all the activities he was able to do before his vacation followed by an inability to do same after his vacation.

Paul Greatting also testified on behalf of Respondent. For the past 20 years, he has worked as a ranger for Respondent. While Petitioner was on vacation, Mr. Greatting saw Petitioner and Petitioner's family going in and out of the skinning shed, carrying things. Beaver and raccoons were lying on the nose of the boat. To the best of Mr. Greatting's recollection he saw Petitioner doing this activity in the month of December. He couldn't say if he saw Petitioner performing these activities after December 23, 2010.

The Arbitrator concludes:

15IWCC0092

In regard to disputed issue (C) – Accident:

Petitioner sustained an accident on October 27, 2010 that arose out of and in the course of Petitioner's employment with Respondent. Petitioner's testimony, Dr. Gornet's testimony, and the medical and chiropractic records support an injury or aggravation to Petitioner's cervical spine that caused a significant change in the severity and persistent nature of Petitioner's neck and radicular symptoms. The mechanism of injury, as described by Petitioner, was significant enough to cause, at least, an aggravation of the pre-existing condition of Petitioner's cervical spine. Petitioner testified he did not suffer any injury to his neck before or after the injury he suffered on October 27, 2010.

While Respondent has challenged accident in light of Petitioner's pre-existing neck and right shoulder pain, the inconsistent history given to Dr. Stewart at the time of their initial visit, and Petitioner's trapping-related activities outside of work, Petitioner's testimony came across as candid, forthright, and credible. Therefore, his testimony was ultimately persuasive on the issue of accident. The Arbitrator also notes that while Petitioner did have some treatment to his right shoulder and neck before the accident he was able to continue working full duty, was never taken off work, or given any restrictions. When comparing Dr. Stenzel's records of June 2, 2010 and November 3, 2010, the Arbitrator notes a difference in the pain drawings, the latter of which suggests worse symptoms than earlier. Also significant is that on prior occasions Petitioner had undergone 2-3 treatment sessions with Dr. Stenzel and was then released. On November 3, 2010 Dr. Stenzel noted Petitioner planned to go see his personal physician if he noted no improvement. This suggests to this Arbitrator that something more significant was going on at the time of the November 3, 2010 visit. Petitioner further credibly explained the difference in his symptoms before October 27, 2010 and thereafter.

In regard to disputed issue (E) – Timely Notice:

The Arbitrator concludes Petitioner provided timely notice of the October 27, 2010 work injury. Petitioner testified he provided oral notice of the injury twice within 45 days of October 27, 2010 to his supervisor Mr. Middleton: October 27, 2010 and November 4, 2010. Mr. Middleton's testimony did not directly contradict Petitioner's testimony. Mr. Middleton did not say Petitioner didn't give him notice on those dates; rather, Mr. Middleton testified he didn't recall whether or not Petitioner gave him notice of the injury on those dates. The Arbitrator finds Petitioner's testimony to be more credible than Mr. Middleton.

The Arbitrator also notes Petitioner provided notice of the injury in writing on December 28, 2010 when Petitioner completed the Employee's Notice of Injury after Mic Middleton gave him the form to complete. Petitioner's description of the accident and his previous discussions with Mr. Middleton are contained therein and are consistent with Petitioner's testimony thereby suggesting the two men did, in fact, have earlier conversations about Petitioner's accident. (PX. 13)

Finally, the Arbitrator notes that the parties agreed that Respondent would receive credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act. (AX 1) A review of PX 11 shows payments made by Healthlink in 2011. Section 8(j) of the Act tolls the time for giving notice where Petitioner receives benefits under Respondent's group health

plan. Under Section 8(j) the time period for giving notice and filing one's application for adjustment of claim does not commence to run until the termination of such payments. See *Bray v. Star Contactor Supply, Inc.* 14 IWCC 0028, 12 WC 10132.

In regard to disputed issue (F) – Causal Connection:

Petitioner's current condition of ill-being in his cervical spine is causally connected to his October 27, 2010 work accident. This conclusion is based upon Petitioner's credible testimony, Dr. Gornet's testimony, and the medical and chiropractic records which support an injury or aggravation occurred to Petitioner's cervical spine that caused a significant change in the severity and persistent nature of Petitioner's neck and radicular symptoms and caused his current condition of ill-being and the need for Petitioner's past and the requested prospective treatment. While the report of Dr. Volarich[2] is not a part of the record, Dr. Gornet's February 7, 2013 office visit makes reference to it and, in particular, Dr. Gornet noted Dr. Volarich's concurrence that Petitioner's symptoms were causally connected to his accident and that Petitioner was not at maximum medical improvement as he had a failed fusion at C6-7.

In regard to disputed issue (J) – Medical Expenses:

The Arbitrator concludes all of the medical treatment provided to Petitioner was reasonable and necessary and Respondent is responsible for the medical bills incurred as a result thereof. Respondent's dispute regarding the medical bills was based upon liability. Having found in Petitioner's favor, Respondent is to pay the medical bills 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 for any medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) – Prospective Medical Care:

Petitioner is entitled to prospective medical care as recommended by Dr. Gornet, including a surgical revision at C6-7 and all concurrent and subsequent related treatment. The need for this prospective care is not refuted. Dr. Gornet opined the need for the initial surgery performed by Dr. Stewart and the need for prospective treatment, including a revision of the fusion at C6-7, was causally related to the October 27, 2010 work injury. Both Dr. Gornet and Dr. Volarich opined Petitioner had not yet reached maximum medical improvement.

In regard to dispute issue (L) – TTD:

Petitioner is entitled to TTD benefits from January 3, 2011 to August 8, 2011. Dr. Walls and Dr. Stewart took Petitioner off work during this period of time due to the injury he had suffered to his cervical spine on October 27, 2010. Petitioner underwent cervical spine surgery on April 1, 2011. Respondent did not pay TTD benefits. None of this is refuted.

---

[2] Respondent's examining physician

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF MADISON	)		

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chaunte Smith,
Petitioner,

vs. NO: 10WC 23362

Holten Meat, Inc.,
Respondent,

15IWCC0093

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, 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 August 8, 2013, 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: FEB 4 - 2015
o012715
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

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

SMITH, CHAUNTE
Employee/Petitioner

Case# **10WC023362**

HOLTEN MEAT INC
Employer/Respondent

15IWCC0093

On 8/8/2013, 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 0.07% 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:

0810 BECKER PAULSON & HOERNER PC
MICHAEL K NOWAK
5111 W MAIN ST
BELLEVILLE, IL 62226

0725 HANSEN & ENRIGHT
ANDREW J KOVACS
701 MARKET ST SUITE 200
ST LOUIS, MO 63101

15IWCC0093

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Chaunte Smith
Employee/Petitioner

v.

Holten Meat, Inc.
Employer/Respondent

Case # 10 WC 23362

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Collinsville, IL**, on **June 27, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ___

FINDINGS

15IWCC0093

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

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

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

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

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

In the year preceding the injury, Petitioner earned $**12,155.00**; the average weekly wage was $**233.75** .

On the date of accident, Petitioner was **41** 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 $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**0.00**.

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

ORDER

The petitioner failed to sustain her burden of proof that she suffered accidental injury in the course and scope of her employment with respondent. Benefits are denied.

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

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

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

Signature of Arbitrator

8/5/13
Date

AUG 8 - 2013

ICArbDec19(b)

Findings of Fact and Rulings of Law

Petitioner worked as a "meat packer' for respondent for a total of thirty hours in March of 2010. The time card submitted by respondent indicates that petitioner worked three eight hour shifts the week one week and one six hour shift the next week, which coincides with her testimony that she left work early after reporting symptoms to her supervisor and being directed to the company physician.

Petitioner's duties as a meat packer involved picking up stacks of five or six frozen hamburger patties, filling a cardboard box with the stacks, and putting the box on a conveyor belt. She did this her entire shift.

Petitioner testified that she began having problems almost immediately after starting this work for the respondent. She went to the emergency room at Belleville Memorial Hospital on March 6, 2010 with complaints about pain and numbness in her upper extremities. She relayed to the staff at Memorial that she had been "breaking up a fight" and that she is numb in all her fingers. She indicated that she had worn a splint for one month, which would be before she even started working with the respondent.

After reporting the injury she went to the company doctor, Brian Ruiz. Dr. Ruiz on March 9, 2010 and indicated to him that she already had an appointment to have testing done to see if she had carpal tunnel. She relayed to the doctor a history of an injury to her left hand in 2008 but she did not provide any specific information other than that, and the doctor indicated that "she seemed to get forgetful and began to question why I was so interested in her left hand problem".

Petitioner saw Dr. Kent Campbell, her primary care physician, on the same day she saw Dr. Ruiz. She complained to him that she had bilateral arm, forearm numbness, tingling and pain. She relayed to Dr. Ruiz that she began having problems with the left arm in 2008 and that her right arm started being a problem "last Thursday" and indicated that "she thinks it could be work related". Dr. Campbell ordered a nerve conduction test. She had the test which showed mild evidence of bilateral carpal tunnel syndrome.

Petitioner saw Dr. Glogovac on referral form Dr. Campbell. Dr. Glogovac is a hand surgeon. He opined that the Petitioner's condition was aggravated by her employment with the Respondent. Dr. Glogovac admits that the petitioner's nerve conduction values could not have come from working thirty hours with the respondent. His opinion on causation is entirely reliant upon the petitioner telling him that her symptoms began while working for the respondent. He testified that the Petitioner had worked 2 weeks for the Respondent before she sought medical treatment from the company physician. He admits that he never saw any of her prior medical records. He admits that he has no specific information regarding petitioner's work duties such as the weights and repetitions involved. Dr. Glogovac had no explanation as to why petitioner symptoms persist after being removed from the allegedly offending source for over two years. Dr. Glogovac admits to having an appointment with petitioner for the sole purpose of discussion issue that he understood would come up in litigation.

Respondent had petitioner examined by Dr. Strecker pursuant to Section 12. Dr. Strecker concluded that he could not diagnose carpal tunnel because of the unusual complaints of forearm

numbness that are not associated with carpal tunnel, her history and distribution of her parasthesias and her physical findings being inconsistent with that diagnosis. Dr. Strecker noted that petitioner was magnifying her symptoms as evidenced by her grip strength measurements that would indicate a complete inability to use her hands effectively, which did not coincide with the physical exam he performed. Regardless of diagnosis, Dr. Strecker concluded that petitioner's work with respondent for thirty hours over four days did not in any way cause, contribute to or aggravate her symptoms, which by petitioner's own history predated her employment by two years.

Dr. Strecker testified that specifically petitioner complained of complete numbness from her elbows down, which does not fit an anatomic distribution. Petitioner's sensation test was normal and her muscle function was normal. Provocative tests for carpal tunnel were also normal. Petitioner showed no evidence of muscle atrophy, but when her grip strength was tested she essentially had no grip strength on the right, and very little on the left which was inconsistent with her muscle bulk and the way she was observed using her hands in the exam room. Dr. Strecker indicated that the grip strength test is subjective inasmuch as the result is dependent upon the subject putting forth an honest effort, which he believes the petitioner did not do in this case because the result would indicate petitioner could not have dressed herself or driven her car. Dr. Strecker indicated that the duration of work with respondent was not of sufficient duration to have caused the findings seen on electrical study.

CONCLUSIONS OF LAW

1. The petitioner has failed to sustain her burden of proof that she suffered an accidental injury in the course and scope of her employment – which the Arbitrator notes was only 4 days. The Arbitrator finds the opinions of Dr. Strecker to be more persuasive than those of Dr. Glogovac, who by self-admission relates the condition to work merely because petitioner tells him this. Dr. Glogovac had no knowledge of the Petitioner's prior medical treatment or any specifics of petitioner's job duties. Furthermore, the Arbitrator finds the petitioner's testimony to be incredible. Whether or not petitioner actually has any symptoms is unclear. In this case, the petitioner is claiming a repetitive trauma injury after only working a total of 30 hours for the respondent in various job duties that rotated positions throughout the day. The fact that the petitioner worked a short period of time doing varied work throughout each day, lead the Arbitrator to initially question the validity of this claim. But the fact that petitioner clearly exaggerated her grip strength to Dr. Strecker's nurse further erode the credibility of Petitioner's claim. That petitioner claims that her symptoms have not abated, and even have become worse over the years since her date of alleged onset is counterintuitive since she is no longer exposed to the allegedly offending activity. Considering all these factors, the Arbitrator finds Petitioner's claim to lack credibility.

2. Based on the findings above, all other issues are rendered moot. Accordingly, benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darrel W. Wright,
Petitioner,
vs. NO: 13WC 00030

AWI Leasing, Certified Automotive Warehouse, Inc.
d/b/a Auto Wares Group of Companies,
Respondent,

15IWCC0094

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 23, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 4 - 2015

o012815
CJD/jrc
049

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WRIGHT, DARREL W Case# **13WC000030**

Employee/Petitioner

AWI LEASING CERTIFIED AUTOMOTIVE WAREHOUSE INC D/B/A AUTO WARES GROUP OF COMPANIES

Employer/Respondent

15IWCC0094

On 6/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

1876 PAUL W GRAUER & ASSOC
CZAPLA, EDWARD A
1300 E WOODFIELD RD SUITE 205
SCHAUMBURG, IL 60173

2837 LAW OFFICES JOSEPH A MARCINIAK
MATTHEW A WRIGLEY
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

THE HARTFORD
PO BOX 4912
SYRACUSE, NY 13221

15IWCC0094

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

Darrel W.Wright
Employee/Petitioner

Case # 13 WC 00030

v.

AWI Leasing, Certified Automotive Warehouse, Inc.
d/b/a Auto Wares Group of Companies
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **May 5, 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. X Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. X Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. X What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **November 6, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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 $**8,578.36**; the average weekly wage was $**226.09**.

On the date of accident, Petitioner was **63** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of $**5,200.07** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**5,200.07**.

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 $226.09 per week for 23 weeks, commencing May 12, 2013 through October 9, 2013, as provided in Section 8(b) of the Act. The Parties stipulated that all TTD benefits have been paid.

Respondent shall pay reasonable and necessary medical services of $475.00, as provided in Sections 8(a) and 8.2 of the Act. Respondent is entitled to a credit for all bills paid.

Respondent shall pay Petitioner permanent partial disability benefits of $226.09 per week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act

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

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

Signature of Arbitrator

6/20/2014
Date

JUN 23 2014

FINDINGS OF FACT

Petitioner was employed by Respondent as a parts driver and stockman. He worked part time and his job duties included receiving stock, making deliveries and putting stock away.

On November 6, 2012, Petitioner was injured in a car collision. Petitioner was making a delivery, driving in Respondent's car, when he was rear-ended. The car that Petitioner was driving was stopped and Petitioner tightened up in anticipation of the impact. Petitioner noticed pain in his left shoulder and neck. Petitioner is right handed.

Petitioner was taken via ambulance to Alexian Brothers Medical Center Emergency Room. He had complaints of left arm and neck pain. X-rays were negative and Petitioner was advised to rest at home. (Pet Ex. 1)

Petitioner began treatment at Barrington Orthopedic Specialists with Dr. Cirrincione. The first visit was on November 8, 2012. Left shoulder and cervical x-rays were interpreted as negative for fractures or dislocation. The diagnosis was left shoulder and neck pain. An MRI of the left shoulder was done on November 21, 2012 and was said to reveal supraspinatus tendinopathy with a small full-thickness distal supraspinatus tendon tear. Dr. Cirrincione recommended surgical repair of the rotator cuff tear. (Pet Ex. 2)

Petitioner was examined by Dr. Theodore Suchy at Respondent's request on April 8, 2013. Dr. Suchy confirmed the rotator cuff tear and recommended surgery. (Res Ex. 2)

Dr. Cirrincione performed surgery on Petitioner's left arm on May 2, 2013. The procedure was: 1. Left shoulder video arthroscopy; 2. Arthroscopic repair of large rotator cuff tear; 3. Biceps tenotomy; 4. Debridement of superior and posterior labrum; and 5. Near subacromial decompression and excision of inferior lateral clavicle. The post operative diagnosis was: Left shoulder large rotator cuff tear; biceps tenosynovitis; degenerative tear, superior and posterior labrum and acromioclavicular joint arthritis. (Pet Ex.2)

Petitioner then underwent a course of physical therapy and work hardening. He was released by Dr. Cirrincione to return to work at full duty after the October 8, 2013 visit. When Petitioner was seen by Dr. Cirrincione for his final visit on April 11, 2014, he had complaints of weakness and pain in the shoulder. There was no neck pain. The physical exam was benign. Mild strength loss in the shoulder was thought to be chronic and related to the delay in surgery. Elbow pathology was not related to this case. (Pet Ex. 2)

Petitioner returned to work at full duty for Respondent. Petitioner testified that his shoulder does not feel right. He has decreased range of motion and difficulty with overhead movement. He favors his right arm when lifting or carrying things. He has difficulty performing household chores. He does HEP excercises.

Petitioner denied any prior left shoulder injuries or problems.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the following Conclusions of Law.

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

Based upon the unrebutted testimony of Petitioner and the medical records, the Arbitrator finds that Petitioner's condition of ill-being with respect to his left shoulder is causally related to the injury.

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

Based upon the Arbitrator's finding on the issue of causal connection, the bill from Barrington Orthopedic Specialists for the last visit of April 11, 2014 ($475.00) is awarded to Petitioner and shall be satisfied by Respondent in accordance with Sections 8 (a) and 8.2 of the Act.

WITH RESPECT TO ISSUE (L), WHAT IS THE NATURE AND EXTENT OF THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

- (i) the reported level of impairment pursuant to subsection (a);
- (ii) the occupation of the injured employee;
- (iii) the age of the employee at the time of the injury;
- (iv) the employee's future earning capacity; and
- (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Thus, no weight is given to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a parts driver and stockman at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. Little weight is given to this factor. Happily, Petitioner was able to return to his prior job.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 63 years old at the time of the accident. He will likely live with his disability for a number of years, although his worklife expectancy is not that long. Some weight is given to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner should be able to find a job with similar wages in the future if he so desires, even in light of the limitations in the function of his shoulder that he has as a result of the accident. Little weight is given 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 extensive surgery that Petitioner underwent. Petitioner's subjective complaints are consistent with the records of Barrington Orthopedic Specialists as is detailed above. This factor is given the greatest weight in determining the award for PPD.

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the person as a whole pursuant to §8 (d) 2 of the Act.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL DONEGAN,

Petitioner,

vs. NO: 07 WC 54522

CITY OF CHICAGO,

15IWCC0095

Respondent,

DECISION AND OPINION ON §8(a) PETITION

This case comes before the Commission on Petitioner's §8(a) Petition, filed on May 24, 2012, alleging that his current low back condition remains causally related to his June 6, 2007 work injury and requesting additional medical expenses and prospective lumbar fusion surgery. A hearing was held before Commissioner DeVriendt on August 4, 2014 in Chicago, Illinois and a record was made.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1) Petitioner sustained a work-related low back injury on June 6, 2007, and received conservative treatment including pain medication, physical therapy, and epidural steroid injections. Despite continued symptoms, he was ultimately released at maximum medical improvement without a surgical recommendation and received a wage differential award in an Arbitration decision dated December 16, 2011.
2) Petitioner returned to work light/sedentary duty at Respondent as a security guard. At the previous hearing, Petitioner testified that his back was still very bothersome but that he was told nothing more could be done so he didn't continue treatment although he had still been taking prescribed Vicodin for his pain.
3) At the current hearing on August 4, 2014, Petitioner testified that on April 14, 2012, he slipped on a step at work and jarred his back. As a result of that incident, he filed an

injury report and, ultimately, a new application for adjustment of claim. This second claim is not part of this hearing.

4) Petitioner testified that prior to April 14, 2012, he had never stopped taking his pain medication and that his back was "not very good" but he didn't return to the doctor because he was still under the belief that there was nothing more that could be done.
5) After the April 14th incident on the stairs at work, he treated at MercyWorks with Dr. Anderson who recorded a history of Petitioner slipping on a stair, which caused a "sudden jarring pain in his lower back." Dr. Anderson diagnosed Petitioner with degenerative disc disease and returned Petitioner to return to work within his previous sedentary restrictions.
6) Petitioner testified that muscle relaxers helped and within about a week after this incident his back felt "about the same" as it did previously, which was 7-9/10 pain. T.10. Petitioner also testified that, even before the April 14th incident, he "was getting to the point where I couldn't live" with the pain but he was under the impression that there was nothing that could be done and that he would have to live with it for the rest of his life. T.33.
7) Petitioner testified that the pain he currently feels is worse compared to when he testified at the previous hearing on December 16, 2011.
8) Petitioner began treating with Dr. Mekhail on April 30, 2012. Dr. Mekhail recorded a history of back pain and intermittent leg pain that Petitioner has had "for quite some time" related to a work injury in 2007. He noted that Petitioner was previously treated with physical therapy and three injections, which Petitioner reported did not help much. Dr. Mekhail noted that Petitioner missed a step at work on April 14, 2012, and Petitioner jarred and aggravated his back. Petitioner's pain was 6-8/10. Dr. Mekhail diagnosed L5-S1 degenerative disc disease, retrolisthesis, back pain, and aggravation of pre-existing condition. Petitioner was given a trial brace but informed Dr. Mekhail that he "cannot survive with this back pain" and wanted to consider surgery. Dr. Mekhail recommended a discogram and specifically noted that this was not due to the April 14, 2012 injury but, rather, for his continuous back pain since 2007 that was recently aggravated.
9) A discogram was performed on October 1, 2012 and, on October 8th, Dr. Mekhail recommended that Petitioner quit smoking and prescribed an L5-S1 fusion.
10) On January 17, 2013, Petitioner was examined by Respondent's Dr. Phillips who, despite the discogram results, diagnosed subjective low back pain unrelated to either the 2007 or 2012 incidents. He believed that the 2012 incident caused only mild temporary aggravation of his symptoms and had not "in any way permanently impacted his underlying condition." Confusingly, however, he also did not believe that Petitioner's condition was related to the "aging process." Dr. Phillips did not agree with the recommendation for surgery because the discogram showed severe pain reproduced at all three levels without a negative control level and there was an "an unpredictable likelihood of surgical success."
11) On November 1, 2013, Dr. Mekhail opined that Petitioner had failed non-operative treatment and continued to suffer from low back pain. He reviewed Petitioner's MRI from 2007, which he felt showed evidence of significant degeneration of the L5-S1 disc with disc protrusion at the same level. Dr. Mekhail interpreted the October 2012 discogram as indicating that the L5-S1 disc appeared to be his primary back pain

generator. He believed that Petitioner had significant enough low back pain from the L5-S1 degenerated disc to warrant surgery prior to the April 14, 2012 injury but that this event exacerbated his pain. Dr. Mekhail opined that Petitioner had always been a surgical candidate but he was dealing with the pain because he was not previously offered a surgical option, based in part on the fact that he smoked. Dr. Mekhail noted that Petitioner agreed to quit smoking in order to decrease the risk of nonunion after surgery. He opined that Petitioner's incident on April 14, 2012 contributed to his decision to pursue surgery and that Petitioner had not reached maximum medical improvement.

12) Petitioner testified that, besides the April 14th incident at work, he has had no new accidents involving his back. However, there was a time in December 2013 when he was off work and bedridden for two weeks after sweeping and mopping the floor in his work area. T.18.
13) Petitioner testified that he smokes 1½ packs of cigarettes per day and that, although he has never tried quitting before, he believes he can quit smoking immediately to proceed with the surgery if that's what it takes. T.29. He would be willing to enter a stop-smoking program if that was recommended by Dr. Mekhail. T.35.
14) Petitioner introduced a bill for $267.00 from Parkview Orthopaedic Group for treatment with Dr. Mekhail. (Px3).

The Commission finds the opinion of Dr. Mekhail to be more persuasive than that of Dr. Phillips on the issues of causation and reasonableness and necessity of surgery. We find that neither the April 14, 2012, slip on the stairs nor the incident in December 2013 when Petitioner had a flare-up of symptoms after mopping and sweeping the floor at work constitute intervening accidents, which would break the chain of causation between Petitioner's current condition and the original 2007 work accident. Rather, we find that Petitioner's 2007 injury remains *a* contributing factor in his current condition and that his need for surgery is sequelae of that injury. We note that Petitioner's filing of a new Application for Adjustment of Claim to protect his rights under the Act regarding the incident on April 14, 2012, does not bind the Commission or preclude us from finding that this was not an intervening accident.

Based on the above, we find that Petitioner is entitled to $267.00 in medical expenses. We also conditionally award the prospective fusion surgery, as recommended by Dr. Mekhail, subject to Petitioner successfully quitting smoking to the satisfaction of Dr. Mekhail prior to surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $267.00 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the L5-S1 fusion surgery, on the condition that Petitioner quit smoking to the satisfaction of Dr. Mekhail, 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.

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

DATED: FEB 4 - 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

SE/
O: 1/13/15
49

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Leonard D. Hanson,

Petitioner,

vs. NO: 11 WC 26924

3M,

15IWCC0096

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission finds that Petitioner is entitled to 15% loss of use of a person as a whole as a result of his injury on February 10, 2009.

The Arbitrator wrote her decision based on a reading of the record prepared by Arbitrator Mathis. Arbitrator Mathis later became a Commissioner and Arbitrator Steffen was assigned to write the decision based on the written record.

The Petitioner was assisting another worker when a chemical tank containing Dimethyl Sulfate began to leak. Petitioner was wearing a protective suit but noticed an unusual smell inside his suit. After he got out of the suit he noticed a red rash on his arm and shoulder and had difficulty breathing. He later developed a blister on his right knee and hip and went to the emergency room at Mercy Medical Center in Clinton, Iowa. He was diagnosed with an acute inhalation injury and was placed into intensive care.

Petitioner was later transferred to the University of Iowa Hospitals and Clinic until February 15, 2009 and was discharged with a chemical inhalation injury and partial thickness burns to his right shoulder, arm, knee and flank.

Petitioner followed up with Dr. Hartley on March 9, 2009 and had an intermittent cough due to the chemical but his pulmonary function tests were normal. On April 29, 2009, Petitioner saw Hartley again and he released Petitioner to work without restrictions. (Petitioner Exhibit 3)

Petitioner once again saw Hartley on February 10, 2010 and although he "perceived" his exercise function had not fully returned, his pulmonary status was significantly improved and he was placed at maximum medical improvement. It was Dr. Hartley's opinion that Petitioner had no ratable impairment attributable to his work injury. (Petitioner Exhibit 3)

Petitioner sought out a second opinion with Dr. Bruyntjens on May4, 2011. He diagnosed the Petitioner with post-inflammatory nodules, occupational lung disease and previous respiratory failure secondary to exposure to chemicals at work. On May 12, 2011 the doctor noted that the Petitioner's lung function tests were essentially normal. The Doctor did testify that Petitioner's pulmonary taken on May 17, 2012 showed a drop of 7% in his lung function. (Petitioner Exhibit 4). However, the Doctor admitted that the results of these pulmonary function tests can deviate between 20-30% depending on the technician. Most importantly, the Doctor or the Petitioner never offered into evidence this alleged test that showed a 7% loss of function. (Petitioner Exhibit 4 Pg. 13, 22)

A CT scan was performed on May 22, 2013 which showed the lung nodules were unchanged and that the healing appeared to have been finished. (Petitioner Exhibit 4 Pg.13)

The Petitioner testified that Dr. Bruyntjens only prescribed him inhalers but did not impose any work restrictions on him. He only sees the Doctor for bi-annual follow up appointments and has not sought any additional treatment. (Transcript Pgs. 22-23)

The Petitioner return to work without restrictions on April 29, 2009 and continued to work in that capacity until he voluntarily retired from his job with the Respondent on October 1, 2013.

The Commission finds Dr. Hartley notes persuasive. Hartley found that Petitioner was at medical maximum improvement on February 10, 2010 with no ratable impairment due to his injury.

Petitioner does have subjective complaints as a result of his inhalation injury and he does have scars as a result of his burns. Petitioner also has post-inflammatory lung nodules as a result of the work injury but as of May 22, 2013, per a CT scan, these lung nodules are unchanged from what they were when he first saw Dr. Bruyntjens on May 4, 2011.

The Commission therefore finds that Petitioner is entitled to an award of 15% of a person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.72 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the the loss of use to the person as a whole to the extent of 15%.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 4 - 2015

Charles J. DeVriendt

Daniel R. Donohoo

Ruth W. White

HSF
O: 1/13/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HANSON, LEONARD D
Employee/Petitioner

Case# **11WC026924**

3M
Employer/Respondent

15IWCC0096

On 6/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0077 BOZEMAN NEIGHBOUR PATTON & NOE
JOHN HARRIS
PO BOX 659
MOLINE, IL 61266

2623 McANDREWS & NORGLE LLC
GREG NORGLE
53 W JACKSON BLVD SUITE 315
CHICAGO, IL 60604

£ OF ILLINOIS)
)SS.
OUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Leonard D. Hanson
Employee/Petitioner

Case # 11 WC 26924

Consolidated cases: ____

v.

3M
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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Rock Island**, on **December 10, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

L. [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

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 **Stephen Mathis**, Arbitrator of the Commission, in the city of **Rock Island**, on **December 10, 2013**. By stipulation, the parties agreed:

On the date of accident, **February 10, 2009**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**59,800**, and the average weekly wage was **$1,150**.

At the time of injury, Petitioner was **56** years of age, *married* with **0** dependent children.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 165 weeks, because the injuries sustained caused the 33 % loss of the person as a whole as provided in section 8(d)2 of the Act.

Medical Benefits

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 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 Ketti Steffen

6-8-14
Date

ICArbDecN&E p.2

JUN 6 - 2014

PROCEDURAL HISTORY

This matter was tried before Arbitrator Mathis on December 10, 2013. Subsequently, Matter was assigned to Arbitrator Ketki Steffen in May, 2014 for a decision. A complete copy of the transcript and exhibits was provided for review to Arbitrator Steffen

The only issue is the Nature and Extent of the injuries. The case arises out of an accident date of February 10, 2009, a date which pre-dates the AMA guidelines amendment to the act.

FACTUAL HISTORY

On February 10, 2009, Petitioner, Leonard D. Hanson was employed by Respondent, 3M.. Petitioner was fifty seven years old at the time of the accident and married with no dependants. He was in good health with no pre-existing pulmonary issues and was a lifetime non-smoker.

On February 10, 2009, Respondent was assisting another worker changing a valve on a chemical tank containing Dimethyl Sulfate, "DMS". Petitioner was wearing a protective suit, which included a respiration unit. Petitioner at some point during his shift, noted that there was an unusual smell inside his suit.. At the end of his shift he changed out of the suit and decontaminated. He noticed a red rash on his right arm and shoulder and had difficulty breathing. He reported the incident to his supervisor.

Upon returning home the rash worsened and Petitioner began to have respiratory issues. He also developed a blister on his right hip and knee. Shortly after midnight on February 11, 2009, Petitioner went to the emergency room of Mercy Medical Center Clinton, Iowa because of respiratory symptoms. Petitioner was diagnosed with acute

inhalation injury with Dimethyl Sulfate and acute topical skin burns with Dimethyl Sulfate. He also had topical skin burns. Petitioner's condition worsened. He was admitted to intensive care and intubated. Ultimately, his condition stabilized. A transfer to University of Iowa Hospitals and Clinics was scheduled by airlift, but ultimately took place by ambulance on February 11, 2009.

Petitioner was admitted to University of Iowa Hospitals and Clinics in serious condition. He remained hospitalized at University of Iowa Hospitals and Clinics from February 11, 2009 until February 15, 2009. During that time, he was intubated on a ventilator until February 13, 2009 and was diagnosed with chemical burns and an inhalation injury. Upon discharge, he was diagnosed with a chemical inhalation injury and partial thickness burns to his right shoulder, arm, knee and flank. Petitioner was discharged from University of Iowa on February 15, 2009 and advised to follow-up with a physician in 15 days.

Follow up appointments at the University of Iowa Hospitals and Clinics continued until February 10, 2010, at which time it was determined that Petitioner had reached maximum medical improvement for his burn injury. Dr. Joseph Chen rated his burn injury as 4% impairment of the whole person. Dr. Patrick Hartley found with regards to his pulmonary function, that he was still having difficulty with exercise tolerance and had not returned to his base line state. Progress had been made and he achieved normal resting spirometry. Continued follow up for pulmonary issues was recommended with a local Pulmonologist. On March 4, 2009, Petitioner was found to be at near normal pulmonary function. He was advised to return to light duty and to follow-up with Dr.

Hartley within 60 days. Petitioner followed up with Dr. Harley and also with a local pulmonologist, Dr. Charles Bruyntjensns of the Quad City Pulmonary Consultants.

Petitioner's Exhibit 4 is the deposition transcript of Dr. Bruyntjens. He testified that he began treating Petitioner on May 4, 2011 for his exposure to Dimethyl Sulfate. Dr. Bruyntjens explained that Dimethyl Sulfate infiltrates the lung and respiratory system and causes major damage to the respiratory bronchial tubes and alveoli. Dr. Bruyntjens performed CT scans of Petitioner's lungs, which showed multiple post inflammatory tissue damage throughout the lungs. Pulmonary function tests, spirometries initially showed normal function. Dr. Bruyntjens explained that the subsequent pulmonary function tests on May 17, 2012 showed a drop of 7% in lung function from the previous test done a year earlier. This was due to the exposure to Dimethyl Sulfate. Dr. Bruyntjens testified that it was his opinion that the Petitioner's respiratory damage from the chemical exposure at work will cause problems in the future with increased infections and additional breathing difficulties. Petitioner will lose between 3 – 4% of his lung function annually as opposed to a normal 1 – 2% loss due to age.

Petitioner testified that he has significant shortness of breath with any exertion such as caring for the family's rabbits or hunting. Initially, Petitioner testified that the exertional issues have affected his intimate relations with his wife.

Petitioner remains under the care of Dr. Bruyntjens. Petitioner worked for the respondent in his regular duty and capacity without medical restrictions and eventually retired on October 1, 2013.

In support of the Arbitrator's decision relating to nature and extent, the Arbitrator finds the following facts:

Petitioner's accident is uncontested and the reasonableness of the medical treatment is not at issue. The sole issue is the nature and extent of the injuries. Petition, a non smoker with no prior pulmonary issue suffered inhalation burn injuries from a faulty protective suit while he was working with a dangerous chemical, Dimethyl Sulfate, "DMS". This inhalation caused severe burn injuries not only to the Petitioner's outer body but also caused burn injuries to his lungs. Although Petitioner ultimately recovered from his injuries and returned back to full time work, his lung capacity is severely diminished.

Dr. Bruyntjens explained that DMS infiltrates the Petitioner's lungs and respiratory system and caused major damage to the respiratory bronchial tubes and alveoli. Objective medical evidence in the form of CT scans of Petitioner's lungs, showed multiple post inflammatory tissue damage throughout the lungs A pulmonary pulmonary function tests performed on May 17, 2012 showed a drop of 7% in lung function from the previous year. Dr. Bruyntjens opined that the DMS exposure will continue to cause problems in the future with increased infections and additional breathing difficulties. Petitioner will lose between 3 – 4% of his lung function annually as opposed to a normal 1 – 2% loss due to age.

A common sense approach and analysis of what Petitioner's injuries are and the long term effects and limitations that they will continue to have on his personal health makes a convincing case that the nature and extent of Petitioner's injuries is grave and

far-reaching. Diminished lung functions has already begun and and will likely harm his entire person. Unlike other inhalation cases where a Petitioner may suffer in the short run, the testimony of Dr. Bruyntiens is credible that the Petitioner will continue to have future medical problems due to this work injury. Although Petitioner is MMI, his work injuries will continue to compromise his abilities.

Therefore, Arbitrator finds that the Petitioner has suffered .a 33 % loss of person as a whole due to his work accident.

Ketki Steffen
Signature of Arbitrator

6-4-14
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andri Yanders,

Petitioner,

vs. NO: 13WC 31775

Bodine Services of Decatur, Inc.,

15IWCC0097

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical, prospective medical and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2014, is hereby affirmed and adopted.

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

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

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

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

DATED: FEB 4 - 2015

o012915
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

YANDERS, ANDRI
Employee/Petitioner

Case# **13WC031775**

15IWCC0097

BODINE SERVICES OF DECATUR INC
Employer/Respondent

On 8/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2427 KANOSKI BRESNEY
THOMAS R EWICK
2730 S MacARTHUR BLVD
SPRINGFIELD, IL 62704

0385 BONALDI CLINTON & DAVIS LTD
DAVID C DAVIS
2900 FRANK SCOTT PKWY WEST
BELLEVILLE, IL 62223

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)

ANDRI YANDERS,
Employee/Petitioner

v.

BODINE SERVICES OF DECATUR, INC.,
Employer/Respondent

Case # **13** WC **31775**

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 **7/16/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/2/13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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 $**38,600.98**; the average weekly wage was $**742.33**.

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

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

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

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

ORDER

The petitioner has failed to prove by a preponderance of the credible evidence that he sustained accidental injuries to his bilateral hands and arms due to repetitive work activities that arose out of and in the course of his employment by respondent on 5/2/13. 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 temporary total disability, medical benefits, or compensation for a permanent disability, if any.

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

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

Signature of Arbitrator

8/12/14
Date

ICArbDec19(b)

AUG 25 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 37 year old laborer/water blaster, alleges he sustained an accidental injury to his bilateral hands and arms due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 5/2/13. Respondent operates a water blasting service – industrial cleaning service. Petitioner began working for respondent in October 2007. He testified that his duties have been the same since he began working for respondent.

Petitioner testified that he works from 40 to 60 hours a week, 5 to 7 days a week. He stated that he does perform overtime and it is mandatory. Petitioner testified that his primary job with respondent is water blasting, and he has done this the entire time he has worked for respondent. Petitioner testified that he uses 10,000 to 20,000 psi of water to clean tanks, piping, or whatever else needs to be cleaned. The water blasting jobs petitioner performs include lancing, shotgun, jetting, tubing, hurricane and hotsy. Petitioner testified that that he had performed shotgunning for 8 to 12 hours a shift depending who was working with. Sometimes he may rotate between jobs at lunch, but other times he may do the water blasting the entire shift. Petitioner testified that when he does lancing he would switch out every hour.

On cross-examination petitioner testified that the days he works per week varies. He stated that some weeks he works more than five days, and other weeks he works less days. He also testified that the number of hours he works each week varies from 20 to 80. Petitioner stated that he worked more 40 to 80 hours, and less 20 hour weeks. Petitioner testified that he does general cleanup three weeks a year. He stated that the job he performs most is the water blasting. He stated that the four types of water blasting jobs include hurricane, shotgun, jetting tubes, and jetting lines.

Petitioner testified that water blasting affects his symptoms. He stated that the number of employees on a crew varies based on the job. He testified that if there is just him and only one other guy he does the water blasting all day. He stated that some weeks he has help with the water blasting. Petitioner testified that on MR jobs no prep work is needed, and he would start working right away. He testified that when the job is completed it could take a couple hours to break it down depending on how many people are there and how big the job is. Petitioner testified that they will stop blasting usually 30 minutes before the end of the shift. His lunch hour is 30 minutes a day. He stated that breaks vary. Petitioner testified that if someone on the crew cannot do the water blasting he will do the entire job. He testified that some people cannot hold the gun no matter how long they have been there. He testified that when the water blasting duties are shared he would work no more than one hour at a time. Petitioner

testified that he never water blasted less than five hours a day on an eight hour shift. Petitioner testified that all water blasting involves vibration.

On 2/23/12 petitioner received a letter from Berkeley Specialty Underwriting Managers Senior Claims Examiner informing him that his claim for workers compensation with the date of loss of 2/7/12 had been denied in its entirety due to lack of supporting evidence to prove a work-related injury as well as his own written statement of 2/23/12 stating that he did not wish to pursue a Worker's Compensation claim.

In the fall of 2012 petitioner started noticing numbness and tingling in his hands, as well as pain in his fingertips. Petitioner testified that he reported his symptoms at that time and was able to rest his hands by being taken off the water blasting jobs. However, when he began water blasting again his symptoms returned. Petitioner testified that his symptoms are made worse by water blasting, lancing, and tubing. Petitioner is right-hand dominant.

On 10/4/12 petitioner presented to DMH Corporate Health. Petitioner reported that his primary problem was numbness, and a tingling sensation located in both hands and forearms. He described it as a feeling of pins and needles. He reported that it had been about four years since the onset of the numbness and tingling sensation. Petitioner stated that it seemed worse at night. He also stated that his symptoms are made worse by water blasting and sleeping. He stated that it was improved when he rested his hands. Petitioner reported that in the past year the symptoms had been occurring almost daily, and he noticed numbness in his bilateral 2nd through 4th fingers. He also recently noticed some decreased hand grasp strength. Petitioner reported that he wakes almost nightly due to numbness, and has to shake his hands out. He stated that the numbness radiates up to his elbows and his neck is sore at times. Petitioner reported that he has performed water blasting for respondent for the past five years. He stated that he water blasts up to eight hours a day on an almost daily basis. Following an examination by physician's assistant Veronda, petitioner was diagnosed with bilateral carpal tunnel. He was released to full duty work. He was given Ace bandages to wear as much as possible, especially at night.

Petitioner returned to DMH Corporate Health on 10/18/12. Between 10/4/12 and 10/18/12 petitioner performed water blasting activities 4 days. Petitioner stated that his carpal tunnel symptoms had improved significantly. He even stated that he considered it to be no longer present. Petitioner noted that he had limited exposure to aggravating activities at work and home which helped his pain and numbness. Veronda examined petitioner and returned him to full duty work. However she recommended

that the company continue to rotate petitioner through various jobs during the week so as not to have repetitive vibration exposure.

On 2/25/13 petitioner presented to Dr. Adarsh Bairsetty for establishing care. Petitioner gave a history of hypertension. Following an examination Dr. Bairsetty's impression included hypertension poorly controlled, and medication. On 3/11/13 petitioner followed up with Dr. Bairsetty for his hypertension. Petitioner stated that he had not started taking the prescription Dr. Bairsetty had prescribed for him for his hypertension.

On 4/25/13 petitioner presented to Dr. Bairsetty complaining of bilateral hand numbness for four years, worse in the past year. Petitioner gave a history of performing high-pressure water blasting work every day. He believed that his condition was work related. He stated that he had seen a corporate doctor four months ago and was told that he had carpal tunnel syndrome, but he had never had any testing. and Petitioner informed Dr. Bairsetty that he wanted to file it as a worker's compensation claim, but the company denied it stating that petitioner symptoms were not work related. Petitioner stated that he wanted to get tested for carpal tunnel syndrome. Dr. Bairsetty assessed numbness in petitioner's hand most likely due to carpal tunnel syndrome. He advised petitioner on the use of wrist splints. He ordered an EMG/NCV.

On 5/2/13 petitioner underwent an EMG/NCV. The results revealed moderately severe carpal tunnel of the left side; underlying cubital tunnel syndrome on the left side of moderately severe variety; no evidence of cervical radiculopathy, peripheral neuropathy, plexopathy or disease at a muscle level. The right upper extremity evaluation did not reveal any carpal or cubital tunnel syndrome, or any cervical radiculopathy.

On 5/22/13 petitioner followed up with Dr. Bairsetty to discuss his test results. Dr. Bairsetty noted that the EMG/NCV was positive for moderately severe carpal tunnel syndrome on the left side and underlying cubital tunnel syndrome on the left of moderate severity. Examination of the right upper extremity did not reveal any carpal tunnel or cubital tunnel. Dr. Bairsetty instructed petitioner to follow-up as needed.

On 6/17/13 petitioner completed a medical history form for Dr. Brustein. He gave a history of hypertension. He reported numbness that began four years ago.

On 7/31/13 petitioner presented to Dr. Brustein with complaints of left hand numbness. Dr. Brustein reviewed the results of his EMG/NCV. Petitioner stated that the symptoms started four years

ago. Following an examination Dr. Brustein discussed with petitioner his left hand numbness and the results of the EMG in detail. He was of the opinion that there appeared to be moderately severe left carpal tunnel and cubital tunnel syndrome. Based on the EMG, Dr. Brustein felt it was reasonable to proceed with surgery at that time. Patient agreed to proceed with the surgery. Dr. Brustein recommended a left carpal tunnel release and left UNSMT.

On 9/4/13 petitioner sustained an unrelated right knee injury. He continues to treat for this injury with Dr. Braco and Dr Jones. During all visits with Dr. Braco and Dr. Jones for his right knee petitioner made no mention of any carpal or cubital tunnel complaints.

Beginning in late October or early November 2013 petitioner was taken off work due to a knee injury. Petitioner did not return to work until the end of March or early April 2014.

On 11/11/13 petitioner returned to Dr. Bairsetty for medical checkup. During this visit there was no mention of petitioner's bilateral hand and arm symptoms.

On 2/18/14 petitioner presented to Dr. Bairsetty for follow-up of his hypertension, and complaints of right-sided neck pain for the last 5 to 6 days. He denied any trauma. He stated that his pain was worse when he moves his neck to the left side. Petitioner denied any tingling or numbness in his arms. Dr. Bairsetty assessed a neck sprain and strain, and obesity. He advised petitioner on diet and exercise and gave him information about a weight management program. He instructed petitioner to follow-up as needed.

On 2/25/14 petitioner completed a Questionnaire for Dr. Joseph Williams at the Bone and Joint Institute. Petitioner complained of left elbow and hand tingling and numbness due to years of constant high pressure water blasting. On the diagram he also added pins and needles sensation and numbness in the right hand.

Petitioner underwent a Section 12 examination performed by Dr. Williams on 2/25/14 at the request of the respondent. Dr. Williams obtained a detailed history, performed a physical examination, and reviewed medical records and diagnostic test results. Dr. Williams noted that he was examining petitioner for his bilateral upper extremities, bilateral hands, elbows, and shoulder injuries, which he allegedly sustained on 5/2/13. Petitioner gave a history of primarily using a high-pressure water system of 10,000 to 40,000 psi. Petitioner stated that he sometimes does other jobs such as sweeping floors and shoveling. Petitioner is right-hand dominant. He also does tubing and shooting the gun down tubes. Petitioner also works on the jet line. He stated that he is primarily responsible for the water pressure

system. He stated that normally there are eight men to a crew and four men do the water blasting, while the other four take a rest for an hour. He stated that they always have four men working and four men resting. He reported that his shift may be from 6 to 8 hours per day and up to 40 to 50 hours per week. He stated that it varies widely. Petitioner reported that the water blaster requires a force for gripping vibrations. He stated that he has a gun on the water blaster and the trigger on the water blaster works like the trigger on a gun. He stated that he has to brace himself because of the 10,000 to 40,000 psi so that he doesn't get pushed backwards. He stated that the actual time spent working is approximately half of his day because he usually works one hour, rests one hour, and then has one hour for lunch. His days range from 6 to 12 hours a day. Petitioner stated that he uses both hands. When his right hand gets tired he then uses his left hand. He demonstrated that his elbows are up against his body to brace his arms. Petitioner complained of numbness and tingling at night in both hands. He stated that he noted the numbness and tingling a few years ago. He reported that in 2012 he wrote a long letter to respondent and they put him on light duty for a month. During that time the numbness and tingling improved in both hands.

Dr. Williams performed a physical examination. Petitioner had full range of motion of both wrists on dorsiflexion, palmer flexion, supination, and pronation. Petitioner had normal ulnar and radial deviation bilaterally. He had a negative Tinel's sign bilaterally, and a negative Phalen's test bilaterally. Petitioner had absolute normal sensation to pinpricks in all 10 fingers, both volarly and dorsally bilaterally. His deep tendon reflexes were 2+ an equal bilaterally. His muscle strength was 5/5. With respect to his shoulders petitioner had full range of motion of both shoulders. He had a negative Neer impingement test bilaterally, and a negative Hawkins test bilaterally. Petitioner also had a negative supraspinatus test bilaterally.

Following his physical examination Dr. Williams noted that he found no objective findings consistent with carpal or cubital tunnel syndrome in either extremity. Dr. Williams' diagnosis was that petitioner had a gunshot wound to his left arm, and his left arm had an abnormal EMG. He believed the abnormal EMG and the symptoms in his left arm are secondary to his gunshot wound. He noted that petitioner had no tenderness to pinpricks, had deep tendon reflexes equal bilaterally, equal motor strength bilaterally, and no objective abnormalities. He noted that petitioner only had subjective complaints. Dr. Williams was of the opinion that the gunshot wound to his proximal arm was most likely the cause of any symptoms that petitioner was currently having. Dr. Williams opined that petitioner's current complaints were not causally related to his work activities. He believed they were due to his past history of a

gunshot wound, his history of drinking, his hypertension, and his obesity. He further opined that he did not believe petitioner sustained a work injury to his upper extremities. He opined that petitioner had no objective abnormalities on his physical examination. Dr. Williams also opined that petitioner does not require any work restrictions with respect to his upper extremities. He noted that petitioner has been working without problems and can continue to do so.

On 3/7/14 the evidence deposition of Dr. Brustein was taken on behalf of petitioner. Dr. Brustein is an orthopedic upper extremity surgeon. He testified that when he saw petitioner on 7/31/13 petitioner did not have any complaints regarding numbness in his right hand. Dr. Brustein testified that generally keeping the elbow in a flexed position, and certain vibrational types of things, can cause symptoms of cubital tunnel. He stated that other things less mechanical can be associated with carpal tunnel and cubital tunnel including diabetes, thyroid problems and pregnancy. He opined that when the median nerve is compressed people get symptoms of carpal tunnel. He further opined that things that can cause compression of the median nerve of the wrist include keeping ones wrist in a flexed position, compression on the wrist, certain vibrational types of activities, and the same medical conditions associated with cubital tunnel. Dr. Brustein opined that given the severity of the carpal tunnel and cubital tunnel syndrome, when he saw petitioner on 7/31/13 surgery was a reasonable and necessary option. This was based on petitioner's physical examination and his EMG/NCV results.

Given a hypothetical that petitioner had never been diagnosed with carpal tunnel or cubital tunnel before his employment with respondent; that he was asymptomatic in the years leading up to his employment; that he works in excess of 40 hours a week, 5 to 6 days a week, sometimes up to 60 hours a week; that he water blasts up to eight hours a day with an hour lunch break, and a morning or afternoon break; that he uses 10,000 to 40,000 psi pressure hoses with the exception of 8 to 15 days during the year where he will vacuum or perform other duties; that the pressure in these hoses causes petitioner to brace himself with his legs; that petitioner's required to wear a protective suit; that the hoses he uses are 3/8" to an inch in diameter; that the hoses he uses vibrate constantly; that he holds the trigger with both hands alternating from his left and his right hand; that the trigger requires four fingers to pull; that when petitioner's pulling it with one hand he will use the other hand to hold or brace the lance; that his elbow is typically in a constant bent and flexed position; that petitioner also uses a 10,000 psi water blaster to do lancing and moves the hose in and out of the pipe as he cleans it, holding the hose with both hands; that the lancing hose subjects petitioner to significant vibration with his elbow in a bent position while he is moving the hose in and out; and that petitioner has performed these job since October 2007; Dr. Brustein

opined that these activities can either aggravate or exacerbate petitioner's carpal tunnel and cubital tunnel symptoms. He could not opine as to whether this hypothetical actually caused petitioner's carpal tunnel and cubital tunnel symptoms. Dr. Brustein opined that if petitioner was asymptomatic before his claimed injury that it would be unlikely that a gunshot wound to the humerus or a fracture to the left distal radius would contribute to his symptoms.

On cross-examination Dr. Brustein opined that there need not be a positive Tinel's or Phalen's to have a symptomatic carpal tunnel syndrome. Dr. Brustein testified that he would not generally expect there to be some thenar atrophy in somebody that had carpal tunnel syndrome for years. Dr. Brustein opined that he recommended surgery for petitioner's left carpal tunnel and cubital tunnel, but petitioner was not ready to have surgeries at that time. Dr. Brustein agreed that people can have positive EMGs and become asymptomatic as it relates to their carpal tunnel and cubital tunnel, however, most people with moderately severe or worse carpal tunnel tend to not become asymptomatic, but it does happen from time to time. Dr. Brustein testified that if he was going to proceed with surgery he would absolutely have to re-examine petitioner to determine whether or not he was still a surgical candidate for either the left carpal or cubital tunnel syndrome. Dr. Brustein admitted, based on his 7/31/13 office notes, there was no history of petitioner's problems being work related. Dr. Brustein testified that when he saw petitioner on 7/31/13 he did not asked petitioner if he believed his complaints were work related. Dr. Brustein opined that obesity is sometimes a risk factor for carpal and cubital tunnel, but he did not feel it was a huge contributing factor to petitioner's carpal cubital tunnel. Dr. Brustein believe that hypertension is a fairly minor risk factor for both carpal and cubital tunnel syndrome. He identified the biggest risk factors are diabetes, thyroid, pregnancy, trauma, and family history. Dr. Brustein agreed that carpal cubital tunnel syndrome can often be idiopathic.

On 4/8/14 the evidence deposition of Dr. Williams was taken on behalf of respondent. Dr. Williams is an orthopedic surgeon. Dr. Williams noted that petitioner completed two different pain drawings. Dr. Williams noted that petitioner's past medical history was significant for hypertension and hyperlipidemia. He also noted that petitioner's past surgical history was remarkable for broken wrist and gunshot wound, both on the left. Dr. Williams also noted that petitioner was morbidly obese. Dr. Williams opined that petitioner's gunshot wound would almost have to be responsible for some type of injury to the median and ulnar nerve since the gunshot went right through where the nerve goes through in his upper arm at the arm. Dr. Williams noted that petitioner told them he had equal problems with his symptoms at night when he exercised, and when he slept. Dr. Williams did not believe that petitioner's

work activities caused any injury because his symptoms occur when he exercises, when he sleeps, and when he does other activities as well. He noted that they do not only occur when he works, but occur at other times, including when he exercises. Dr. Williams noted that when he saw petitioner 6 to 7 months after Dr. Brustein saw him, whatever symptoms petitioner had previously, had gone away. He stated therefore it was his opinion that petitioner required no surgery.

On cross-examination Dr. Williams stated that petitioner was inconsistent with the way he drew his pain drawings and his complaints. Dr. Williams agreed that it is possible for someone to sustain a gunshot wound 16 to 18 years ago and still develop carpal tunnel and cubital tunnel syndrome from work. Dr. Williams stated that it was fairly unusual for patients to have carpal or cubital tunnel syndrome in only one extremity but not the other, especially since petitioner is right handed and his left side was abnormal. Dr. Williams opined that he did not think one could be shot in the arm where petitioner got shot without making the nerve more sensitive. He admitted that this was speculation on his part. He expected the nerve to be more hypersensitive and have more of a tendency to have an injury later in life. Dr. Williams agreed that if petitioner was applying forceful gripping to the hoses and triggers and was exposed to vibration with his elbow in bent positions 3 to 4 hours a day these activities could contribute or aggravate the symptoms of carpal tunnel or cubital tunnel. However he did not believe that they caused carpal tunnel syndrome. Dr. Williams stated that he believed petitioner's work aggravates his symptoms, but did not think it caused symptoms.

Petitioner testified that since returning to work at the end of March or early April 2014 his symptoms have increased with his performance of the water blasting. He testified that his symptoms are always there, but worse when he performs water blasting.

Petitioner denied that he exercised every night and had pain associated with his exercise. Petitioner testified that the exercise he was doing was in order to get his knee stronger. He testified that he did not do any weightlifting. With respect to his gunshot wound petitioner testified that he was shot in the left arm above the elbow and underneath the bicep approximately 17 or 18 years ago. He stated that he was shot in the inner side of his arm and it went right through and came out the outer side of his arm. Petitioner did not undergo any surgery for the gunshot wound. He stated that he treated at the ER and never had any further treatment after that. Petitioner denied any numbness or tingling in his hands before he started working for respondent.

Justin Butts, corporate safety manager, was called as a witness on behalf of respondent. Butts oversees all worker comp injuries and claims. He testified that there exists safety policies with respect to

water blasting. All employees that water blast are required to wear protective clothing, and there is a backup prevention system used on jetting. He stated that there is a job rotation where an employee water blasts for one hour and is then taken off the job for an hour. He stated that the employees are limited to no more than two hours water blasting per job. He testified that environmental factors can also affect the rotation. He stated that if the temperature gets very high rotation is every 15 minutes. He testified that an employee would not shotgun more than two hours at a time. He also stated that an employee would not perform the hurricane more than 3 to 4 hours at a time. Butts testified that they enforce the two-hour rotation. He stated that this is performed by the safety manager at each location. He testified that water blasting can be performed anywhere from 0 to 7 days a week. He testified that no employee is to water blast more than four hours a shift.

On cross-examination Butts testified that he has only been in his current job since 1/1/12. He testified that he currently spends 10 to 15% of his time in the field per week. Butts testified that petitioner approached him regarding his complaints at work due to water blasting. He stated that petitioner told him that the tasks he was performing caused a lot of vibration in his hands. Butts admitted that there is no written policy regarding the hours employees spend performing each task.

Respondent offered into evidence calendars from January 2012 through July 2014 outlining the tasks petitioner performed on any given day. The calendar shows that during this period petitioner could work as little as one day a month performing water blasting duties, or up to 14 days a month. On average, petitioner performed water blasting activities 8 days a month in 2012, 7.4 days a month in 2013, and 4 days a month in 2014. The most consecutive days petitioner performed waterblasting in 2012, 2013, and 2014 was 5 and the least was 1.

Petitioner testified that he currently experiences numbness in his left and right hands. He stated that the grip strength in his left hand is not as strong as his right hand. He testified that he experiences tingling, burning sensation in his middle finger and index finger. He stated that his symptoms are present constantly. He stated that the water blasting aggravates these symptoms. Petitioner testified that he experiences numbness at night and it awakens him.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

As a general rule, repetitive trauma cases are compensable as accidental injuries under the Illinois Worker's Compensation Act. In Peoria County Belwood Nursing Home v. Industrial Commission (1987) 115 111.2d 524, 106 Ill.Dec 235, 505 N.E.2d 1026, the Supreme Court held that "the purpose behind the Workers'

Compensation Act is best serviced by allowing compensation in a case ... where an injury has been shown to be caused by the performance of the claimant's job and has developed gradually over a period of time, without requiring complete dysfunction.." However, it is imperative that the claimant place into evidence specific and detailed information concerning the petitioner's work activities, including the frequency, duration, manner of performing, etc. It is also equally important that the medical experts have a detailed and accurate understanding of the petitioner's work activities.

Since petitioner is claiming an injury to his bilateral hands and arms due to repetitive work activities, 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 the case at bar, there is conflicting evidence as to the frequency, duration and manner in which petitioner performed the alleged repetitive activities. It is unrebutted that petitioner's job includes various types of waterblasting. Petitioner has worked for respondent for 5 years. At trial, he testified that he works 40-60 hours a day, 5-7 days a week. Then on cross-examination he stated that the number of days he works per week varies, and can be more or less than 5 days a week. He also admitted that his work week can vary from 20-80 hours, but claims more weeks were 40-80 hours, and less weeks were 20 hours. The arbitrator finds it significant that petitioner failed to offer into evidence any timesheets to support the number of hours he worked in the years preceding the injury, and what tasks he performed on any given day.

The arbitrator finds there is a discrepancy in the evidence as to the hours petitioner spent water blasting on any given day. Petitioner testified that he water blasts all day on certain days if it is just him and another worker and the other worker can't water blast. He did not testify how often this happens. He then went on to state that when water blasting duties are shared he would work no more than an hour at a time, but then went on to state that he never water blasted less than 5 hours in an 8 hour shift.

Petitioner told Veronda that he water blasts up to eight hours a day on a daily basis. He also reported to Dr. Bairsetty that he performed high pressure water blasting work every day. Petitioner told Dr. Williams that he is primarily responsible for the water pressure system. He reported that there are normally 8 men to a crew and four men do water blasting while the others rest for an hour, and then they switch. He told Dr. Williams that his schedule varied widely. Dr. Brustein was given a hypothetical

wherein petitioner water blasts up to 8 hours a day, with the exception of 8-15 days a year where he will vacuum or perform other duties.

Butts testified that respondent has safety policies with respect to water blasting. He testified that employees who water blast are restricted to an hour on and then an hour off, with no more than two hours water blasting per job. He testified that it could even be as little as 15 minutes at a time if the temperature gets very high. He also testified that an employee would not hurricane more than 3-4 hours at a time. Butts testified that the two hour rotation for water blasting is enforced by the safety managers at each location. He also testified that water blasting can be performed as few as 0 days a week and as many as 7 days a week.

Respondent is the only one that offered into evidence any work records to support the actual activities performed on any given days. The respondent offered into evidence calendars from January 2012 through July of 2014 that outline the tasks petitioner performed on any given day. The calendar shows that during this period petitioner could work as little as one day a month water blasting, or as much as 14 days a month waterblasting. On average, petitioner performed water blasting activities 8 days a month in 2012, 7.4 days a month in 2013, and 4 days a month in 2014. Additionally, the calendar shows that the most consecutive days petitioner performed water blasting in 2012, 2013 and 2014 was 5 days, and the least was 1.

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 accidental injuries to his bilateral hands and arms due to repetitive work activities that arose out of and in the course of his employment by respondent, and manifested itself on 5/2/13. Based on the petitioner's own testimony, the history he provided his healthcare providers, the testimony of Butt, and the calendar of petitioner's work activities from January 2012 through July of 2014, the arbitrator finds the petitioner has not shown by a preponderance of the credible evidence that his work activities involved constant or repetitive activity that *gradually* caused the deterioration of or injury to his bilateral arms or hands. The arbitrator finds the petitioner has failed to place into evidence specific and detailed information concerning his work activities, including the frequency, duration, manner of performing, etc.; or credible evidence to support a finding that the medical experts had a detailed and accurate understanding of his work activities. The arbitrator finds the credible evidence supports a findings that the work history petitioner provided the various healthcare providers was varied and not consistent.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?
J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found the petitioner has failed to prove by a preponderance of the credible evidence that he sustained accidental injuries to his bilateral hands and arms due to repetitive work activities that arose out of and in the course of his employment by respondent and manifested itself on 5/2/13, the arbitrator finds these remaining issues moot.

15IWCC0098

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF PEORIA	)	

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Betty Schmidt,
Petitioner,

vs. NO: 12WC 9405

Caterpillar, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 July 14, 2014, is hereby affirmed and adopted.

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

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

Bond for 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: FEB 4 - 2015
o012915
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHMIDT, BETTY Case# **12WC009405**
Employee/Petitioner

CATERPILLAR INC 15IWCC0098
Employer/Respondent

On 7/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1824 STRONG LAW OFFICES
TODD A STRONG
3100 N KNOXVILLE AVE
PEORIA, IL 61603

5035 CATERPILLAR INC
DARCY GIBSON
100 N E ADAMS ST
PEORIA, IL 61629-4340

15IWCC0098

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

- [ ] 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

Betty Schmidt
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # **12** WC **9405**

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 **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **May 20, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

L. [x] What is the nature and extent of the injury?

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On **February 23, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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 $**35,843.08**; the average weekly wage was $**689.29**.

On the date of accident, Petitioner was **51** years of age, *married* with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**9,269.19** for other benefits, for a total credit of $**9,269.19**.

Respondent is entitled to a credit of $**6,433.07** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**459.76**/week for **21** weeks, commencing **April 5, 2012** through **August 29, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **February 23, 2010** through **May 20, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $**283,711.24**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**413.57**/week for **125** weeks, because the injuries sustained caused the **25%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Arbitrator Anthony C. Erbacci

July 7, 2014
Date

JUL 14 2014

FACTS:

The Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent on February 23, 2010. The Petitioner testified she was employed by Respondent as a material specialist and had been so employed since 2005. The Petitioner testified that on February 23, 2010 she was training on a new job which required her to lift heavier parts out of a tub. The Petitioner testified that she bent over and picked up a part and, as she was turning and twisting to put the part into another tub, she felt pain and a "pop" in her low back. The Petitioner reported the incident immediately and was sent to the Caterpillar Medical Department where she saw Dr. Kent Miller.

The Petitioner saw Dr. Miller on February 24, 2010 and he returned her to work in a light duty capacity. The Petitioner testified that she worked light duty for two days and the pain in her low back and right leg continued to worsen. The Petitioner testified that her pain got so severe that she was taken from her home by ambulance and transported to the emergency room at OSF St. Francis Hospital. At the hospital, x-rays were performed and an MRI was prescribed. The Petitioner was also prescribed pain medications. The diagnosis was low back pain with sciatica.

On March 4, 2010, the Petitioner saw Dr. Miller again and he noted that she continued to have low back pain with right sciatica which resolves temporarily with pain medication. Dr. Miller noted that he had reviewed the MRI findings and his assessment was acute low back pain with sciatica and degenerative disc disease. Dr. Miller also noted that the Petitioner wanted to see her chiropractor and had an appointment with a pain specialist. Dr. Miller continued the Petitioner's work restrictions.

The Petitioner began seeing her chiropractor on March 5, 2010 and on March 16, 2010 Dr. Miller noted that the Petitioner reported that she was improved and that her right sciatica had resolved and her remaining back pain was mild. On March 25, 2010, Dr. Miller noted that the Petitioner reported that she was improved and tolerating her restricted work well although she had a temporary setback at home over the weekend. On April 6, 2010, Dr. Miller noted that the Petitioner reported she felt she was at her pre-incident normal baseline and had no further symptoms and normal function. The Petitioner continued to see her chiropractor through April 14, 2010, and at that time was released without restrictions.

On August 12, 2010, Dr. Miller noted that the Petitioner reported a new onset of low back pain at the L5-S1 level without any new mechanism or trauma. Dr. Miller noted that the Petitioner was pain free and functioning normally since being released from her chiropractor's care in April. Dr. Miller also placed the Petitioner on "protective restrictions". On September 9, 2010 Dr. Mller noted that the Petitioner reported that she had no improvement with acupuncture and that her pain had decreased temporarily after being off work for three days. Dr. Miller noted that the Petitioner had chronic right lower back pain that was not improving with chiropractic care and acupuncture and he suggested referral to a pain management doctor, Dr. Henry, for a trial injection. The Petitioner declined having an injection but continued to have chiropractic treatment and acupuncture through October 26, 2010.

The Petitioner returned to Dr. Miller on November 4, 2010 and he noted that the Petitioner reported that she was back to her pre-injury baseline "as best as she knows" but continued to have transient low grade ache in the low back. It was noted that the Petitioner was working in a very light job with only occasional lifting of less than 20 pounds and no cart pushing or pulling. Dr. Miller removed all restrictions and indicated that the Petitioner was likely at maximum medical improvement.

The Petitioner testified that she continued to follow up with Dr. Miller in 2011 seeing him in May, June and August. The Petitioner testified that she continued to have pain in her back and down her right leg which was transient and fluctuated in its intensity. The Petitioner testified that, over all, her pain continued to worsen to the point that she began to have difficulty with walking.

The Respondent's medical clinic records indicate that on May 20, 2011, the Petitioner reported that her back was hurting, and had been bothering her for 3 months, and she requested approval to see her Chiropractor. Dr. Miller saw the Petitioner on May 26, 2011 and noted that she had no new injurious mechanism and was doing the same light clerical job. Dr. Miller noted that the Petitioner had developed a reoccurrence of insidious right sided low back pain at the L5-S1 level and his assessment was a non-occupational flare up of low back pain with a history of right sciatica, low back pain, and degenerative disc disease. Dr. Miller placed the Petitioner on "protective restrictions" and noted that that he had previously opined that the Petitioner had been at maximum medical improvement. Dr. Miller noted that he had discussed the matter with the Respondent's workers' compensation adjuster and that, with no further injurious mechanism, the Petitioner would have to follow up with her personal medical provider under her group medical plan.

On June 22, 2011 the Petitioner returned to Dr. Miller and reported that she was the same but was able to do her regular duties, which were very light, without restrictions. On August 17, 2011, Petitioner returned to see Dr. Miller and reported that she was still the same with continued low back pain and right sciatica. On December 1, 2011, the Petitioner followed up with Dr. Miller and he noted that the Petitioner was at maximum medical improvement in his opinion. Dr. Miller noted that the Petitioner was status quo with the same chronic pain in her low back and right sciatica which was variable in frequency but occurred daily.

The Respondent's medical clinic records indicate that on March 5, 2012, the Petitioner called and reported that she had hurt her back again on March 3, 2012 from doing light dusting at waist height and that she had severe back and hip pain. The Petitioner was taken off work by her primary care doctor, apparently through March 8, 2012.

Thereafter, the Petitioner came under the care of Dr. Richard Kube on referral from her primary care doctor, Dr. Griebel. The Petitioner first saw Dr. Kube on March 13, 2012, and Dr. Kube noted a history of an injury at work in February of 2010 and low back pain and intermittent pain down her leg since that time. Dr. Kube noted that the Petitioner had been working, not doing as much lifting, but that any kind of activity level intermittently increased

her pain level. Dr. Kube's assessment was chronic pain due to trauma, lumbosacral degenerative disc disease, and lumbago. His impression was that the Petitioner sustained a strain/sprain injury but he noted that the Petitioner never really had a vigorous rehab program to try to promote strength and healing and that since she did not have an adequate level of work endurance and tolerance and strength endurance and tolerance, she continued to "re-tweak" her back condition. Dr. Kube prescribed continued light duty work and a vigorous rehab program.

The Petitioner participated in the prescribed course of physical therapy from March 15, 2012 through April 13, 2012. The physical therapy records demonstrate that there was no significant change in the Petitioner's status and that she continued to have pain with walking.

On March 28, 2012, the Petitioner returned to Dr. Miller and reported that her condition was worsening and affecting her ability to walk very long or to sit very long. On April 5, 2012 Dr. Kube noted that the physical therapy did not seem to be helping and he prescribed a discogram and nerve studies. Dr. Kube took the Petitioner off work at that time. An EMG was performed on April 16, 2012 and showed right L5 radiculopathy. The discogram was conducted on April 20, 2012 and was reported to be positive at L5-S1. On April 24, 2012, Dr. Kube recommended surgery consisting of decompression and fusion at L5-S1 and the surgery was carried out on July 13, 2012. Post surgically, the Petitioner participated in a course of physical therapy and, over all, reported improvement in her condition.

On September 20, 2012, at the request of Respondent, the Petitioner was examined by Dr. Michael Kornblatt. It was Dr. Kornblatt's opinion that the Petitioner's MRI results from February 2010 did not correlate with her subjective complaints of pain in the low back and pain radiating down the right leg. Dr. Kornblatt opined that the Petitioner's February 23, 2010 injury resulted in a self-limiting lumbo-sacral strain and that the Petitioner's MRI findings pre-dated the injury and were unrelated. Dr. Kornblatt reported that he reviewed the Petitioner's x-ray and MRI films and he opined that the findings had no clinical significance and there was no herniated disc, spinal stenosis or nerve root impingement. Dr. Kornblatt agreed that the Petitioner had reached maximum medical improvement from her work injury by December 1, 2011 and he opined that the work incident did not result in a surgical lesion such as a herniated disk or instability. He acknowledged that the Petitioner reported that she was much improved as compared to her preoperative condition, but he noted that she still had subjective complaints of low back pain and right radiculopathy. Dr. Kornblatt opined that the Petitioner's surgical procedure was unrelated to the work injury of February 23, 2010.

Following the Petitioner's course of post-operative physical therapy, her condition continued to improve and on August 29, 2012 the Petitioner was released to return to light duty work. Dr. Kube eventually recommended a functional capacity evaluation which was carried out on May 31, 2013. The Petitioner saw Dr. Kube for the last time on June 20, 2013 and she was given a permanent 40 pound lifting restriction and placed at maximum medical improvement.

In his testimony of August 5, 2013, Dr. Kube opined that the Petitioner's L5-S1 fusion

was reasonable and necessary and causally related to her original work injury of February 23, 2010. Dr. Kube noted that the Petitioner had a contemporaneous onset of symptoms with the work incident and that the symptoms produced were persistent from the time of the injury, more or less, and that she had undergone a variety of treatment that had not completely alleviated the symptoms.

The Petitioner testified that prior to her work injury of February 23, 2010, she had no pain or problems in her back nor had she sought or received any medical care or treatment for her back. She testified that her back and right leg pain commenced with her injury on February 23, 2010 and that, while the pain was somewhat transient and temporarily alleviated by the chiropractic treatment she received, it continued through the date of surgery. The Petitioner testified that her condition is much improved after the surgery performed by Dr. Kube although she no longer runs or bowls. The Petitioner testified that she does occasionally experience back pains similar to those she experienced prior to surgery, but she doesn't have them as often.

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 Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent on February 23, 2010 when she felt pain and a "pop" in her low back while lifting and moving a part. The Petitioner testified that prior to that work injury of February 23, 2010, she had no pain or problems in her back nor had she sought or received any medical care or treatment for her back. She testified that her back and right leg pain commenced with her injury on February 23, 2010 and that, while the pain was somewhat transient and temporarily alleviated by the chiropractic treatment she received, it continued through the date of surgery. The Petitioner testified that her condition was much improved after the surgery performed by Dr. Kube.

The Arbitrator finds the testimony of the Petitioner to be credible and supported by the medical records which demonstrate that the Petitioner continued to have complaints of back pain from the date of injury through the date of the surgery performed by Dr. Kube. While it appears from the records that the Petitioner's condition did improve for varying periods of time and to varying degrees following the chiropractic and acupuncture treatments she received, it is clear that her complaints of back and leg pain were consistent with her initial complaints and that they continued to persist.

The Arbitrator notes that following her injury, the Petitioner was sent to the

15IWCC0098

Respondent's Medical Department where she saw Dr. Kent Miller. The Petitioner continued to follow up with Dr. Miller and to receive chiropractic treatment for her back complaints through April 14, 2010. On August 12, 2010, the Petitioner returned to Dr. Miller and reported low back pain at the L5-S1 level without any new mechanism or trauma. On September 9, 2010 Dr. Mller noted that the Petitioner had no improvement with acupuncture and that the Petitioner had chronic right lower back pain that was not improving. The Petitioner returned to Dr. Miller on November 4, 2010 and he noted that the Petitioner continued to have transient low grade ache in the low back. The Petitioner continued to follow up with Dr. Miller for her complaints of back and leg pain in 2011 and the Respondent's medical clinic records indicate that on March 5, 2012, the Petitioner called and reported that she had had severe back and hip pain. The Petitioner testified that the pain that she experienced in March of 2012 was no different than the pain that she had been experiencing off and on since her work injury and was not the result of a new injury or an intervening event.

When the Petitioner eventually came under the care of Dr. Kube, he noted a history of an injury at work in February of 2010 and low back pain and intermittent pain down the leg since that time. Dr. Kube's impression was that the Petitioner sustained a strain/sprain injury and that she thereafter continued to "re-tweak" her back condition. A course of physical therapy prescribed by Dr. Kube resulted in no significant change in the Petitioner's status and on March 28, 2012, the Petitioner returned to Dr. Miller and reported that her condition was worsening and affecting her ability to walk very long or to sit very long. An EMG performed on April 16, 2012 showed right L5 radiculopathy and a discogram conducted on April 20, 2012 was reported to be positive at L5-S1. On July 13, 2012, Dr. Kube performed surgery consisting of a decompression and fusion at L5-S1. Post surgically, the Petitioner participated in a course of physical therapy and, over all, reported improvement in her condition.

Dr. Kube opined that the Petitioner's L5-S1 fusion was reasonable and necessary and causally related to her original work injury of February 23, 2010. Dr. Kube noted that the Petitioner had a contemporaneous onset of symptoms with the work incident and that the symptoms produced were persistent from the time of the injury, more or less, and that she had undergone a variety of treatment that had not completely alleviated the symptoms. The Arbitrator finds the opinions of Dr. Kube to be credible, reliable and persuasive.

While the Arbitrator notes the opinions of Dr. Kornblatt, the Respondent's examining physician, the Arbitrator finds that the opinions of Dr. Kube are sufficiently credible, reliable and persuasive so as to satisfy the Petitioner's burden of proof in the instant matter.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's condition of ill-being with respect to her low back at L5-S1 and corresponding right-sided radiculopathy is causally connected to the work accident of February 23, 2010. The Arbitrator further finds that the medical care and treatment prescribed and rendered by Dr. Miller, Durbin Chiropractic, Prairie Spine and Pain Institute, and Dr. Richard Kube was reasonable and causally related medical care which was medically necessary to treat and alleviate the Petitioner's condition of ill-being as it related to the February 23, 2010 work 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, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions with regard to the issue of causation are adopted and incorporated herein.

The Petitioner introduced Petitioner's Exhibit 11 into the record which represents the medical bills which remain outstanding. The parties have stipulated that the Respondent has paid $6,433.07 under its group health medical plan. The parties have further stipulated that some medical bills were paid under workers' compensation provisions and the Respondent has entered the workers' compensation medical payments into the record as Respondent's Exhibit No. 7. Petitioner's Exhibit No. 11 represents outstanding unpaid medical bills which have already taken into consideration the medical bills paid under the employer's workers' compensation benefits self-insured program and has taken into consider the 8(j) credit of medical payments paid under the Respondent's self-insured group health insurance plan for which there are various write-offs and contractual PPO discounts. Therefore, given the parties' stipulation and based upon the Arbitrator's prior finding that there exists a causal connection between the Petitioner's condition of ill-being and the medical care and treatment that she received as a result of the work accident of February 23, 2010, the Arbitrator awards to the Petitioner the following medical bills:

PROVIDER	TOTAL CHARGES	AMOUNT OUTSTANDING
Airway Anesthesia	$3,300.00	$3,300.00
Broncor, Inc.	$2,726.49	$2,726.49
Central IL Radiological	$53.00	$53.00
Champion Fitness	$980.00	$980.00
Durbin Wellness	$5,830.00	$330.00
Gray Medical	$14,050.00	$14,050.00
Memorial Medical Center	$1,522.00	$1,522.00
Methodist Family Medical Group	$3,312.80	$0
Methodist Occupational Medical	$407.00	$407.00
OSF St. Francis	$1,137.65	$0
OSF St. Francis	$4,136.00	$0
OSF St. Francis	$1,908.00	$0
OSF St. Francis	$249.00	$0
OSF St. Francis	$1,343.58	$0
OSF St. Francis	$5,357.55	$0
OSF St. Francis	$357.00	$0
OSF St. Francis	$385.00	$0
Prairie Spine & Pain Institute	$195,267.41	$150,082.13
Prairie Surgicare	$132,454.09	$132,454.09
Dr. Edward Trudeau	$3,518.00	$195.02
TOTALS	$378,294.57	$283,711.24

The Arbitrator finds that the Respondent is responsible for payment of $283,711.24 in

15IWCC0098

medical bills subject to the limitations prescribed under the Illinois Workers' Compensation Fee Schedules with the appropriate discounts to apply after the application of the fee schedule.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions with regard to the issue of causation are adopted and incorporated herein.

The Petitioner's testimony and the records of Dr. Kube demonstrate that the Petitioner was off work as a result of her injury from April 5, 2012 through August 29, 2012, a period of 21 weeks. The Petitioner testified that she returned to light duty work following her release to do so by Dr. Kube on August 29, 2013 and that she has continued to work for the Respondent since that time.

The Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from April 5, 2012 through August 29, 2012, a period of 21weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions with regard to the issue of causation are adopted and incorporated herein.

As a result of her injury, the Petitioner underwent a decompression and fusion at L5-S1. The Petitioner underwent a post-operative course of physical therapy and was eventually released from medical care with permanent work restrictions of no lifting greater than 40 pounds. The Respondent has continued to provide work for the Petitioner within those restrictions and the Petitioner has continued to work for the Respondent within those restrictions. The Petitioner testified that her condition is much improved after the surgery performed by Dr. Kube although she no longer runs or bowls. The Petitioner testified that she does occasionally experience back pains similar to those she experienced prior to surgery, but she doesn't have them as often. Based upon the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's injury resulted in a 25% permanent disability to her whole person.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher McClure,
Petitioner,

15IWCC0099

vs.

NO: 13 WC 16865
14 WC 1523

State of Illinois - IDOC,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability 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 24, 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.

DATED: FEB 5 - 2015
KWL/vf
O-1/26/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0099

McCLURE, CHRIS Case# **13WC016865**

Employee/Petitioner

14WC001523

STATE OF ILLINOIS - IDOC

Employer/Respondent

On 7/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2217 SHAY & ASSOCIATES
STEPHANIE SHAY
1030 S DURKIN DR
SPRINGFIELD, IL 62704

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

4138 ASSISTANT ATTORNEY GENERAL
WARREN WILKE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUL 24 2014

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0099

Christopher McClure
Employee/Petitioner

v.

State of Illinois- IDOC
Employer/Respondent

Case # **13** WC **016865**

Consolidated cases: **14 WC 001523**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **June 26, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **April 22, 2013 and December 5, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**72,800.00**; the average weekly wage was $**1,400.00**.

On the date of accident, Petitioner was **47/ 48** years of age, *married* with **2** dependent children.

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

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

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

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

ORDER

Pursuant to the attached findings of fact and conclusions of the Arbitrator finds and orders as follows:

Respondent shall pay all the reasonable and related outstanding medical bills, as set forth in Petitioner's Exhibit 3, directly to the medical providers pursuant to the Medical Fee Schedule set forth in Section 8(a) of the Act.

Petitioner failed to show any permanent partial disability resulting from either of the above referenced accidents.

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

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

July 15, 2014
Date

JUL 24 2014

The Arbitrator hereby makes the following findings of fact:

Petitioner testified that while working at the Logan County Correction Center, he was injured twice. The incidents, which will be discussed in detail below, occurred on April 22, and December 5, 2013.

Petitioner testified that, on April 22, 2013, an inmate in segregation threw a clear odorless liquid through an opening in the segregation cell. Specifically, this liquid made contact with Petitioner's face, left ear, eyes, nose , mouth and left arm. Petitioner stated that the liquid caused physical irritation on the contact points. Petitioner testified that the liquid was clear and had no discernible smell. Petitioner stated that the liquid was not brown or yellow and did not smell of urine or feces. The liquid left no stains. Petitioner immediately reported the incident and washed his face at the healthcare unit.

Although there are no specific guidelines for what to do when plashed with an unknown liquid, Petitioner testified that it is commonly accepted practice to immediately seek medical attention. Pursuant to this practice, Petitioner sought treatment at the Springfield Clinic on April 22, 2013. Pathology tests were performed and Petitioner was instructed to remain diligent for signs on infection. The medical record for this date indicates that Petitioner's eye was "a little irritated" but that Petitioner had no vision problems. Petitioner's medications on this date included Zegerid, Diclofenac Sodium, Hydrocodone, Amitriptyline, Lisinopril, and Hydrochlorothiazide, which all have potential side effects that include dry skin, rashes, and mouth sores. The diagnosis was that of a possible exposure to a contagious disease. (PX. 1).

The following day, April 23, 2013, Petitioner presented to a different clinic, Midwest Occupational Health Associates, with complaints of *mild* left eye irritation and a headache. A second round of blood born pathogen tests were performed that were *identical* to those performed one day prior. (PX. 2)

On April 26, 2013, Petitioner sought additional treatment Springfield Clinic with complaints a migraine headache which began with, and had not subsided since, the accident. Petitioner complained that his migraine medication did not alleviate this migraine. Petitioner noted increased stress after the incident, and testified that increased stress had, in the past, been a trigger for his chronic migraines. The record indicates that Petitioner had prior eye irritation, but appears to indicate that the irritation was in the past and not ongoing. The same is true of Petitioner's skin irritation. On this date, Petitioner was told that his blood-borne pathogen tests were negative. (PX 1).

During the April 26, 2013 visit, Petitioner was referred to a psychiatrist. However, Petitioner never sought such treatment. Petitioner claimed that workers' compensation insurance would not cover psychiatric treatment, but produced no such denial letter. Petitioner also testified that he did not seek psychiatric treatment because he felt that he would be ostracized by his co-workers for seeking such help.

On April 29, 2013, one week after the accident, a report was issued showing that Petitioner's blood borne pathogen test returned negative results. (PX 2). Petitioner was scheduled for a June 6, 2013

follow-up for more testing to confirm that the first test did not return any false negatives. The results for the June 6, 2013 test came back on June 10, 2013 and returned negative results. (PX. 2). Similarly, on June 10, 2013, the inmate that threw the clear odorless liquid onto Petitioner had similar blood born pathogen tests that returned negative results. (PX.2)

At trial, Petitioner testified as to his mental condition between the accident date and the date on which he received the test results. During this time, Petitioner sought no medical treatment for his alleged mental conditions, and thus there is no medical evidence to support his testimony. Moreover, Petitioner's stress, due to not knowing the results, was temporary and was alleviated once his results were returned one week later on April 29, 2013. Thus the trial record shows that Petitioner's alleged mental conditions were, at worst, temporary in nature. With regard to exposure, Petitioner testified that he had a prior hepatitis vaccination.

Petitioner testified that the December 5, 2013 incident occurred when an inmate spit on him. Petitioner stated the saliva contacted his mouth, eyes, nose, and ears. Like before, Petitioner immediately reported the incident and sought treatment at the health unit. Later that day, Petitioner went to the Springfield Clinic where he was told to follow up at Midwest Occupational Health Associates. Blood-borne pathogen testing was not recommended because there was no blood or any unknown bodily fluid which in turn placed Petitioner at a low risk of contracting a disease. (PX 1). The medical record reflects that Petitioner expressed understanding in response to this recommendation. (PX. 1).

Petitioner testified that he was unable to follow-up with MOHA because Respondent did not approve his visit. Petitioner received a letter stating that he had not submitted a complete workers' compensation packet. Petitioner testified that he submitted all of his workers compensation paperwork on time. Petitioner did not offer into evidence any materials from his workers' compensation packet. Similarly, Petitioner did not testify as to any inquires made on his behalf as to what was missing from his packet. Petitioner's actions indicate that he did not intend to seek further treatment at MOHA. Petitioner's desire not to seek further treatment is reinforced by his posture at trial in that he did not file a 19(b) petition or request authorization for further treatment.

On December 18, 2013, Petitioner returned to Dr. Michael Brewer at Springfield Clinic with complaints of mental stress following the accident. Petitioner testified that he had blood work done which returned negative results. Petitioner testified that the spitting incident resulted in a loss of consortium and caused mental stress. Similar to the earlier injury, this stress was at worst temporary. With regard to exposure, Petitioner testified that he had a prior hepatitis vaccination. Petitioner was also diagnosed with maybe having some mild perioral dermatitis, for which he was prescribed metronidazole creame. The medical record from this discusses food and soda as a possible source of aggravation, but does not offer a causation opinion with regard to the spitting incident. In fact, the medical record appears to treat the symptoms related to the spitting as being different in source then Petitioner's skin condition. (The record discusses the skin condition as "the other issue" in a manner that suggests it is unrelated to the spitting issue) (PX. 2). No eye issues were discussed on this date.

Petitioner testified that, as a result of having saliva in his eye, he can no longer wear contacts. Petitioner stated he saw an ophthalmologist, but that the ophthalmologist could not offer a diagnosis or causation opinion. The records for the ophthalmologist visit not included in the medical records, nor was a bill submitted for such a treatment date. Thus Petitioner's claim remains an unsubstantiated medical conclusion not offered by a medical expert and found only in Petitioner's testimony.

F. Is Petitioner's current condition of ill-being causally related to the injury and did he suffer any permanent partial disability as a result?

The record reflects that on April 22, 2013, Petitioner was not exposed to a blood born pathogen. Petitioner's blood-born pathogen test was negative as was that of the segregated inmate that splashed him. In fact, due to the inmate's segregation, and since the inmate had no blood borne pathogens, there was no possibility of Petitioner contracting a blood-borne pathogen from the incident in question. The Arbitrator finds that there is no causal connection between accident and exposure to any blood-borne pathogens.

The record reflects that Petitioner complained of skin irritation as a result of the April 22, 2013 Accident. The medical record reflects that Petitioner's complaints of skin irritation subsided after the first physician visit. Furthermore, Petitioner sought no further treatment for any skin conditions until after two weeks after the second incident on December 18, 2013. Since Petitioner went without complaint or treatment for almost eight months, the evidence in the record does not support a finding of causation between petitioner's complaints at trial of ongoing skin ailments and the accident of April 22, 2013. The Arbitrator finds causal connection between the April 22, 2013 accident and the temporary skin irritation the ended on the same day.

The record reflects that Petitioner complained of eye irritation as a result of the April 22, 2013 accident and continued to have complaints on April 23, 2013. Petitioners had no complaints of eye irritation on April 26, 2013 and the medical records submitted into evidence show that Petitioner did not have resumption of such complaints until after the second incident. Petitioner's testimony at trial did not indicate that any irritation, related to the April 22, 2013 accident, occurred after April 26, 2013. Accordingly, the Arbitrator finds causal connection between the April 22, 2013 accident and the temporary eye irritation that subsided on April 23, 2013.

At trial, Petitioner complained of various forms of stress and mental ailments related to not knowing whether he had contracted a blood-borne illness. The medical records show that Petitioner wanted to "see a psychiatrist to make sure that his mental status was satisfactory for working in the prison." (PX. 2). That same medical record notes no specific complaints of mental illness. The record contains no diagnosis, no prognosis, and no treatment recommendations outside of a psychiatrist referral. This is the only medical record in the file that touches upon Petitioner's mental health. Accordingly, the arbitrator finds no medical causation between Petitioner's allegations of mental ailments at trial and the accident in question.

The Arbitrator notes, that with regard to Petitioner's mental ailment allegations, Petitioner also alleged at trial that the psychiatrist referral was denied by workers' compensation. However, the medical and billing records submitted into evidence, and Petitioner's own testimony, suggest that Petitioner's decision not to seek psychiatric treatment was his alone. According to the record, Petitioner put all of his medical bills through group health. (PX. 3) When asked at trial, Petitioner explained that he told the treating facilities that his medical insurance was Health Alliance. Petitioner never explained to any facility that his injuries were workers' compensation in nature. Petitioner did this despite knowing that the time of treatment that this was a workers' compensation claim. At trial, Petitioner testified that he completed his workers' compensation packet and was aware that his claim had been accepted. Petitioner did not testify that he received a denial letter regarding psychiatric treatment. In either event, Petitioner had been putting all his treatment through group health and it is unclear why he did so. However, it is even more confusing as to why an alleged denial of psychiatric treatment under workers' compensation would preclude him from going about business as usual and putting his treatment through group health.

Moreover, Petitioner testified that he did not want to seek psychiatric treatment due to an alleged stigma that might be applied to him. The Arbitrator finds this testimony to lack credibility. The Petitioner filed two workers compensation claims alleging psychological injuries as a result of the two above referenced accidents. The claims are public records. The Petitioner knew or should have known that the claims would be investigated by the Respondent and that his co-workers might become aware of said claims.

The record reflects that Petitioner complained of migraines following the April 22, 2013 accident. Petitioner testified that he had a prior migraine history, and that stress increased the intensity and frequency of his migraines. The medical records show that Petitioner had a prior history of migraines and was prescribed medication to treat his condition at the time of the accident. On April 26, 2013, Petitioner was given a toradol injection for his headache. After April 26, 2013, Petitioner did not seek treatment for migraines until the second injury. The Arbitrator finds that Petitioner failed to meet his burden of proof with regards to causation because there is no medical opinion, or any other evidence, confirming a causal connection between Petitioner's migraines, which subsided on April 26, 2013, and the accident in question.

DECEMBER 5, 2013 ACCIDENT – CAUSAL CONNECTION

The record reflects that on December 5, 2013, Petitioner was not exposed to a blood-borne pathogen. Blood-borne pathogen testing was not recommended because there was no blood or any unknown bodily fluid which in turn placed Petitioner at a low risk of contracting a disease. (PX 1). The medical record reflects that Petitioner expressed understanding in response to this recommendation. (PX. 1). Petitioner testified that he was not exposed to blood. The medical records show that neither Petitioner nor the inmates were infected with such pathogens. Petitioner did not testify, or inform a medical professional of contact with any such fluids. As there are zero medical records to support Petitioners argument, the Arbitrator finds that there is no causal connection between accident and exposure to any blood-borne pathogens.

Petitioner testified that he suffered a skin condition as the result of being spit on. In support of his claim, petitioner offered no medical causation opinion. Petitioner's skin diagnosis is perioral dermatitis, which means skin condition around and near the mouth. The medical records related to this condition appear to discuss it as a condition that is wholly separate from the spitting incident with the only relation being that it started around the same time. No pathology tests were recommended because Petitioner was at low risk for contracting hepatitis or HIV. (PX. 1). Petitioner did not seek further treatment, despite the fact that he could have through his group health insurance. The Arbitrator finds that Petitioner failed to meet his burden of proof with regards to causation because there is no medical opinion, or any other evidence, in the record confirming a causal connection between Petitioner's skin condition and the accident in question.

At trial Petitioner testified that he could no longer wear contacts because some spit got into his eye. Petitioner testified that because some spit went into his eye, his eyes now itched whenever he would wear contacts. Petitioner's testimony is not support by medical opinion or evidence. Only the December 5, 2013 medical record discusses potential eye irritation related to the spitting incident, which states that Petitioner eyes "have not been irritated." The record is from the date of accident and states that Petitioner, contrary to his testimony, was wearing glasses and not contacts. During the December 5, 2013 visit, the doctor saw no redness and no signs of conjunctivitis. Petitioner alleged that he saw an ophthalmologist for his eye condition, but did not submit any records of such a visit. Furthermore, at trial Petitioner testified that the ophthalmologist could not determine the cause of his alleged eye condition. The Arbitrator finds that Petitioner failed to meet his burden of proof with regards to causation because there is no medical opinion, or any other evidence, confirming a causal connection between Petitioner's eye condition and the accident in question.

At trial Petitioner complained of various forms of stress and mental ailments related to the spitting incidents. The only medical record that discusses stress related to the December 5, 2013 incident is the December 18, 2013 treatment record. (PX.1). The record states that Petitioner took a "few days off because he ***was*** quite stressed mentally." (PX. 1) (***emphasis added***). The record uses the past-tense with regard to Petitioner's claimed stress and offers no diagnosis or treatment recommendations. The Arbitrator finds that Petitioner failed to meet his burden of proof with regards to causation because there is no medical opinion, or any other evidence, confirming a causal connection between Petitioner's stress and the accident in question.

J. Were 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 parties have stipulated, and the Arbitrator orders, that Respondent shall pay all reasonable and related outstanding medical bills, as set forth in Petitioner's Exhibit 3, pursuant to the Medical Fee Schedule set forth in Section 8(a) of the Illinois Workers' Compensation Act.

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

In light of the Arbitrator's findings of no causal connection to any ongoing conditions related to either of the Petitioner's accidents, the issue of permanent partial disability becomes moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lamoin Smith,
Petitioner,

15IWCC0100

vs. NO: 13 WC 14895

Dynegy Midwest Generation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of nature and extent of Petitioner's 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 23, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,200.00. 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: FEB 5 - 2015
KWL/vf
O-1/27/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0100

SMITH, LAMOIN Case# **13WC014895**
Employee/Petitioner

DYNEGY MIDWEST GENERATION
Employer/Respondent

On 6/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

0384 NELSON & NELSON
BOB NELSON
PO BOX Y
BELLEVILLE, IL 62222

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0100

Lamoin Smith
Employee/Petitioner

v.

Dynegy Midwest Generation
Employer/Respondent

Case # **13** WC **14895**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 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. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **01/10/13**, 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 $**79,040.00**; the average weekly wage was $**1,520.00**.

On the date of accident, Petitioner was **62** years of age, *married* 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. Respondent is entitled to a credit under Section 8(j) of the Act for all amounts paid for Petitioner's care and treatment but shall further pay pursuant to the Fee Schedule any other outstand amounts for the reasonable, necessary, and causally related medical treatment Petitioner received on account of this claim.

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

ORDER

- Respondent shall pay Petitioner **38** weeks of Permanent Partial Disability at the rate of **$712.55/week** as Petitioner has suffered permanent partial disability of **10%** loss of use of the right hand and **10%** loss of use of the left hand under §8(e)9 of the Act.

- Petitioner has failed to prove entitlement to Temporary Total Disability benefits as Petitioner voluntarily retired from active employment prior to undergoing surgery with Dr. Mirley for his carpal tunnel conditions.

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

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

Nancy Lindsay
Signature of Arbitrator

June 12, 2014
Date

JUN 23 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner worked for Respondent as a heavy equipment operator in Respondent's coal yard. This involved operating various bull dozers, tractors, scrapers, and sometimes working with railroad cars. Petitioner testified that he worked for Respondent for 15 years and prior to that worked in the coal mine industry. While working for Respondent, Petitioner claimed to have bilateral hand symptoms while operating the heavy equipment because it vibrated his hands.

Petitioner testified that he sought medical treatment with Dr. Mirly who had treated his wife in the past for thumb conditions. He began treating with Dr. Mirly on January 10, 2013. Dr. Mirly diagnosed Petitioner with bilateral carpal tunnel syndrome.

On March 27, 2013 Petitioner notified Respondent of his intent to voluntarily retire as of may 26, 2013. (RX 3)

Petitioner ultimately underwent a left carpal tunnel release on August 7, 2013 and a right carpal tunnel release on September 4, 2013. Treatment was uncomplicated according to the records of Dr. Mirly. As of September 12, 2013 Dr. Mirly noted continued progress and was quite pleased with Petitioner's results. He also noted Petitioner was a retired operator so a return to work date wasn't necessary; however, he anticipated a full release at six weeks. Petitioner was last seen on December 31, 2013 and was reportedly doing very well and his hands were no longer going numb. He was released from care and told to follow up on an as-needed basis. (PX 1)

At trial Petitioner stated that if he uses a push lawn mower for 30 minutes or drives for more than an hour his hands become painful. He denied any symptoms that awoke him from sleep but reported use of a device to assist with opening jars because of reduced grip strength. The use of sledgehammers and wire cutters caused him discomfort and he claimed to have swelling in his fingers if he walked long distances. Petitioner testified that his hands go numb and a little tingling when driving over sixty miles so his wife drives alot. He did admit that Dr. Mirly released him without restrictions and that he did have diabetes that he controlled with diet. Petitioner did acknowledge that he has not sought medical treatment since being released by Dr. Mirly.

Petitioner testified that he voluntarily retired from Respondent on May 25, 2013 having given written notification of his intent to do so on March 27, 2013. (RX 3) He acknowledged that he did not retire because of his hands. He is receiving social security and a pension in conjunction with his retirement. There was no reduction in his pension while he was recovering from his surgery.

The Arbitrator concludes:

Issue K. What temporary benefits are in dispute?

Respondent did not dispute Petitioner's period of temporary total disability only liability for the benefits.

Petitioner voluntarily retired from Respondent on May 25, 2013. Petitioner admitted he planned to retired at least as early as March 27, 2013. This is when he filed his Retirement Notification with Respondent to trigger his retirement pension. (RX 3) Petitioner voluntarily removed himself from the work force for reasons unrelated to his injury prior to undergoing his first surgery by Dr. Mirly on August 7, 2013. There was no evidence presented that Petitioner looked for alternate employment after leaving Respondent. At trial Petitioner made a claim for Temporary Total Disability benefits for dates of August 7, 2013 to October 23, 2013. The records of Dr. Mirly do not indicate that Petitioner was given any restrictions following surgery until Dr. Mirly commented on September 12, 2013, that Petitioner was retired and since he was filing for workers' compensation he would be expected to return to full duty in six weeks. (PX1) Petitioner testified at trial that he received uninterrupted Social Security and pension benefits during his period of recovery.

The Illinois Supreme Court has set forth the principle that "When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled *and whether the employee is capable of returning to the work force.*" Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 23 Ill.2d 132, 146, 923 N.E.2d 266, 274, (January 22, 2010)(emphasis added). In the case of Sharwarko v. Village of Oak Lawn, 07 W.C. 40637, 12 I.W.C.C.1050 (2012) the Commission specifically stated that when Petitioner voluntarily retired from Respondent the entitlement to Temporary Total Disability benefits ceased. 2012 WL 5857354, page 10. The matter at bar is nearly identical also to John T. Berry v. Olin Corp., 08 W.C. 12239, 12 I.W.C.C. 128, 2012 WL 991168 (2012) wherein Petitioner retired before undergoing surgery that resulted in temporary restrictions on his activities. The Commission affirmed the decision of the Arbitrator denying Temporary Total Disability benefits.

Based upon the forgoing, Petitioner has failed to prove entitlement to Temporary Total Disability benefits as he had removed himself from the work force by voluntarily retiring.

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

Petitioner suffered from bilateral carpal tunnel syndrome that was treated with surgical releases. The left hand surgery was performed on August 7, 2013 and the right release was performed on September 4, 2013.

Pursuant to Section 8.1b of the Act, the following criteria and factors must be considered in assessing permanent partial disability:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment

that include, but are not limited to: loss of range of motion, loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

The Act provides that no single enumerated factor shall be the sole determinant of disability. With respect to these factors, the Arbitrator notes:

1. The reported level of impairment under the AMA Guides. No evidence was presented by either party.

2. The occupation of the injured employee. At the time of trial, Petitioner was retired. Prior to this he was a heavy equipment operator, but since voluntarily retiring there was no evidence presented of subsequent employment since voluntarily retiring.

3. The age of the employee at the time of the injury. At the time of his accident, Petitioner was 62 years old. No evidence was presented as to how Petitioner's age might affect his disability.

4. The employee's future earning capacity. Petitioner testified that he is retired and is receiving his employee pension and retirement Social Security benefits.

5. Evidence of disability corroborated by the treating medical records. Although Petitioner made complaints of ongoing symptoms at trial, this was not consistent with Dr. Mirly's records. The last notes of Dr. Mirly from December 31, 2013 show "he is doing very well," and that "he reports that his hands no longer go numb." There is no mention of reduced grip strength, pain, or any type of swelling in the hands or fingers. Petitioner stated at trial that his fingers swell if he walks long distances. He also reported reduced grip strength when opening jars and discomfort with the use of wire cutters or sledgehammers.

After considering all of these factors, the Arbitrator concludes that Petitioner has sustained permanent partial disability of 10% loss of use of the left hand and 10% loss of use of the right hand ((190 weeks x 10%) x 2 = 38 weeks)[1].

---

[1] For carpal tunnel repetitive trauma accidents after 6/28/11 disability is to be based upon 190 weeks.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James O'Hara,
Petitioner,

vs.

15IWCC0101

NO: 10 WC 17902

State of Illinois, Tamms Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent partial disability, admissibility of PX 20 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 5, 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.

DATED: FEB 5 - 2015
KWL/vf
O-1/27/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0101

O'HARA, JAMES Case# **10WC017902**
Employee/Petitioner

ST OF IL TAMMS CORRECTIONAL CENTER
Employer/Respondent

On 8/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 5 2014

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0101

James O'Hara
Employee/Petitioner

v.

State of Illinois, Tamms Correctional Center,
Employer/Respondent

Case # 10 WC 17902

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **June 4, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] 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 **Admissibility of PX 20**

15IWCC0101

FINDINGS

On **April 13, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

On the date of accident, Petitioner was **47** years of age, ***single*** with **3** children under 18.

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

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

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

Respondent is entitled to a credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove he sustained an accident on April 13, 2010 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his neck, right shoulder, and bilateral arms, elbows, hands, and/or wrists is causally connected to his alleged injury. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

[signature]
Signature of Arbitrator

August 1, 2014
Date

AUG - 5 2014

James O'Hara v. Tamm's Correctional Center, 10 WC 17902

Petitioner alleges repetitive trauma injuries to his neck, right shoulder, and bilateral hands, wrists, and arms. (AX 2) He alleges an accident/manifestation date of April 13, 2010. At the commencement of the hearing on June 4, 2014, the parties reviewed one another's exhibits with Respondent objecting to the admissibility of Petitioner's Exhibit 20, the deposition of Zachary Weiss dated March 15, 2013 and taken in a completely different case. The issue of its admissibility was taken with the case. Thus, the disputed issues are: accident; notice; causal connection; medical expenses; the nature and extent of Petitioner's injury; and the admissibility of PX 20.

Additionally, proofs were re-opened by agreement of the parties on June 25, 2014 for the sole purpose of agreeing to the admissibility and admission of PX 21 into evidence. (See AX 5)

Arbitrator's Findings of Fact and Conclusions of Law

The Arbitrator finds:

There is no dispute that Petitioner injured his right shoulder prior to April 13, 2010 when he was involved in a work-related accident on November 12, 2008. Medical records show that Petitioner presented to Dr. Mark Smith on November 17, 2008 due to an injury occurring on November 12, 2008 when he was at work at Respondent's facility and got caught in an electric sliding door, injuring his right shoulder. Initially Petitioner thought he was okay but he was experiencing pain the next day. He had missed work for two days and been off since then on vacation time. Petitioner denied any complaints of numbness. Petitioner was diagnosed with right shoulder tendonitis/contusion and given work restrictions. (PX 13)

Petitioner followed up with Dr. Smith on November 24, 2008 and reported he was improving although his shoulder was still sore. He was not given any work restrictions. (PX 13)

According to Commission records, on March 25, 2009 Petitioner filed his Application for Adjustment of Claim in case #09 WC 13185 alleging an accident date of November 12, 2008.

According to Petitioner's timesheets (RX 7) Petitioner began a leave of absence with Respondent around May 17, 2009.

Petitioner's claim in case # 09 WC 13185 proceeded to arbitration on July 16, 2009.[1] In his Decision dated July 28, 2009 the Arbitrator found that Petitioner sustained an accident on November 12, 2008 that arose out of and in the course of Petitioner's employment with Respondent. Summarily, the Arbitrator found that Petitioner was struck in the right shoulder when an electric door closed on his shoulder. Petitioner missed a couple of days from work but, when examined by his family doctor, he was noted to still be off work on vacation time. Dr. Smith believed Petitioner had suffered a contusion to his right shoulder resulting in tendinitis. Petitioner testified to no further treatment thereafter but noted difficulty lying on his right shoulder while trying to sleep for very long. He also testified that his shoulder contusion had impaired his ability to perform painting and drywall work that he did in addition to his

[1] The decision (RX 8) references a hearing on "7/16/08;" however, this has to be a typographical error as that would mean the case went to trial before the alleged accident even occurred. The Arbitrator's Decision issued on July 28, 2009.

correctional job duties. Petitioner was using over the counter medication for pain relief. Petitioner was awarded his medical bills but no permanent partial disability. (RX 8) The decision was not reviewed.

According to medical records Petitioner was referred for physical therapy in November of 2009 per Dr. Mark L. Smith due to a cervical strain. (PX 3)

Petitioner's leave of absence which began earlier in May of 2009 ended in early December of 2009. (RX 7)

In early March of 2010 Petitioner took began a leave of absence from Respondent stemming from a non-work-related foot injury. He would remain on that leave of absence through December of 2010. (RX 7)

On March 11, 2010 Petitioner was again examined by his primary care physician, Dr. Smith. Petitioner was complaining of fatigue, chills, shortness of breath, hiccups and heartburn. The doctor noted a complaint of neck pain and that Petitioner was scheduled to see Dr. Jones on March 18, 2010[2]. Petitioner's neck pain was accompanied by numbness radiating down his right arm and tingling. Petitioner reported "sensations in arm unable to let anyone touch." Dr. Smith further noted, "last night about 1 a.m. [he] got weird pain in rt shoulder like electric shock. numbness and pain equal, then would subside and then come back, pressure chest with sob." Petitioner's social history was summarized, with his occupation as a correctional officer for Respondent being noted. Petitioner displayed full range of motion of his spine and extremities. He was diagnosed with GERD and spinal stenosis. Petitioner underwent an EKG. (PX 3)

Per the order of Dr. Jones, Petitioner underwent a nerve conduction study on April 13, 2010 at SI Neurology & Sleep Medicine, LLC. Petitioner's history noted he had neck pain traveling down his arms and hands with numbness and tingling involving both hands and fingers. Petitioner reported that an x-ray of his cervical spine had shown moderate degenerative disc disease at C5-6 and C6-7[3]. (PX 4) Petitioner's electrodiagnostic study was consistent with moderately severe bilateral carpal tunnel syndrome and mild to moderate bilateral ulnar neuropathy at the elbows. There was no evidence of cervical radiculopathy; however, Dr. Alam recommended an MRI of the cervical spine due to a "strong clinical suspicion for additional diagnosis of cervical radiculopathy." (PX 4)

Petitioner signed his Application for Adjustment of Claim in this case on May 4, 2010 alleging injuries to his neck, right shoulder, right elbow, and bilateral wrists due to repetitive trauma which manifested themselves on April 13, 2010. (AX 2)

Petitioner was then examined by Dr. Jon Taveau at Trinity Neuroscience Institute on May 10, 2010 after having undergone emg/ncv studies. Petitioner was complaining of neck, shoulder, and bilateral upper extremity pain, numbness, and tingling. He denied any weakness. Dr. Taveau noted that activity seemed to worsen Petitioner's symptoms. Petitioner reported no change in his writing nor was he dropping items. Petitioner's job as a corrections officer was noted. Tinel's signs and Phalen's signs were negative. Petitioner had no evidence of atrophy of his hands. Dr. Taveau noted a cervical MRI showed degenerative disc disease at C4-5, 5-6, and 6-7 which was most significant at C5-6. He also noted the EMG revealed no radiculopathy but moderate to severe bilateral carpal tunnel syndrome. The doctor did not feel surgery was necessary at that time but referred Petitioner to pain management for cervical

---

[2] No such office visit/note is found in the record.
[3] Not in the record.

epidural steroid injections. Petitioner was given a script for neutral position splints and told to take ibuprofen. Petitioner was also advised he need not return unless he felt he needed to. (PX 5)[4]

Dr. Gornet examined Petitioner on May 14, 2010, primarily in conjunction with Petitioner's complaints of neck pain to his right shoulder and numbness and tingling into both arms and hands (moreso on the right than the left). As part of the examination Petitioner completed a Medical Information sheet in which he indicated the doctor would be seeing him for a work-related injury (no details provided) which resulted in neck pain. Petitioner claimed he was currently disabled, his disability having begun on May 14, 2009. Petitioner also completed a pain drawing in which he marked neck pain, right shoulder pain, right arm and hand complaints and left finger complaints. (PX 6, pp. 4, 5)

According to the doctor's note of the same date, "He states his original problem began in what he feels is late 2008. He was at work in [Respondent's] facility and apparently he was struck by a door." Thereafter Petitioner sought medical attention for his shoulder and neck and lived with it over time but he felt his symptoms slowly became worse. "He attributes this to numerous repetitive tasks including moving large doors, operating different appliances and equipment." Dr. Gornet noted that Petitioner had brought a written job description with him to the appointment. The doctor continued:

> At this point he states his symptoms then became worse in 2009. He said he was off for a non related work issue for his foot. Apparently he went back to work light duty. He was placed in a control room. His job there involves significant reaching, changing positions. Often the seats are not at appropriate height or length and he was required to turn and rotate his head to see the different control panels. He states at that point his symptoms in his shoulder which had never gone away became more severe and he noticed increasing tingling in his arms and hands. He eventually was referred to a Dr. Smith in December and he continued to have constant pain and symptoms. (PX 6)

Dr. Gornet reviewed Dr. Alam's nerve conduction studies which Petitioner had also brought with him. He noted Petitioner denied any significant left arm pain but he did have left arm numbness and weakness. Petitioner reported he had worked fifteen years for Respondent. Cervical spine x-rays were taken in the doctor's office and showed some loss of disc height at C5-6 and to a lesser extent C6-7, foraminal stenosis at C4-5 on the left and C4-5, 5-6 and 6-7 on the right. His MRI from February 1, 2010 revealed disc osteophytes, foraminal stenosis, and central disc protrusion at C5-6 and, to a lesser extent, at C6-7 and "what appear to be more significant on the right side with foraminal stenosis and what may be a foraminal disc herniation [at] C5-6." (PX 6, p. 2)

---

[4] It appears that Dr. Jones and Dr. Taveau work together. Dr. Taveau wrote a letter to Dr. Smith regarding the visit.

Dr. Gornet advised Petitioner that he might have several problems including peripheral nerve entrapment, cervical radiculopathy, and possibly a shoulder injury for which he referred him to Dr. Milne. He also recommended cervical spine injections for which he referred Petitioner to Dr. Granberg. Finally, he ordered physical therapy. A CT myelogram was to be done in six to seven weeks. Dr. Gornet concluded, "He understands, based on the history provided to me, I do believe his current symptoms are causally connected to not only his work related injury of 2008 when he was struck by a door but also the change in work activities and the repetitive nature which seems to have increased his symptoms in 2009." Dr. Gornet felt Petitioner could work in a light duty capacity (light duty, no lifting greater than 10 pounds, and no overhead work). (PX 6, pp. 2,3)

Petitioner underwent his initial evaluation with Nova Care Rehabilitation on May 19, 2010. Petitioner reported he first started noticing his neck symptoms in the end of December of 2009. At that time he was going back to work and was put on light duty which primarily consisted of sitting with frequent reaching and head turning. Petitioner was then taken off work in March due to residual ankle problems. Since the initial onset of pain Petitioner reported it has gradually worsened. Petitioner reported that he was initially seen by a local neurologist who diagnosed him with bilateral carpal tunnel syndrome and cubital tunnel syndrome but he was told his neck was fine. "He states that after this he came in contact with an attorney, to get help claiming a work related injury." He was then sent to a neurologist who diagnosed him with neck pain, underwent an MRI and was told he had degenerative disc disease, stenosis, and bulging discs that "pushed on his spinal cord." According to NovaCare notes, the evaluator was unable to find objective findings that would correlate with Petitioner's subjective complaints at this time. Petitioner was noted to be inconsistent with accessory testing of vertebral segmental and neurological components. Four weeks of therapy was recommended. (PX 7)

On May 25, 2010 Petitioner was seen at Millennium Pain Management (Dr. Grandberg) as recommended by Dr. Gornet. According to the history, "[Petitioner] was struck by a door at Tams Correctional Facility in 2008. He treated this conservatively over time until this year when his symptoms have become much worse." Petitioner described posterior right-sided neck pain with radiation in to his shoulder blades, as well as his right shoulder with occasional radiating down his right arm. Therapy and medication were reportedly of "only minimal benefit." Petitioner was given a cervical epidural steroid injection at C5-6. (PX 8)

Petitioner's physical therapy visits at Nova Care are found in PX 7. Of note, on May 28, 2010 the evaluator noted, "Petitioner reports he has become a believer of the recent injection therapy he received; he states pain is at 1/10 max and he is able to rotate and hold his hand in that position for a prolonged time without c/o discomfort. (PX 7, p. 10)

On June 7, 2010, and upon referral of his attorney, Petitioner was examined by Dr. David Brown, who is affiliated with The Orthopedic Center of St. Louis. Petitioner was there for an upper extremity evaluation. According to a "New Patient Questionnaire" Petitioner was seeing the doctor for a work-related injury and had filed a "work comp claim" for the problem. Petitioner also acknowledged having a work comp claim before noting he took two days off work after being smashed in a sliding door at work (right shoulder injury). Petitioner added "not like this." Petitioner also provided a "Job Description List" indicating, "lot of the locks and service posts doors are hard to operate; unlocking and locking cell doors and services posts (frequently); lots of writing (log entries); applying and removeing [sic] restraints; collecting and distributing heavy laundry bags; pulling and pushing them thru service ports; distributing and collecting food trays; combining hot and cold food trays, placing them in portable tray carriers approximately 30 lbs; sweeping, mopping, cleaning; a lot of logging and writing and doing paperwork;

dragging 50 to 60 lb. mail bags; sorting mail and passing out mail; escorting sometimes combative inmates; excessive stair climbing, walking and bending; due to design of cell house control room panels you are forced to turn your head in order to observe inmates entering or exiting their cells, either escorted or unescorted; control panel rocker switches require moderate pressure with your finger in order to operate them and must be depressed constantly while opening or closeing [sic] cell doors, etc.; inspecting weapons, unloading and loading bullets from magazines; in core control constantly reaching and turning your head watching monitors, always in a awkward position; and chairs are of poor quality for this job ." (PX 9)

At the time of their visit on June 7th, Petitioner explained to the doctor that he worked for Respondent, having begun in 1995. Petitioner reportedly worked eight hours a day, forty hours a week applying and removing restraints on prisoners, locking and unlocking cell doors and sliding cell doors repeatedly throughout the day. Petitioner reported that he first developed problems with his upper extremities in early 2009 when he developed numbness and tingling in both his hands, worse on the right than the left and some lateral elbow pain. Petitioner advised the doctor he had undergone several steroid injections in both elbows with only temporary relief and that nerve conduction studies performed on April 3, 2010 revealed moderate to severe bilateral carpal tunnel syndrome and mild to moderate bilateral cubital tunnel syndrome. A physical examination followed and Dr. Brown's assessment was bilateral carpal tunnel syndrome for which he recommended bilateral splints to be worn at night (both wrists and elbows) Petitioner's history of lateral epicondylitis was noted but it appeared minimally symptomatic on that date. Dr. Brown felt Petitioner could work with no restrictions. "Based upon [Petitioner's] description of his job as a correctional officer, combined with [his] own understanding of that job, combined with his lack of medical problems that would put him at risk for these conditions, " Dr. Brown was of the opinion that Petitioner's work as a correctional officer would be considered, in part, a contributing and/or aggravating factor in the development of these conditions. Petitioner was advised to return in six weeks. (PX 9)

Petitioner returned to see Dr. Grandberg on June 8, 2010 reporting "significant improvement" and "partial relief" with the first injection and he wished to proceed with a second one which was performed. Petitioner was instructed to return in one to three weeks. (PX 8)

Petitioner reported for physical therapy on June 9, 2010 reported that he could not tell if the second injection from the day before was really helping. Petitioner also questioned the script for therapy believing it was for pain, not strengthening. Petitioner did not feel his neck needed strength. He asked about Ultrasound and IFC as possible treatments and the therapist was going to consult accordingly. Petitioner declined to perform certain activities because it "kills his shoulder/arm and he would rather wait until his MRI 6/17/10." (PX 7)

At therapy on June 15, 2010 Petitioner reported his girlfriend was doing most of his chores because he was currently "too crippled." Petitioner was noted to be able to drive himself by truck or motorcycle to and from his appointments. He also reported that with his current limitations and restrictions he was unable to work. Petitioner reported he had "all kinds of restrictions" from his doctors and felt that he should not be doing much of anything in therapy with his upper extremity due to his current disability and outcome of surgery is affected by overhead reaching, lifting activities, etc. Petitioner further reported that he knew he would be undergoing some major surgery for his hands, wrists, elbow, and shoulder. However, the evaluator noted Petitioner had no documentation to that effect and admitted no surgery had yet been recommended. Despite explanation from the therapist as to the importance of therapy, Petitioner "flatout refuses to participate in said activities." (PX 7)

At the June 15, 2010 therapy appointment the evaluator noted Petitioner did not seem to be engaging in symptom magnification; however, he was self limiting his activity and no objective findings or observations correlated with his level of self disability. At his visit on the 16th Petitioner reported his neck was hurting more than usual and he was trying a variety of things to help with the pain, including rubbing, a heat pad, and his sister's TENS unit. Petitioner also noted that his foot doctor had given him a new anti-inflammatory medication that he had just ran out of and, perhaps, that was contributing to his pain. Petitioner again reiterated that he was only there for pain management on his neck and "not a tri athlete muscle building program." Petitioner reported pulling straight back on his lawn mower string hurt his shoulder a bit and while he could ride his Harley he would experience some numbness in doing so. (PX 7)

Dr. Gornet re-examined Petitioner on June 17, 2010 after Petitioner had been examined by Dr. Milne regarding his shoulder. Dr. Gornet's notes indicate that Dr. Milne felt Petitioner had some shoulder pathology that would require surgery. Additionally, Petitioner's CT myelogram revealed fairly significant foraminal stenosis at C6-7 on the right which correlates with his right-sided neck pain and shoulder pain. Dr. Gornet also felt Petitioner had disc pathology at C6-7 and C5-6 with some mild pathology at C3-4 but he didn't feel that was the main source of Petitioner's current pain and symptoms. Dr. Gornet recommended surgery at C5-6 and C6-7 with disc replacements and a right-sided foraminotomy at C6-7. Noting Petitioner had failed injections and physical therapy Petitioner was told to continue working light duty and return when he desired to move forward with surgery. (PX 6, p. 7; PX 10)

Petitioner canceled therapy on June 18, 2010 citing his myelogram of the day before. (PX 7)

At his June 21, 2010 physical therapy visit Petitioner reported increased pain on the left side of his neck the day before. He also reported increased discomfort with rotation and turning. Petitioner stated his doctor wants him to undergo shoulder surgery and then neck surgery. (PX 7)

At the June 23, 2010 therapy visit Petitioner also expressed reluctance to fully participate as nothing was helping with his pain, the exercises "kill his shoulder" and he realized he was not going to get any relief until they get those discs off his spinal cord." (PX 7)

According to the June 25, 2010 physical therapy report Petitioner was washing his motorcycle earlier in the day and it increased his neck pain to 3/10. He also reported his right arm "feels dead." (PX 7)

On June 27, 2010 Petitioner completed a Workers' Compensation Employee's Notice of Injury form (RX 2). Petitioner claimed a repetitive trauma injury to his "wrists, elbows, shoulders, and neck" which occurred on April 13, 2010. Petitioner stated that he did not report it earlier because he was off work for an unrelated injury to his foot/ankle. Petitioner more specifically indicated that he was engaged in the following duties at the time of his injury: "keying chuckholes - applying and removing repetative [sic] tasks/ laundry - mail, pressing buttons, etc." He also mentioned that his right shoulder was "crushed in cellhouse using slider in late 2008, injuring right shoulder - documented." (RX 2) Petitioner's supervisor completed a Report of Injury or Illness on July 22, 2010. He had no details of any accident. He further represented that the alleged accident was not reported to him. (RX 3)

At his June 29, 2010 therapy visit Petitioner reported feeling a little better that week having recently received a cortisone shot in his left heel. Petitioner participated in therapy on June 30, 2010. He cancelled his appointment on July 2, 2010 citing a family conflict. He canceled again on July 6, 2010

citing "other plans." When he presented on July 8, 2010 he was stiff and sore but tolerated the treatment with mild complaints of pain. (PX 7)

According to Commission records, Petitioner filed a Petition Pursuant to Section 19(h) and Section 8(a) in case #09 WC 013185 (the 11/12/08 case) on June 29, 2010.

Petitioner was re-examined by Dr. Brown on July 12, 2010 with Petitioner reporting no improvement in his hand and elbow symptoms (bilaterally) and reporting upcoming surgery for his shoulder followed by neck surgery. On examination Petitioner displayed good active range of motion of both extremities with some tenderness over the elbows and discomfort with resisted wrist extension bilaterally. Petitioner had negative Tinel's over the ulnar nerves at the elbows bilaterally. Elbow flexion test was negative bilaterally. Phalen's test was negative bilaterally. Petitioner did have a positive Tinel's and direct compression test over both carpal tunnels. Petitioner had good sensation and perfusion in the digits of both hands. Petitioner's diagnoses remained unchanged. The doctor recommended continued conservative treatment and still felt Petitioner could work full duty. (PX 9)

On July 19, 2010 the Illinois Department of Corrections, vis a vis, Betty Holder (Respondent's workers' compensation coordinator) the issued a "Memorandum" to Petitioner advising him his claim for workers' compensation had been approved. A copy of a Request for TTD benefits was enclosed with the Memorandum. (PX 25)

On July 22, 2010 Petitioner filed an Amended Application for Adjustment of Claim in this case alleging additional injuries to his right and left arms as a result of his repetitive trauma. (AX 2)

Petitioner's same complaints and progress (as noted in June and early July) were noted in the physical therapy record of August 16, 2010. (PX 7)

Petitioner was discharged from physical therapy on August 16, 2010. Petitioner's progress was described as "fair." Petitioner was able to perform frequent overhead lifting two handed with 15 lbs. He could move his head in all planes with pain reported at less than 1/10 for normal activities of daily living. He could hold, lift, and carry forty pounds with two hands. Petitioner declined to engage in muscle testing/grip/pinching. It was noted Petitioner was scheduled for shoulder surgery on July 19, 2010. (PX 7)

At the request of Genex Petitioner underwent an examination with Dr. Richard Johnston on September 11, 2010. Dr. Johnston issued a written report after the examination was concluded. In it he referenced Petitioner's "recent history of multiple orthopedic problems" but noted his examination was limited to Petitioner's right shoulder. In conjunction with the examination Dr. Johnston reviewed records from Drs. Milne and Brown as well as Dr. Alam. Petitioner told the doctor that he worked as a corrections officer. A "work description" was available for review. Petitioner stated his job involved activities including reaching and lifting as well as opening heavy doors and throwing heavy laundry bags to an overhead level. According to a "demands of the job statement" less than three times a month Petitioner was required to lift 31-40 pounds once a day, reaching above shoulder level was required less than 3 times per week, lifting more than 41 pounds was never required and lifting 1 - 10 pounds was required two times a day but fewer than three times a week. Petitioner related that he initially injured the "left shoulder" while at work in the latter part of 2008 when he was standing in the track of a heavy electronically controlled door made of one inch thick glass. He was having a disagreement with a co-worker who was controlling the door and the co-worker subsequently closed the door on him hitting

him directly on the posterior lateral aspect of the "right shoulder." Petitioner stated he immediately experienced the onset of pain and took two days off. His primary care physician did not order any x-rays or other diagnostic studies at that time. Dr. Johnston had no treatment records from that injury. (RX11 and RX 12, Def.X. 2)

According to Dr. Johnston's report Petitioner told him that since that injury he had continued to have pain in his right shoulder that was exacerbated by activities such as reaching or lifting overhead or throwing heavy objects overhead. He denied any avocational activities or activities outside of work which would have caused or exacerbated his shoulder problems. Despite his ongoing pain he sought no additional treatment until the spring of 2010. Petitioner also reported that he had no further injury but sought treatment in the spring of 2010 for problems in his neck, shoulder and hands and this led to the treatment with Drs. Brown, Milne, and Gornet. (RX 12, Def. X. 2, pp. 1-2/4)

Dr. Johnston reviewed the records of those physicians noting that when Petitioner was examined by Dr. Milne in early June of 2010 Petitioner's complaints included constant shoulder pain in the superior posterior aspect and a grinding sensation/gravel sound in his shoulder. At the time of that exam Petitioner had been off work since March of 2010 for a left foot injury. Petitioner's shoulder x-ray revealed a type III acromion and mild acromioclavicular joint arthrosis. Dr. Milne believed Petitioner had right shoulder impingement with a possible rotator cuff or labral tear and right shoulder acromioclavicular joint injury. An MRI was ordered and performed on June 17, 2010 showing supraspinatous tendinopathy greatest in the anterior insertional fibers, mild infraspinatus tendinopathy and mild to moderate acromioclavicular osteoarthritis with mild lateral downsloping of the acromion. No labral tear was noted. There was mild edema in the anterior aspect of the greater tuberosity without a fracture line. Dr. Milne recommended surgery which was performed on July 19, 2010 during which the doctor found evidence of a 2 cm. full thickness rotator cuff tear which required repair and, additionally, an arthroscopic subacromial decompression and distal clavicle resection. Petitioner was subsequently referred for physical therapy which Petitioner was undergoing at the time of the examination with Dr. Johnston. (RX 12, Def. X 2, p. 2/4)

Petitioner's complaints at the time of the examination included pain and stiffness associated with the surgery. On exam he displayed tenderness over the posterior lateral aspect of his right shoulder and at the acromioclavicular interval. Dr. Johnston limited his exam due to the post-operative condition of Petitioner's right shoulder. Dr. Johnston did not feel Petitioner was yet at maximum medical improvement with regard to his shoulder. Dr. Johnston could not correlate Petitioner's work activities "as documented in his job description" with any repetitive use trauma that could cause significant shoulder problems. He noted the low-level of overhead use of the arm was well within the normal capacity of the shoulder. Petitioner's stated injury of 2008 did not appear documented in the records reviewed by the doctor and the interval of two years between the stated injury and Petitioner's initiation of further treatment indicates that any correlation between the rotator cuff pathology noted in 2010 and the injury in 2008 is questionable. In Dr. Johnston's opinion Petitioner had independent non-work-related risk factors for rotator cuff pathology as he had a type III acromion and is a smoker and smokes one pack per day. Dr. Johnston did not believe Petitioner's surgical findings correlated with the MRI images he reviewed. He requested images from the surgery to compare. Finally, he believed Petitioner could have continued working from April 13, 2010 onward based upon his job description and presenting complaints. At the present time, however, Petitioner would need limited duty (ie. only engaging in paperwork with his right arm). (RX 12, Dep. X 2, p. 3/4)

Dr. Matthew Gornet was deposed on October 25, 2010. (PX 21) Dr. Gornet, a board certified orthopedic spine surgeon, testified consistent with his medical records. Dr. Gornet further testified that Petitioner may require cervical spine surgery but, unlike other procedures, it is a little more invasive and given Petitioner's other medical issues (shoulder and hands/wrists/elbows) they should be attended to first. At the time of his deposition he had last seen Petitioner on June 17, 2010. Petitioner's condition remained the same and Dr. Gornet believe Petitioner's current condition was caused by both the 2008 accident and his repetitive work activities as he believed Petitioner aggravated or developed a new cervical spine process at the time the door struck him in 2008 and that really caused his shoulder pain and then the activities he described aggravated that condition along with the other issues Petitioner was dealing with and, therefore, it was a contributing factor. Dr. Gornet acknowledged that he has never restricted Petitioner from working. (PX 21, pp. 1 - 12, 13-14)

Dr. Gornet further testified that assuming Petitioner recovered nicely from the shoulder surgery recommended by Dr. Milne he would want to see him again and see how his symptoms were doing. Options might include restricted duty, surgery, or nothing -- it would all depend upon Petitioner's symptoms. (PX 21, p. 12)

On cross-examination Dr. Gornet acknowledged that his causation opinion was based upon the history provided to him by Petitioner as well as his review of pertinent studies supporting shoulder pain as a direct result of a cervical process. Dr. Gornet also admitted he was unaware that Petitioner's 2008 work injury had already been tried. When asked if he would be surprised to find out that the Arbitrator's Decision in that case never mentioned any neck injury or treatment, he replied "Not necessarily." (PX 21, p. 15) He then explained that shoulder problems are often hidden with two potential causes and the fact that Petitioner has significant foraminal stenosis which would have been there in 2008 would support two etiologies. (PX 21, p. 16) When further advised that the Arbitrator awarded zero permanency in the shoulder case, Dr. Gornet interpreted that to suggest Petitioner was experiencing neck problems at that time. Additionally, if Petitioner did have foraminal stenosis in 2008 (as the doctor "guaranteed" he did) sedentary activities such as reaching pulling and those types of thing would further aggravate it. (PX 21, p. 17) Dr. Gornet explained that he is aware of situations where, as here, a patient suffers blunt trauma (being hit by a door) in the upper back and not necessarily the neck but the trauma applies such a sudden force that one's neck moves. "Just like in a motor vehicle accident, you're not struck in your neck, but we all know that those cause neck injuries." (PX 21, p. 19) It starts the process off and then the repetitive activities play a role, too. (PX 21, p. 19)

On further cross-examination Dr. Gornet acknowledged that he was aware that Petitioner had a non-work-related foot problem but he could not recall if Petitioner had said it resulted from a motorcycle accident. He then testified that "clearly" a motorcycle accident could be a contributing factor for aggravating Petitioner's condition but he didn't know if it would change his opinion because he possessed information telling him Petitioner was symptomatic before and after the accident. (PX 21, p. 18)

Dr. Brown re-examined Petitioner on November 9, 2010 at which time Petitioner reported he had nearly recovered from his shoulder surgery but was still experiencing numbness and tingling in his hands. Petitioner's examination was consistent with his ongoing diagnoses of bilateral carpal and cubital tunnel syndromes. Having failed conservative treatment, Dr. Brown recommended surgery. Pending surgery Petitioner could continue working full duty. (PX 9)

Petitioner underwent right carpal and cubital tunnel releases on December 16, 2010. (PX 9) In conjunction with the surgery Dr. Brown took Petitioner off work. (PX 9; PX 11)

A Job Site Analysis Report for a corrections officer was conducted at Respondent's facility on December 20, 2010[5]. (RX 9)

Throughout the foregoing period of time Petitioner was on a medical leave of absence. (RX 7)

Post-operatively Petitioner underwent physical therapy at Joyner Therapy Services. (PX 12)

As of January 4, 2011 Dr. Brown noted Petitioner had been undergoing therapy and there was some concern about some redness for which he had been on Bactrim since December 29, 2010. Petitioner reported the numbness in his hand prior to surgery was gone. Petitioner was released to return to work with no use of the right upper extremity and no inmate contact. (PX 9) As of January 11, 2011 he was continuing to heal with improved hand numbness. Dr. Brown described Petitioner as doing well overall. He was allowed to return to work in a primarily one-handed capacity with the right arm being allowed to assist with light tasks. (PX 9)

Dr. Brown re-examined Petitioner on February 16, 2011 noting Petitioner was continuing to do very well post-operatively. He still had some soreness over the scar in his palm and the doctor recommended two more weeks of supervised therapy. Petitioner still had evidence of persistent, chronic left cubital and carpal tunnel syndrome but Petitioner advised that the surgeries, while once approved, were now "on hold." Petitioner was released to return to work with a ten pound lifting limit on his right arm and no imate contact. He was given a full duty release effective February 28, 2011. (PX 9)

The deposition of Melanie Welch, taken on September 9, 2011, in the case of "Bobbi Crespi v. State of Illinois, Department of Corrections," was admitted into evidence. Ms. Welch testified that she is employed by CorVel Corporation, a national corporation which provides services to employers, third party administrators, insurance companies, and government agencies. Ms. Welch testified that she has never performed a job site analysis for an injured worker.

Ms. Welch testified that she toured Respondent's facility for approximately three hours and took approximately ten (10) minutes of video. She testified that she was restricted from filming actual correctional officers performing their regular duties; rather, she and those with her were met by Major Markel and taken to an area of Respondent's facility that was vacant and shot video in an empty cell with job duties of a correctional officer being demonstrated. No actual video of a corrections officer performing his duties was taken.

Ms. Welch acknowledged that her report and the video she took contained no information regarding mail delivery or the weight of the delivery bags, nursing rounds or the administration of bandages or wraps. She testified that she was unaware of what a security inspection entailed and that she did not witness how an inmate was required to be secured for movement. Ms. Welch acknowledged that the procedure was simulated by two Correctional Officers; however, it was not referenced anywhere in her report. She similarly did not know often shakedowns were performed nor did she have any information as to which movements were conducted on different shifts, or how many movements were required to secure and move an inmate.

---

[5] RX 9 references photographs being attached but they were not.

Ms. Welch testified that she did not know much keying or cuffing and uncuffing was done each day and no estimate was included in her report. Although she knew that sweeping and mopping was done by the Correctional Officers, she did not know who emptied the trash receptacles, washed the windows, cleaned the showers, toilets, ice machines, stainless steel, furniture and ducts, and stocked the janitorial closets. She testified that she did not know the Area Cleaning Cycle sheet stated, "Area will be inspected and officers will be held accountable for ensuring areas are clean and orderly." Counsel for Petitioner questioned Ms. Welch extensively regarding data not included in her analysis. She ultimately conceded that her analysis omitted a tremendous amount of data.

Ms. Welch was specifically questioned regarding the effort involved in inmate feed duties. The following exchange took place:

Q: Okay. I'm going to now read you some descriptions that I have from some of my other clients. Do you know if -- and if you don't know, Miss Welch, it's okay. I sort of don't expect you to know, but at least I figured I'd ask to try and lay some foundation. Do you know if a gentleman named Rollin, R-O-L-L-I-N, Raugust, R-A-U-G-U-S-T, works there?

A: I don't know.

Q: Do you know how many food trays are carried up steps at one time?

A: We do have a picture of a cart type thing that they carry with a handle on the top, and I thought they said five at a time.

Q: Very good. Do you know how much they weigh?

A: We had just what the empty tray. They didn't have full food on them when we were there. We did get a weight I believe of just the tray.

Q: Okay. When you open a chuckhole, do you have to turn the key clockwise?

A: I don't remember.

Q: Do you pull down the chuckhole at the same time?

A: It's in the video how they turn it and when the door is pulled. I really don't remember.

Q: Are the chuckhole doors heavy?

A: I don't know.

Q: Do they pull down easily?

A: It appeared to.

Q: Do all the chuckholes turn easily?

A: I don't know.

Q: When these gentlemen are keying the inmates, do they open, that is, key open the chuckhole, pull down the door with one hand and hold the loaded

food tray with the other and then attempt to slide the food tray through the chuckhole while still holding down the chuckhole and keying it open?

A: I didn't observe the food being passed through, but that sounds accurate based on what portions of it I did see.

Q: Okay. When they're cuffing and uncuffing inmates, do they also have to key open and hold open the chuckhole at the same time just like passing in the food tray?

A: Yeah. I do think it is a two-handed component.

Ms. Welch was unaware of Respondent's mission statement, and was further unaware that Yolanda Johnson, former Warden of Respondent's facility, had indicated that "work at the Tamms Correctional Center will be demanding." When asked to assume that the description of job duties given by Bobby Crespi was true, she agreed that the job was arm-and-hand intensive and repetitive. (PX 19)

According to medical records, Dr. Smith referred Petitioner to Dr. George Paletta on November 23, 2011 due to left elbow and wrist complaints. (PX 3)

Dr. Smith referred Petitioner for physical therapy on November 28, 2011 due to neck pain. (PX 3)

On December 28, 2011 Dr. Smith referred Petitioner to SI Ortho Associates for left elbow and wrist complaints. (PX 3)

Petitioner was examined by Dr. Steven Young (SI Ortho) on February 20, 2012 having been referred by Dr. Smith. Petitioner's chief complaint was bilateral hand numbness. Petitioner explained that he had been experiencing bilateral hand numbness for four to five years and originally it was in all the fingers of both hands but he had undergone a right carpal and cubital tunnel release and was doing well; however, about two months after surgery he started to have numbness and tingling in the right small and fifth fingers again. Petitioner reported he had been seeing a doctor in St. Louis but he stopped taking "workman's comp patients" so he was referred to Dr. Young's office. Dr. Young performed a physical examination and concluded Petitioner had bilateral cubital tunnel syndrome and left carpal tunnel syndrome. He ordered a new nerve conduction study. Petitioner noted a history of neck issues for which he was seeing a spinal surgeon and Dr. Young explained to him that he might still have symptoms even after a surgical release. Petitioner understood, noting that he had an attorney and couldn't undergo surgery as his case was in litigation. However, he wished to proceed with the nerve conduction study. (PX 13)

The nerve conduction study was performed on March 9, 2012. Petitioner reported a "several year history of numbness/tingling in both hands. Dr. Newell's assessment was right ulnar neuropathy at the elbow of moderate severity and mild bilateral carpal tunnel syndrome. (PX 13; PX 14)

Petitioner followed up with Dr. Young on March 16, 2012. Dr. Young's impression was right ulnar nerve entrapment and left carpal tunnel syndrome. He did not feel Petitioner had right carpal tunnel syndrome as the findings on the study probably stemmed from the prior surgery. Surgical intervention was recommended pending resolution of his litigation. (PX 13)

At the request of Respondent, Petitioner was examined by Dr. Anthony Sudekum on April 16, 2013. (RX 13) A written report followed.

Dr. Anthony Sudekum issued a second report on August 22, 2013 after being furnished additional medical records and documents to review. (RX 14)

PX 15 is comprised of the records of Dr. Whitehead. Petitioner has treated with him from June 17, 2013 through July 12, 2013, primarily for Petitioner's upper back and neck pain complaints. Petitioner reported ongoing back problems for at least four years and for which he has seen numerous physicians. Overall, Petitioner believed he had improved over the last 2-3 years. Muscle stimulation and heat with massage were provided to him throughout this time. Petitioner saw Dr. Whitehead ten times. As of July 12, 2013 Petitioner reportedly felt "much improved since his original onset" rating his pain at "2/10." Petitioner was released having reached maximum medical improvement as well as the limit of his treatment schedule as allowed by his current plan. Dr. Whitehead anticipated some recurring cervical complaints in the future as a result of the chronicity of his condition and "prior injuries" that have been lost into the spinal degenerative changes and mild cervical intervertebral disc syndrome. Petitioner completed neck disability index questionnaires with his visits. (PX 15)

Dr. David Brown, a hand surgeon, was deposed on June 18, 2013. (PX 22) Dr. Brown is a hand consultant for the St. Louis Cardinals. He gives lectures and presentations on a variety of subjects as set forth in his CV. He focuses his practice on the hand, elbow, and wrist as well as complex reconstructive surgery of the upper extremities. Dr. Brown testified regarding his care and treatment of Petitioner and his testimony was consistent with his medical records as discussed herein. (PX 22, pp. 1 - 24)

Dr. Brown further testified that he last saw Petitioner on February 16, 2011. Petitioner was advised the doctor would be glad to proceed with surgery on the left side once the status of his litigation was determined. Assuming Petitioner did return to see him Dr. Brown would want to re-examine him since almost three years have lapsed. (PX 22, pp. 24-25)

On the issue of causation, Dr. Brown testified that he received a job site analysis commissioned by the State of Illinois, a DVD (9'27" in length), and a repetitive motion study commissioned by the State of Illinois, all of which he reviewed. The DVD showed a correctional officer opening three doors during the entire length of the DVD. On one door, the person had trouble turning the lock. He tried three times and the video cut off. According to the doctor the video never showed the individual getting the door open. The DVD also showed people talking about what they were doing, opening a chuckhole, and explaining how they would pass a tray through the chuckhole (but without actually doing so). (PX 22, pp. 26-27)

Dr. Brown also testified regarding the job site analysis performed by CorVel. He noted it reflected a medium strength demand (ie., lifting 50 lbs. maximum with frequent lifting and/or carrying up to 25 pounds and frequent meaning 2/3 of one's day). Dr. Brown testified that if someone is doing that amount of lifting over the course of fifteen years he believed it would be considered, "at least, an aggravating factor...." (PX 22, p. 27-28) Dr. Brown further testified that the importance of the job site analysis lay in what it didn't say. It didn't quantitate the information he felt would be important in making a determination as to whether "these" activities would be a factor. While it talked about keying and cuffing and uncuffing it didn't indicate how often it was done or the amount of forces involved. Dr. Brown really felt it was inconsistent with the information from the repetitive motion study which was done two months later. He explained that the repetitive motion study (RMS) talked about doing very frequent keying on all shifts but the job site analysis (JSA) was silent on that. Furthermore, the physical

demands analysis (PDA) broke down different activities that correctional officers performed and it was inconsistent with the repetitive motion study. To illustrate he noted the PDA references opening doors is done one to 32 reps per day but the RMS states it's 261 to 276 times per day. He noted a similar disparity in the amount of grasping identified by the two studies. (PX 22, pp. 29-30) When asked if activities such as key turning, firm grasping and repetitive wrist turning could cause and contribute to the development of bilateral carpal and cubital tunnel syndromes, Dr. Brown testified, "I think over the course of 15 years, it would be considered an aggravating or a contributing factor." (PX 22, pp. 29-30) Dr. Brown testified that Petitioner lacked any medical problems which would put him at risk for either syndrome. (PX 22, p. 31, 47)

According to Dr. Brown Petitioner told him he turned keys, opened doors, used chuckholes, carried laundry bags, "etc." "a lot and it's done repeatedly." He further testified that they use Folger Adams keys and a Medeco key which is a little smaller than a Folger Adams key. (PX 22, p. 32)

Dr. Brown also reviewed the deposition of Melanie Welch who performed the JSA. Dr. Brown believed that Ms. Welch was an ergonomic counselor. Based upon his review of her deposition he really didn't think she understood what the correctional officers were doing. (PX 22, pp. 32-33)

Dr. Brown has seen maybe two or three other officers from Tamms. He's performed surgery on one of them. (PX 22, p. 34)

Dr. Brown further testified that Dr. Sudekum was hired to do a records review for the State of Illinois and he has reviewed his report a couple of times. Dr. Brown also testified that he believed Petitioner engaged in some recreational (meaning infrequent) motorcycle riding and occasional golf and that engaging in those activities at that level would not contribute to the development of bilateral compression neuropathies in the upper extremities. (PX 22, pp. 34-35) According to Dr. Brown, Dr. Sudekum attributed Petitioner's bilateral compression neuropathies to motor cycle riding, obesity, and golf. When asked if he agreed with the doctor, Dr. Brown testified he would need more information to render an opinion (including the frequency with which Petitioner played golf, rode a motorcycle, etc. (PX 22 , pp. 35 - 37) Dr. Brown further noted that Dr. Sudekum excluded some of Dr. Brown's findings when reviewing the doctor's records. He also noted that Dr. Sudekum disagreed with Dr. Milne's opinions on Petitioner's shoulder, with Dr. Milne being an orthopedic surgeon specializing in shoulder surgery. (PX 22, pp. 37-39)

Dr. Brown testified that Petitioner was referred to him by his attorney and that he sees a number of patients for Mr. Rich. However, he said that number is very small compared to the number of referrals from other sources. Dr. Brown acknowledged that Dr. Sudekum's report references Mr. Rich as a case manager; however, he has never made that notation. (PX 22, pp. 39-40) He further testified that Mr. Rich did not schedule any testing nor did he attend any appointment. Dr. Brown testified that because Mr. Rich's name was on a work status form Dr. Sudekum must have believed Mr. Rich was the case manager. (PX 22, pp. 40 - 41) Dr. Brown also noted that Dr. Sudekum did not comment on whether Petitioner's care and treatment with Dr. Brown had been reasonable and acceptable. (PX 22, p. 41)

Dr. Brown further testified that Petitioner may not have noticed symptoms in his hands and elbows as soon as he started working because in repetitive trauma cases it takes a long time for the microtrauma to accumulate to a point where it reaches a threshold and enough damage has occurred to cause symptoms. It's common with professional athletes such as golfers and pitchers. (PX 22, pp. 41- 45) He

also explained that some people never get these neuropathies because they have a higher threshold and it's highly individualized. (PX 22, p. 45)

Dr. Brown testified that his bills have not been paid despite the fact his office has explanations of benefits stating services have been approved and were going to be paid but then in 2011 someone changed his/her/its mind and denied the claim. (PX 22, p. 23) Dr. Brown testified that Petitioner couldn't run the charges through his regular health insurance because once he'd been told he had a valid compensable claim his private insurance wouldn't cover it and, additionally, the doctor is an out-of-network provider and the bills might be deemed untimely. (PX 22, p. 25)

On cross-examination Dr. Brown acknowledged that his causation opinion is based upon what Petitioner told him about his job and that terms such as "a lot" could vary from one person to another. (PX 22, pp. 48-50) He acknowledged that he had just about as much information available to him as Dr. Sudekum. He also acknowledged having Dr. Milne's records but wasn't aware that Dr. Milne had advised Petitioner to stop driving his Harley-Davidson. Dr. Brown admitted he didn't advise Petitioner not to ride his Harley but given the restrictions he had imposed it probably would have limited his ability to drive it. (PX 22, pp. 50-51)

Dr. Brown also acknowledged that his own office forms, including one dated January 11, 2011, list "T.R." (Tom Rich) as the case manager. (PX 22, p. 53) He also acknowledged other dates and references to "Tom Rich" or "Tom" in faxes from his office. (PX 22, pp. 53- 58) He acknowledged that his staff has some familiarity with Mr. Rich as during a period of time he referred quite a few patients to his office. (PX 22, p. 58) When asked if he still sees patients referred by Mr. Rich, Dr. Brown testified, "Very infrequently." (PX 22, p. 59) When asked why that was the case, Dr. Brown testified, "I think you know why. It is our office policy for injured workers that we will not see them unless we have approval to see the, especially for the State of Illinois...I no longer take the State's word that it's an approved claim. I need something in writing." (PX 22, pp. 58-59)

On further cross-examination Dr. Brown testified that he did not know what post or posts Petitioner held with Respondent.(PX 22, p. 59-60) Dr. Brown also excluded Petitioner's smoking as a factor testifying that it is not one of the factors strongly associated with compression neuropathies. (PX 22, p. 61) He knew "a little bit" about Petitioner's cervical condition but felt it was separate from his compression neuropathies but that one could have two conditions (peripheral neuropathy and compression neuropathies) (PX 22, pp. 61-62)

Dr. Brown was unaware that Petitioner was seeing another orthopedic surgeon for his upper extremities. He was also unaware that Petitioner was reporting complications from his right upper extremity operative procedures. Dr. Brown testified Petitioner was "doing well" when he last saw him. (PX 22, pp. 62-63)

Dr. Brown acknowledged that carpal and cubital tunnel syndrome can be idiopathic in nature. It was his understanding Petitioner's symptoms in his upper extremities began in early 2009 but he understood that Petitioner may have told Dr. Gornet it was in 2008. He reiterated that his causation opinion as of the date of the deposition was based upon Petitioner's job description, the duration of exposure (since 1995 with an onset of symptoms in 2008m early 2009, and information from the JSA and RMS). (PX 22, pp. 64-65) He believed the RMS actually re-affirmed his opinion. (PX 22, p. 65) He was not concerned with what "job posts" Petitioner had; more important were his duties. He further testified that the job duties Petitioner provided to him at the time of their initial visit were ones he had performed since

going to work for Respondent. He further believed there was a point in time in late 2009 when he switched to the control room due to his neck or shoulder injury. (PX 22, p. 65) If those job duties listed in his handwritten description were not the ones he performed during his tenure with Respondent Dr. Brown would need additional information before he could render an opinion. (PX 22, pp. 65-66) He suspected the job duties for correctional officers at minimum security and maximum security units might differ and when asked if it would matter if Petitioner had ever been assigned to the minimum security unit, Dr. Brown testified, "I would need to have more information." (PX 22, p. 66) Dr. Brown did not know what shift Petitioner worked, he has never held a Folger Adams key in his hand, opened a cell door, opened a chuckhole utilizing a Folger Adams key, or cuffed/uncuffed an individual using facility handcuffs and keys. He never saw/reviewed a job post description for one of Respondent's correctional officers. (PX 22, pp. 67-68, 74)

Dr. Brown was asked about Petitioner's lateral epicondylitis which was negative when the doctor initially examined him but positive on their second and third visits; however, he acknowledged he never rendered any treatment for the condition. (PX 22, p. 68)

As of his deposition, Dr. Brown did not know if Petitioner was working. (PX 22, p. 69)

Regarding the billing issues, Dr. Brown suspected that his billing expert submitted the bill to Petitioner's personal health insurance after treatment was denied in late 2011 but he did not know what the term "untimely filing" exactly means but in Petitioner's case it would have been over a year. (PX 22, pp. 70-71) He also indicated that Petitioner did not tell him his case had been denied; rather, it was "on hold." (PX 22, p. 72)

Dr. Brown testified that the outside materials provided to him to review had been reviewed over the days preceding his deposition but also reviewed in other cases. (PX 22, p. 72) It was the doctor's understanding that Petitioner was working full duty up until the first time he examined Petitioner. (PX 22, p. 74) He also acknowledged that motorcycle riding involves exposure to vibration and that current medical literature indicates that the use of vibratory tools or objects can be a factor in the development of peripheral compression neuropathies. (PX 22, pp. 74-75) He further testified that studies focusing on biomechanics have found key-turning can cause increased pressure on the carpal tunnel and cubital tunnel at the elbow. (PX 22, p. 75) He testified that the DVD didn't show the doors at Tamms being opened but he believed the doors were hinged. According to the JSA, there are two correctional officers assigned at Tamms per pod. He didn't know how many floors were at Tamms. Dr. Brown also believed there were two officers present when cuffing/uncuffing an imate and the number of times inmates are moved varies. Dr. Brown didn't know how many job posts assignments there are at Tamms. He didn't know how often officers changed posts. Petitioner gave the doctor a general description of the key turning activity while the RMS gave him the numbers. (PX 22, pp. 75-77) When asked if his opinion might change if the evidence at trial showed Petitioner turned keys less often than shown on the RMS he replied "It [would] depend." Dr. Brown received the additional information to review (DVD, RMS, JSA) in late or mid 2011. (PX 22,pp. 77 -78)

Dr. Brown did not know the amount of revenue he has generated from treating correctional officers for the Illinois Department of Corrections. He acknowledged that he has a ten percent interest in the Timberlake Surgery Center. Dr. Brown recalled no specific traumatic injury in 2009 being mentioned by Petitioner. He believed he had an injury to his shoulder that Dr. Milne was treating him for but there was no traumatic injury in 2009 that he (Dr. Brown) was seeing Petitioner for. (PX 22, p. 80) He further testified that an individual who would have held a Folger Adams key and opened a chuckhole at several

facilities would have familiarity with what it took to open up a particular door with a particular key but it would be misleading to translate that into every single door, every lock at all the facilities are the same because that isn't what the correctional officers say. (PX 22, pp. 82-83)

Dr. Brown was asked about Petitioner's cervical condition and the doctor again noted one can have multiple compression and problems. Petitioner's cervical spine pathology is at C5-6 and C6-7 which would be more on the median nerve distribution. (PX 22, p. 84) That type of pathology could present symptoms in the median nerve distribution but Petitioner had evidence of compression neuropathy on electrical diagnostic studies which cannot be ignored. (PX 22, p. 84) When asked if Petitioner's reports of complications from the surgery Dr. Brown performed and recurrent symptoms might suggest Petitioner's symptoms were being generated from his cervical spine all along, Dr. Brown indicated he would need more information. (PX 22, p. 85)

Dr. Brown believed Petitioner "frequently" applied or removed restraints throughout the day but the doctor lacked any hard numbers. (PX 22, p. 86) He also didn't know hard numbers for the other tasks written in Petitioner's job description (taken to the initial visit with the doctor) although he thought he did sweeping, mopping and cleaning about three to four times per shift per officer. He didn't know how often mail was passed out. (PX 22, pp. 87 -88) Dr. Brown did not believe Petitioner had ever worked in a control pod prior to 2009. He had no knowledge regarding the frequency of walking, bending, and stair climbing. (PX 22, pp. 88-89)

After Dr. Brown's deposition was taken, Dr. Young was deposed.

Dr. Steven Young testified on July 23, 2013 and January 28, 2014. (PX 23) Dr. Young testified that Petitioner gave him a list of his job duties which included, doing a lot of the locks and service post doors, unlocking and locking, frequent writing, applying and removing restraints, getting and collecting heavy laundry bags, pulling and pushing them, sweeping, mopping, and cleaning. Dr. Young testified that he did not have specific amounts of time listed for these activities, other than the Petitioner stated that he does it a lot. Dr. Young testified that he believed the activities which Petitioner participated in over a prolonged period of time could contribute to the development of his problem, and that he believed his symptoms were prominent while at work.

On cross-examination Dr. Young admitted that on his Patient History Questionaire Petitioner stated that almost anything worsened his symptoms, which includes activities outside of work. Dr. Young testified that he has not toured Tamms or any other DOC facility, he had never handled Folger Adams keys, cuffed or uncuffed handcuffs, or used the buttons in control pods. Dr. Young testified that he did not know if there were bars at Tamms, but he suspected that Petitioner may have bar rapped at Tamms. Dr. Young admitted that he did not recall any specifics on how long Petitioner performed any particular duty. Dr. Young testified that in order to make a firm causation opinion with regards to whether or not an activity caused or contributed to the development of carpal or cubital tunnel syndrome he would need to know the frequency, intensity, and duration of the activities performed. Dr. Young further admitted that without knowing or having an estimate of how often Petitioner was performing these activities that he could only make a supposition with regards to causation. Dr. Young agreed that at the time of deposition that, at most, he could only say Petitionier's work activities may or probably caused or contributed to the development of his condition. Dr. Young also agreed that Petitioner's increased BMI, age, and history of hypertension could predispose him to the development of carpal and cubital tunnel syndrome.

Thereafter, Dr. Anthony Sudekum was deposed on September 26, 2013. (RX 15) Dr. Sudekum testified that he has not toured Respondent's facility but had toured four other correctional centers in Illinois. Dr. Sudekum further testified that while at those facilities he performed several correctional officer duties, including utilizing small keys, padlock keys, Folger Adams keys, regular door keys, manipulating a chuckhole, handling property boxes, handling trays from dietary, operating handcuffs, operating buttons in a control room, and observing the activities of the cleaning crew.

For the records review, Dr. Sudekum testified that he had also reviewed the position description of a correctional officer at Respondent's facility, several reports of injury, the employee's notice of injury from November 2008, a timesheet for the Petitioner, a demands of the job form, Illinois Form 45, Corvel Job Analysis, Corvel DVD's, repetitive movement memo from Major Markel, Respondent's housing unit control pod duties, and a handwritten job description prepared by Petitioner. Dr. Sudekum also testified that he reviewed Petitioner's medical records from Dr. Mark Smith, Dr. Jeffrey Jones, Dr. Fakhre Alam, Dr. John Taveau, Dr. Steven Granberg, Dr. David Brown, Dr. Michael Milne, Dr. Matthew Gornet, Dr. Richard Johnston, Dr. Brent Newell, records from Southern Illinois Orthopedics, various imaging studies, and therapy notes from Novacare.

Dr. Sudekum testified that he has found certain activities correctional officers perform could be potentially causative or aggravating factors for upper extremity complaints. Specifically the vibration associated with bar rapping and moving heavy sliding doors by hand repeatedly. Dr. Sudekum testified that Petitioner did not describe performing either of these job duties in his records. In fact Dr. Sudekum testified that he did not see any bars at Respondent's facility on the DVD he reviewed. Therefore, Dr. Sudekum did not feel that Petitioner's upper extremity conditions were causally related to his job duties as a correctional officer. Dr. Sudekum acknowledged that he never examined or met Petitioner. He was questioned at length regarding his opinion and the records he reviewed as part of his report. (RX 15)

Dr. Richard Johnston was deposed on April 16, 2014 with regard to his right shoulder examination of Petitioner performed in 2010. (RX 12) Dr. Johnston is an orthopedic surgeon licensed in Missouri. He focuses his practice on adult orthopedic reconstructive surgery primarily addressing problems of the knees, shoulders, and hips. Ninety-eight and one-half percent of his practice is devoted to treatment. He performs a "few IMEs." (RX 12, pp. 5-6) Dr. Johnston testified consistent with his written report. (RX 12, pp. 6 - 9) Dr. Johnston re-iterated his opinion that Petitioner's right shoulder condition in April of 2010 was not caused or aggravated by his alleged work activities due to his underlying risk factors (smoking, type III acromion, and degenerative changes in the shoulder) together with his job description which did not include significant activities which could be reasonably expected to cause significant damage to the rotator cuff in and of itself. (RX 12, pp. 9, 12) He explained that Petitioner's type III acromion is a congenital/anatomical variant that one is born with and, by its very shape and location it leads to impingement on the rotator cuff tendon by pinching the tendon. (RX 12, p. 10) Petitioner also had acromioclavicular degenerative changes present in his shoulder which cause a decrease in the space available for the rotator cuff to move and causes impingement/pinching of the rotator cuff. (RX 12, pp. 10-11) Dr. Johnston further explained that when he noted the differences between the surgical findings and MRI in his written report he was referring to the fact that MRI scans are usually quite accurate in determining the size of a rotator cuff tear and it was silent. (RX 12, p. 11) While Petitioner's complaints during that time were consistent with rotator cuff tendinitis and/or rotator cuff pathology, the 5/5 strength and empty can testing being pain free were inconsistent with a tear (the latter being noted at the time of the September 11, 2010 exam) (RX 12, p. 12) Dr. Johnston also believed it "unlikely" that

Petitioner's shoulder condition in 2010 in any way related to the door shutting on his shoulder in 2008. He did believe the mechanism of injury would be consistent with a supraspinatus tear. (RX 12, p. 13)

Dr. Johnston also testified that if Petitioner engaged in hobbies or outside work activities of golf, hanging drywall and/or painting, such activities could affect the rotator cuff as some of them involve overhead activities and others involve high velocity torsional activities on the shoulder (such as golf). (RX 12, pp. 13-14)

On cross-examination Dr. Johnston acknowledged that he mostly performs total knee and hip replacements. (RX 12, p. 17) Only about 20% of his practice in 2010 would have involved arthroscopic shoulder surgeries. (RX 12, p. 17) He acknowledged that he performed his examination of Petitioner at the request of Genex, Respondent's third party administrator and didn't review any records from Dr. Mark Smith , Dr. Tovall, Dr. Gornet, Dr. Gransberg, or Dr. Young. (RX 12, pp. 20-21) He did not recall how he came to have a copy of a work description although a cover letter came from Genex. (RX 12, pp. 21-22) The doctor did not have a copy of it available. Dr. Johnston acknowledged that Petitioner was a correctional officer at Respondent's facility but he did not know what type of institution it was. He has never been to Respondent's facility, lacked any knowledge as to what the door were made of, what a chuckhole was, or whether force was required to open stuck doors, (RX 12, pp. 22, 30-31) He also acknowledged not receiving any treatment records or information such as an arbitration decision pertaining to the 2008 injury. (RX 12, pp. 22-23) He did not recall receiving a Job Site Analysis or a DVD with job duties to review. (RX 12, p. 32) When asked whether using a significant amount of force when pulling open a difficult to open heavy door could cause a degenerative or pre-existing shoulder problem to become more symptomatic or aggravated, Dr. Johnston replied that it would depend upon how many times one had to do that. "Occasional use" of the arm in a physiologic nature would not cause a significant worsening. (RX 12, pp. 30-31) Dr. Johnston did not believe the pushing of 5 to over 25 lb. bags of laundry would aggravate a pre-existing rotator cuff tear because the weights are not heavy. Similarly lifting and carrying 20 to 25 pound food trays would be below shoulder level. However, if someone was required to lift that amount over the shoulder, overhead, frequently it could cause a rotator cuff tear to become more symptomatic. Moreover, it would have to be fairly consistent lifting such as performed by a drywaller or electrician working overhead. Dr. Johnston did not believe dragging a 50 - 60 lb. mail bag would bother the arm but lifting it overhead frequently, could. (RX 12, pp. 34-35, 39)

Dr. Johnston further testified that the history Petitioner provided to Dr. Milne regarding the 2008 accident was a little different that the one Petitioner provided to him as he was unaware that Petitioner claimed he was pinned between the other door. (RX 12, p. 24) Dr. Johnston further felt that Petitioner's rotator cuff tear was degenerative, rather than acute, because of the way it was described in the surgical report. (RX 12, p. 29) He also acknowledged that a degenerative tear can be made symptomatic by an acute injury or activities. (RX 12, pp. 29-30) However, he believed it unlikely that the 2008 incident aggravated Petitioner's degenerative shoulder condition due to the mechanism of injury. Furthermore, based upon the information he had been provided regarding Petitioner's job duties, he did not believe they would have exacerbated Petitioner's shoulder problem as Petitioner's job duties were within the range of abilities of a human shoulder. (RX 12, p. 36)

Finally, Dr. Johnston acknowledged that Petitioner denied any outside hobbies or interests that might exacerbate his shoulder problems; however, on redirect he also acknowledged, that when Petitioner was examined by Dr. Milne in June of 2010, Petitioner noted he enjoyed golf and motorcycle riding, which would have contradicted what Petitioner told him. (RX 12, pp. 37, 40)

At the arbitration hearing Petitioner testified that prior to going to work for the Department of Corrections (IDOC), he graduated from high school, obtained an Associate's Degree, worked in electrical engineering and commercial painting. He was hired by the Department of Corrections in 1995.

Petitioner identified PX 17 as a "Work History Timeline" he prepared at his attorney's request. In it Petitioner indicated he took a leave of absence for approximately six months in 2009 when he injured his left foot and ankle in a non-work-related injury. He believed he was off work from May until December of 2009. He then returned to work in December of 2009 on a light duty basis for ninety days and was again off work as of March 4, 2010 through "the present." The "Timeline" also requested information on former workers' compensation claims and Petitioner noted, "You represented me in order to get 2 service connected sick days back, after being smashed in that electric sliding door at Tamms C.C. Arbitrator found in my favor."(PX 17)

Petitioner identified PX 16 a hand-written list of his job duties for Respondent that he prepared. From 1995 through 1998 Petitioner worked at a minimum security unit at Tamms (referred to as a "MSU") and his job required "lots of paperwork, searching inmate living quarters, common areas, using metal detector during searches for weapons on yard areas, strip searching inmates, applying restraints, removing restraints, etc....." (PX 16) From 1998 through "the present" Petitioner worked at a closed supermaximum security prison located at Tamms (referred to as "C-Max") and he performed the following duties:

- Lots of paperwork, log entrys, count sheets, etc.
- Locking & unlocking door locks & inmate service ports (chuckholes) many of these locks are difficult to operate due to key wear and poor maintenance of locks & service parts (work orders do little good)
- Applying and removing restraints, with intermittent difficulty, worn keys, etc.
- Collecting & distributing heavy inmate laundry bags - pulling & pushing them through the cell door service port, sorting laundry bags when returned from laundry, throwing laundry bags up to 2nd level to be caught and returned to inmates. bags could weight [sic] from 5 - 25+ lbs.
- Distributing and collecting inmate food trays, combining hot and cold trays from foot cart, placing up to 5 food trays in a portable carrier 20-25# up the stairs, lifting it up and hanging it on the security rail, then passing out the food trays to inmates.
- Sweeping, mopping, cleaning, inmates are locked down at the C-Max, all cleaning in cell houses is performed by the corr. officers.
- Dragging 50-60 lb. mail bags to our assignments, then sorting the mail, then passing it out
- Escorting inmates to Dr., mental health, nurse, barber/[?] (yard & shower if on restricted movement.
- Excessive stair climbing, walking, kneeling, bending frequently in awkward positions. 30 min. wing checks done round the clock, 17 or 18 stairs to climb and descend every 30 minutes (X 6 wings) that translates into over roughly 2500 stair steps per shift up and down divided by 2 officers, if you are lucky enough to have a partner, not counting all the other tasks performed on the wings (laundry, mail, [showers?]. etc....)

- Due to the design of the cellhouse control room you are forced to awkwardly turn your head in order to observe the inmates entering or exiting their cells, yard area, or showers whether they are being escorted or not
- Control panel (rocker switches) located throughout the facility require moderate pressure with your fingertips to operate them and must be depressed constantly while opening cell doors or closing cell doors, wing sliders, pod entry sliders, etc.
- Inspecting weapons, keys, unloading and loading ammunition from magazines
- The core control assignment, as well as the armory, [?waiting] room etc. all have the same crude switches as the cell house control room
- Chairs throughout the facility are of poor quality, broken down in need of replacement, the union has had no luck in this venture.
- All of these tasks are performed on a daily basis, with the exception of laundry & of course Sundays and holidays for mail. Laundry is done once per week. (PX 16)

Petitioner testified on direct examination that inmate services at Respondent's facility, a super max facility, are mainly delivered through a chuckhole, which required use of a large Folger Adams key to open. Petitioner demonstrated how food is passed through a chuckhole. Petitioner normally used his right hand to hold the key. He would have the tray in his right hand and open/fold the chuckhole with his left arm and slide the tray in with his right hand. Petitioner testified that the chuckholes are made of quarter-inch to three-eighths inch solid steel and don't always open smoothly due to debris getting caught in the hinges and lack of maintenance. Petitioner also testified that he sometimes had to use force to open the chuckholes. Although Respondent employed a locksmith on staff and employees could request that a door or lock be repaired by work order, Petitioner testified that he and others completed a fair share of work orders but the problem was seldom remedied.

Petitioner testified that he spent the majority of his time at Respondent working the 7 to 3 shift. The assignment roster submitted by Respondent only covered 4 of the 17 years that Petitioner worked at Respondent, 15 of which he spent in the super maximum facility

Petitioner testified that since Respondent was a super maximum security facility, and no inmate help was available, he was also responsible for cleaning the facility, including such as sweeping, mopping the wings, wiping down handrails, cleaning toilets, emptying trash, and cleaning windows and stainless steel. Petitioner would also at times be required to clean inmate cells in the event that an inmate cut themselves or went to the bathroom on the floor or spread their bodily waste throughout the cell.

Petitioner testified that self-cleaning items, laundry, and mail are distributed through the chuckhole. Petitioner testified that the Folger Adams keys can be easy to turn -- it just depends on the locks. On occasion, it might take multiple tries to turn a key. Petitioner would use both hands in performing these jobs.

Petitioner testified that mail bags for a cell house were as big as a trash can. Petitioner denied ever having the use of a dolly to carry mail bags, Petitioner testified that before Respondents closed there were mail carts, but all the time prior to that he had to drag an oversized duffle bag full of mail to the housing unit.

Petitioner testified that in a pod at Respondent's facility there are six wings with ten cells on each wing, for a total of 60 cells. Petitioner testified that the majority of the time he worked at Respondent he was

either a pod officer or a controlling (control room) officer in the cell houses. As a control room officer Petitioner testified that there is not so much key turning, but he would be constantly manipulating rocker switches that you have to press for six to seven seconds to open a door. Petitioner believed he spent 80 % of his time at Respondent's Super Max facility as a pod officer.

Petitioner testified that whenever inmates at Respondent's "C-Max" needed to come out of their cells, they first had to be strip searched. Petitioner described this process as requiring him to first open the chuckhole and have the inmate hand him clothes through the chuckhole. Next, after the inmate's clothing was searched, the clothing was handed back to the inmate and the chuckhole was re-secured while the inmate got dressed. Then, after the inmate was redressed, the chuckhole would be reopened and the inmate would be required to place his hands behind his back and through the chuckhole in order to be handcuffed. Petitioner testified that it was difficult to cuff inmates in this position. Petitioner also testified that some inmates resisted this process, which placed increased strain and pressure on his hands. Petitioner testified that cuffed and uncuffed inmates in this fashion on a daily basis.

Petitioner further testified that he performed shakedowns, a procedure in which inmates would be removed from their cells and their property would be searched for contraband. Petitioner testified that for a time, an inmate's leg irons also had to be secured to an I-bolt. Petitioner thoroughly described a shakedown as follows:

> . . . They had tools available for us, a stress bar we had to put on the window bar to make sure that they haven't been trying to hacksaw through that. They had a trowel that we had to scrape underneath, up and around searching for contraband that could be hidden within the sliding door area. You know, a thorough process.

Petitioner testified he was also required to move the inmate's mattresses and lift property boxes which weighed anywhere from thirty to sixty (30-60) pounds, and was required to search through the possessions contained therein with his hands and arms.

Petitioner testified that in the course of his job duties he was required to perform 30-minute wing checks, also known as welfare checks. He indicated that he made tours through the cell house and pulled or shook the cell doors to ensure that the door was secure. He stated that he shook doors thousands of times during his career.

Petitioner was asked by his attorney whether during the course of performing the foregoing job duties he began developing symptoms in his arms and hands and Petitioner replied, "Yes." He also testified that he began to have symptoms in his shoulders and neck. When next asked if he sought medical care and treatment for those conditions as outlined in Petitioner's Exhibits 3 - 15, Petitioner testified, "Yes."

Petitioner testified that he was referred to Dr. Alam in April of 2010 by Dr. Smith, his primary care physician. After he saw Dr. Alam he completed an Incident Report.

Petitioner was asked about the surgeries he subsequently had. He testified that he first had shoulder surgery but added that it was his understanding they weren't in court for that at this hearing. He then replied that he had undergone extensive right shoulder surgery and a right carpal and cubital tunnel release. Petitioner is right handed and used his right hand more than his left hand at work. When asked if the surgery improved his condition, he responded "Absolutely." He further testified that he has

incredible, moderate pain in his left upper extremity. With regard to his right arm, he still feels his thumb, index finger and long middle finger but after going back to work for Respondent his right ring and pinky fingers went dead again. His grip strength is no longer what it once was. Regarding the flexibility and range of motion he had in his elbow and wrist before his problems started he described it as "close."

Petitioner testified that Respondent's facility closed and while he is still employed with IDOC he now works at Vienna which he feels is a minimum security prison where he doesn't have near the amount of key turning and interaction with inmates as before. Thus, he doesn't have the "persistent pain and stuff" as he did with Respondent.

Petitioner testified that his neck is "not good" and it hasn't improved since he switched jobs. It hurts and aches on both sides and radiates down the center of his back. Dr. Smith prescribes medication and steroids for him on and off. When asked if he had any further appointments with a specialist scheduled, Petitioner replied "not for the issues we're here for today."

Petitioner testified that he was already off work for an unrelated non-work-related foot problem when he had his elbow and wrist surgeries.

Petitioner testified that he reviewed Respondent's evidence regarding the job site analysis, videos, and depositions of the various examining physicians. He testified that the video was very vague for lack of a better word and didn't last very long. He did not believe it showed the work he performed on a daily basis in a cell house.

Petitioner testified on cross-examination that he became aware that his condition was work-related in April of 2010 when he had a nerve conduction study. He further testified that he spoke with the doctor at the April 13, 2010 visit and asked him if his condition was work-related and he was told it was.

On further cross Petitioner was asked about his 2008 accident. He explained that there was a wing enter slider, a huge electrically operated sliding door and the officer in charge of the control room purposely closed it on him hitting his right shoulder. When asked if the numbness and tingling in his hands and pain in his elbows began after that accident, Petitioner replied it began before he went to see Dr. Alam. Petitioner was then asked why he told Dr. Brown his problems began in 2009 to which Petitioner responded he was an only child having been preceded in death by two sisters and he was caring for his elderly parents single-handedly and "kind of" letting his condition go until their untimely death in March of 2010. He then sought treatment from his primary care physician. He then reiterated that he had symptoms in 2009 but just didn't seek treatment for them. However, when Dr. Alam told him his condition was work-related that was the first time he related it to work and Petitioner related his condition to work.

Petitioner testified that his work at Respondent MSU was "more laid back", that officers had inmate porters and inmates did their own laundry. Petitioner testified that dorms did not have doors on them, so officers did not have to lock or unlock cell doors. He stated that they had a Folger Adams key on their key rings, but they did not utilize them very often. He further testified that there was no bar rapping at Respondent MSU. Petitioner agreed that when he moved to Respondents it was a brand new facility with brand new locks, chuckholes, and cell doors that operated effectively. Petitioner admitted on cross that Respondent had a locksmith on staff. Petitioner testified that if a chuckhole malfunctioned officers

could fill out a work order to have it repaired. Petitioner testified that in 15 years he filled out approximately 50 work orders for a malfunctioning chuckhole.

Petitioner admitted on cross that the cell house was not always full, that at times they would have as few as 28-30 inmates in the 60 cell house pod. Petitioner also testified on cross that cell doors were not keyed open, doors were opened via rocker switch in the control room. Petitioner stated that if an inmate received mail that could fit through the crack of the cell door then the officer would slide it through there rather than open the chuckhole. Petitioner testified that laundry was done once a week, and some inmates would do their own laundry and some inmates would not hand out laundry very often.

Petitioner admitted on cross that if an inmate was extremely violent they would only be moved by the tactical unit.

Petitioner further testified on cross-examination that at Respondent's facility the inmates are on lockdown 23 out of 24 hours a day. Petitioner testified that the only time that they're moving during that one hour a day is to go shower, yard, or healthcare. Petitioner further testified that inmates could have other services that they went to at other times during the day. He testified that they could go to the multi-purpose room to receive mental health visits, the nurse's station, or the satellite law library. However, Petitioner admitted that some inmates have unrestricted movement. Petitioner testified that inmates with unrestricted movement do not have to be strip searched or cuffed in order to go to shower or yard. Petitioner testified that when an inmate with unrestricted movement went to yard or shower his cell door was opened via rocker switch in the control room and he walked himself to the shower or yard. Petitioner admitted that even in B pod, where the majority of troublemakers were held, that 70% of the inmates housed there could have unrestricted movement.

Petitioner testified on cross-examination that Respondent's Exhibit 6 accurately represented his staff assignment history from April 19, 2009 to April 9, 2012, which indicated that he worked the 3:00 p.m. to 11:00 p.m. shift. (RX 6) Petitioner admitted that the only time he would be sending an inmate to yard, shower, or healthcare on the 3-11pm shift would be if they did not complete these tasks on day shift. Petitioner further stated that some evenings he might have to send zero inmates to shower, yard, or healthcare on the 3-11pm shift, and some evenings it might be a maximum of 15. Petitioner testified that he would be responsible for one feed on this shift, and that he and another officer would split the work between themselves.

On further cross-examination Petitioner testified that shakedowns would only occur once every 7 days for high risk inmates and once a month for other inmates. Petitioner admitted that that he would not have to shakedown a cell every shift. Petitioner testified that it would take him and another officer approximately 10-15 minutes to shakedown a cell. Petitioner testified that when doing a wing check he and another officer would split the 60 cells, and he would be responsible for 30 cells. Petitioner testified this would take him approximately 18 minutes to complete.

Petitioner testified that the correctional officers cleaned the pods, which included sweeping, mopping the wings, wiping down handrails, cleaning toilets, emptying trash, cleaning windows, and cleaning stainless steel. Petitioner testified on cross-examination that inmates cleaned their own cells.

Petitioner testified that when he was assigned as a control officer he was not using Folger Adams keys or cuffing and uncuffing inmates. Petitioner described working in the control room and stated when opening and closing doors he had to physically turn and look virtually behind you and put your finger on the button you want to push. Petitioner testified that he would have to look behind him at the wing to see the door he was about to open. Petitioner testified that there were no switches overhead.

Petitioner testified that he worked as a health care officer per his staff assignment history. Petitioner agreed that on average there were three inmates in the infirmary at a time.

Petitioner testified that per his staff assignment history he was assigned to the kitchen and roving patrol. Petitioner testified that in the kitchen he would be observing minimum security inmates, and the only doors he might have to key would be the bathroom door and the entry door. He agreed that opening those two doors required the use of a small key. Petitioner testified that as a roving patrol officer he was driving a passenger van on black top around the facility.

Petitioner testified that at times he was assigned to J-control and J-1 wing officer. Petitioner testified that J wing was where they held mental health patients and that there were only two wings with ten inmates on each wing.

Petitioner testified that there is no bar rapping at Respondent's facility.

Petitioner testified that he rides a motorcycle but not very often. Petitioner stated his motorcycle is a Harley Davidson Electra Glide. He testified that he bought the bike in 2009 with 16,000 miles on it and it now has 35,000 miles on it. Petitioner admitted on cross-examination that he has anti-vibration gloves for when he rides because his hands were going numb while riding.

Petitioner testified that he has smoked since 2008, and at most would smoke around a pack a day. Petitioner also admitted that he has hypertension. Petitioner testified that his weight has not fluctuated since 2010, and that his is 5'10 and 235 lbs.

Petitioner testified that there is no claim for temporary total disability (TTD) benefits in this claim because when he had surgery he was already off work for an unrelated medical issue.

Petitioner's counsel called Mr. Jason Hall to testify after Petitioner completed his testimony. Mr. Hall testified that he is currently employed by the Department of Corrections, Vienna Correctional Center. Mr. Hall testified that he worked at Respondent's facility from 1997-2001 and 2004-2013. Mr. Hall testified that he started as a correctional officer and when he returned to the facility he was an Administrative Assistant II. As a correctional officer Mr. Hall testified that he worked in a cell house. Mr. Hall testified that he worked with Petitioner during his tenure with Respondent. Petitioner's counsel asked Mr. Hall if there were any inaccuracies in Petitioner's testimony. Mr. Hall testified that he believed Petitioner's testimony did contain inaccuracies.

Mr. Hall disputed Petitioner's testimony with regard to the mail bags. He testified that on a busy day, such as after a holiday, the mail bags were maybe 30 lbs. and on a light day they were 2-3 lbs. He testified that carts were available, and before carts were available there were flatbed carts officers could utilize to take all the mail bags to all the housing units at one time. Mr. Hall testified that the bulk

of mail inmates received were legal mail, which would have been hand delivered by Petitioner's supervisor.

Mr. Hall disputed Petitioner's testimony regarding the lock issues. Mr. Hall said there were minimal issues with the operations of locks, and because the facility was never fully occupied with inmates if a lock did not work properly they could simply move the inmate to a working cell until the locksmith could fix it. Mr. Hall also testified that problems with chuckholes sticking or being difficult to open was also minimal. He testified that the facility employed a full time locksmith and there was a regular maintenance schedule that was fulfilled by the locksmith.

Mr. Hall disputed Petitioner's description of how the control room was operated. He stated Petitioner would be facing forward, and that there would be no need for him to look behind himself to operate a panel. Mr. Hall testified that as a control officer Petitioner would be facing the control panel and the wing he was operating would be on his left or right, but there were no panels behind him.

Mr. Hall disputed Petitioner's testimony with regard to how much cleaning he did. Mr. Hall testified that on the 7-3pm shift very minimal, if any, cleaning would be done. Mr. Hall testified that the majority of cleaning was done on the 3-11pm shift and midnight shift, but the overall housekeeping cleaning had to be fulfilled monthly. He testified that officers were required to sweep the yard for the inmates, but that was only on the weekends.

Mr. Hall disputed Petitioner's testimony that a correctional officer was required to shake cell doors during a wing check. Mr. Hall testified that the control room has switches that indicate the security of the doors. He testified that the standard procedure for wing checks was designed to check on the inmate, not the integrity of the door. In fact, the cell door did not even have a handle on it. Mr. Hall testified that if Petitioner testified he was required to shake cell doors per his post description that would be untrue.

According to Commission records, Petitioner filed a Petition pursuant to Section 8(a) in case # 09 WC 13185 on June 27, 2014.

__The Arbitrator concludes:__

1. The Admissibility of PX 20. Petitioner seeks to admit Petitioner's Exhibit No. 20, which is the deposition of Zachary Weiss taken in the cases of *Richard Brueggeman Et Al v. SOI/Menard CC*, 10 WC 47285, 12 WC 40657, 12 WC 42758. Respondent objected to the admission of this document based upon hearsay pursuant to the rules of evidence, specifically rule 804. Pursuant to rule 804 depositions taken in other proceedings constitute hearsay unless proven by the party introducing them that the witness is unavailable.

   The Arbitrator further notes that the Commission recently addressed not only this issue, but the admissibility of this exact deposition, in *Stephen Bradshaw v. State of Illinois/Menard Correctional Center*, 14 IWCC 0394.

Petitioner's Exhibit No. 20 is hearsay and inadmissible. The exhibit is rejected and will travel with the record.

2. Petitioner's credibility. Petitioner was not an entirely credible witness. In support thereof the Arbitrator notes multiple inconsistencies in Petitioner's statements to medical providers. To illustrate: (1) the evaluator at Nova Care initially noted inconsistencies between Petitioner's objective presentation and subjective complaints; (2) Petitioner reported to the evaluator that the injections he received to his neck were very helpful but Petitioner later denied any improvement when examined by Dr. Gornet; (3) When Petitioner reported his alleged repetitive trauma injury to Respondent on June 27, 2010 he mentioned his right shoulder being "crushed" in a 2008 work injury. While Petitioner described a "crush injury" at that time, he would later be examined by Dr. Johnston in September of 2010 at which time the doctor noted ongoing shoulder pain exacerbated by reaching and lifting overhead or throwing heavy objects overhead. Petitioner did not describe the 2008 accident to the doctor as a "crush" injury. The history provided to Dr. Johnston in September of 2010 was inconsistent with Petitioner's testimony at his arbitration hearing held with regard to his 2008 accident. Additionally, the Arbitrator notes that in the Arbitrator's Decision in the 2008 accident case, the Arbitrator noted Petitioner noticed pain in his right shoulder with drywalling and painting activities he did outside of work. When seen by Dr. Johnston, Petitioner denied any activities outside of work which had caused or exacerbated his shoulder condition. Finally, the Arbitrator notes Petitioner testified he was referred to Dr. Alam in April of 2010 by his primary care physician, Dr. Smith. That is incorrect. He was referred there by Dr. Jones, whose record pre-dating the April 13, 2010 test is not in the record.

3. The Issues. (Accident; Causal Connection; Notice; Medical Expenses; Nature and Extent)

The Arbitrator notes that the records of Dr. Smith (PX 3) contain no suggestion of/correlation between/or reference to a problem or association of Petitioner's shoulder and or bilateral hand/arm complaints with Petitioner's job duties for Respondent until June 12, 2013 when Petitioner requested pain medication to assist with pain that was "interfering with work due to increasing numbness and burning." At most, Dr. Smith's records identify Petitioner's employer as Respondent and note Petitioner works as a correctional officer. However, that information is included as part of Petitioner's social history and nothing more. The Arbitrator also finds the history contained in Dr. Smith's March 11, 2010 office visit of significance. Petitioner reported no left upper extremity complaints at that time. Furthermore, Petitioner reported neck pain for which he already had an appointment scheduled with Dr. Jones. Petitioner also reported, in conjunction with the neck pain, right arm numbness radiating downward with tingling and "sensations" in the arm limiting the ability to be touched there. Finally, Petitioner reported experiencing a "weird pain" in his right shoulder like an electric shock the evening before his visit. Dr. Smith's notes also reference Petitioner being referred for physical therapy to his neck in November of 2009. This was during the time Petitioner was off work for another problem. There is no additional information pertaining to the circumstances surrounding that referral nor were any records submitted into evidence. (PX 3) Dr. Smith was not deposed.

It is also very disconcerting that the medical record from Petitioner's March 18, 2010 office visit with Dr. Jones is not in the record. It must have taken place as Petitioner was referred to Dr. Alam for the EMG/NCS by Dr. Jones. Furthermore, Petitioner was seen in "follow up" at Trinity

Neuroscience Institute on May 10, 2010. Dr. Taveau, an associate of Dr. Jones at Trinity, examined Petitioner on May 10th. (See PX 4, p. 1; PX 5, pp. 1, 5) Also, when Petitioner was tested by Dr. Alam Petitioner made no reference to any association between his symptoms and his work for Respondent. Unlike his visit with Dr. Smith in March of 2010 when Petitioner only had neck and right arm complaints. Petitioner was now complaining of bilateral upper extremity complaints. (PX 4)

Dr. Taveau's May 10, 2010 office note pertaining to his visit with Petitioner on that same date also fails to contain any reference to alleged work-related complaints. Petitioner simply stated "Activity makes his symptoms worse." He had no change in his writing nor was he dropping things. The doctor merely noted Petitioner worked as a corrections officer and nothing more. The Arbitrator notes Petitioner's personal health insurance company was being billed for the visits. (PX 5)

In sum, prior to Petitioner retaining an attorney, there is nothing in Petitioner's medical records suggesting Petitioner had been seeking medical care for problems he associated with a work-related problem.

Petitioner then signed his Application for Adjustment of Claim in this case on May 4, 2010. Thereafter, he was examined by Dr. Gornet on May 14, 2010. This is the first mention in any of the medical records that Petitioner is associating his symptoms with two events: (1) his accident in 2008 and (2) light duty work for Respondent which was provided to him when he returned to work after being off work for a non-work-related foot injury and was placed in the control room. Dr. Gornet's history also states that Petitioner was referred to Dr. Smith in December of 2009. There is no corroboration for a referral to Dr. Smith in 2009 nor is there corroboration for who, why, and under what circumstances a "referral" was made. It is also unusual that Petitioner would bring a written job description with him to his first doctor's visit after filing his claim.

While Dr. Gornet goes so far as to express a causation opinion at the time of his initial examination with Petitioner, the Arbitrator affords no weight to that opinion. Dr. Gornet opined Petitioner's symptoms at that time were causally related to both Petitioner's 2008 work accident and his change in work activities and the repetitive nature thereof which increased Petitioner's symptoms in late 2009. Dr. Gornet clearly stated his causation opinion was based upon "the history provided to [him]." That history was not borne out by Petitioner's testimony at arbitration.

Petitioner was also examined, upon referral of his attorney, by Dr. Brown, an associate of Dr. Gornet's. Petitioner discussed the 2008 accident but presented, as he had with Dr. Gornet, a job description he had prepared. This description included activities Petitioner allegedly performed before being assigned light duty in the "control room" and afterwards. Petitioner reported that he first developed problems with his upper extremities in early 2009 when he developed numbness and tingling in both his hands, worse on the right than the left and some lateral elbow pain. Petitioner advised the doctor he had undergone several steroid injections in both elbows. There is no evidence in the record of Petitioner receiving bilateral elbow injections. "Based upon [Petitioner's] description of his job as a correctional officer, combined with [his] own understanding of that job, combined with his lack of medical problems that would put him at risk for these conditions, " Dr. Brown was of the opinion that Petitioner's work as a

correctional officer would be considered in part a contributing and/or aggravating factor in the development of his bilateral carpal and cubital tunnel syndromes. The Arbitrator is not persuaded by Dr. Brown's opinion. It is not supported by the medical records and is based upon an incorrect and incomplete history from Petitioner.

Of additional significance is the fact that, despite a causation opinion from Dr. Brown, between Petitioner's job and his upper extremity conditions, he allowed Petitioner to continue working for Respondent full duty.

On June 27, 2010 Petitioner reported his alleged repetitive trauma work injury. He gave a manifestation date of April 13, 2010. Interestingly, he does not allege his injury is due to his work in the "control room;" rather, he mentions chuckholes, laundry, pressing buttons, mail, "etc." (RX 3)

Petitioner began treating with Dr. Milne in early June of 2010 regarding his right shoulder complaints. Petitioner did not introduce any of these records into evidence. The Arbitrator's knowledge of any treatment afforded by Dr. Milne is limited to that which is made known by Respondent's examining physician, Dr. Johnston. Petitioner had been off work since March of 2010 for a left foot injury (non-work-related). Whether Dr. Milne believed Petitioner's right shoulder condition was causally related to Petitioner's 2008 accident or his allegedly repetitive work duties is not known.

Thereafter, the battle of the experts began and Petitioner submitted the depositions of Dr. Brown, Dr. Gornet, and Dr. Young in support of his position. An opinion on causal connection is only as good as the history upon which it is based. All of these doctors relied upon the history as given to each of them by Petitioner. However, Petitioner has not been fully candid and complete in those histories. Thus, their opinions are not persuasive. None of these doctors had a full, complete, and thorough understanding of Petitioner's job duties for Respondent. For example, while Dr. Brown testified that activities such as key turning, firm grasping, and repetitive wrist turning could cause or contribute to the development of bilateral carpal and cubital tunnel syndrome he never rendered an opinion based upon the particular facts of Petitioner's case. Petitioner's job description which he prepared was simply a summary of some of his job duties over time and Dr. Brown's causation opinion was based upon that general description of a correctional officer's job. While Dr. Brown was quick to criticize the Job Site Analysis performed by Melanie Welch and the records review by Dr. Sudekum, Dr. Brown's cross-examination revealed flaws and missing information in his own analysis. In the end, his opinion was not based upon accurate facts and was unpersuasive. Dr. Young's and Dr. Gornet's opinions were equally lacking inn adequate and accurate information. None of these doctors factored in Petitioner's lengthy absences from work.

Regarding Petitioner's right shoulder, the Arbitrator notes that some of Petitioner's testimony was perplexing at best. From the moment Petitioner filed his Application for Adjustment of Claim he has claimed a repetitive trauma injury to his right shoulder. (See AX 2) However, when asked about the surgeries he has undergone with regard to this claim he clearly stated that his shoulder wasn't what he was in Court for that day. Thus, by his own admission at the hearing, it appears Petitioner isn't really pursuing a right shoulder injury with regard to this accident. This would appear consistent with the filing he has made in the 2008 workers' compensation claim also.

Therefore, based upon the foregoing:

1. The Arbitrator concludes that Petitioner failed to prove he sustained a repetitive trauma accident that manifested itself on April 13, 2010 involving his neck, right shoulder, and/or upper arms, hands, and wrists. April 13, 2010 is the date of Petitioner's nerve conduction study which revealed bilateral carpal and cubital tunnel syndromes. The record of that test/visit contains no reference to Petitioner's job for Respondent or any known or believed correlation between Petitioner's symptoms and his job duties for Respondent. Petitioner's testimony that the doctor told him his condition was work-related wasn't credible. There is nothing in the doctor's records corroborating such a discussion. The doctor was not deposed.

2. The Arbitrator further concludes that, even if April 13, 2010 were a date of manifestation, Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment with Respondent or that his current condition of ill-being in his right shoulder, neck, arms, elbows, and hands/wrists is causally related to his job duties for Respondent. The burden is on the claimant to prove all of the issues of the case by a preponderance of the credible evidence. This includes the issues of accident and causal connection. Petitioner's testimony wasn't credible. His histories to the various medical providers were not consistent and accurate. In turn, the opinions of his treating physicians were not credible. Petitioner's physicians testified that they relied upon the history and information provided to them by Petitioner and as the basis for their causation opinions. Petitioner testified extensively about his job duties but his doctors were never provided with all of this information nor did they factor in Petitioner's leaves of absences from those duties (May of 2009 - December of 2009 and March of 2010 through late 2010/early January 2011).

With further regard to Petitioner's right shoulder, the Arbitrator also notes that Petitioner told all of his doctors about his November 12, 2008 right shoulder injury and worsening symptoms over time. While Petitioner has alleged worsening symptoms over time he never testified or told his doctors he was asymptomatic after that accident.

There is no need to address the opinions of Respondent's physicians or the weight to be afforded the DVD, job site analysis (JSA), repetitive motion study (RMS), or Ms. Welch's testimony as Petitioner failed to meet his burden of proof.

3. Timely notice of an alleged accident was provided. Petitioner claims an accident date of April 13, 2010. While a Notice of Injury was not provided by Petitioner to Respondent until June 27, 2010, which is more than 45 days after the alleged accident, Petitioner signed his Application for Adjustment of Claim on May 4, 2010 and it was filed with the Commission on May 10, 2010. By the Proof of Service (AX 2) Respondent was mailed a copy on May 4, 2010. Presumably Respondent received it in a timely fashion and certainly within 45 days of April 13, 2010. Petitioner acknowledged in his Notice of Injury form that he didn't give notice any earlier than June 27, 2010; however, the filing of an application for adjustment of claim within the 45 day notice period does satisfy the notice requirement under the Act.

4. Consistent with her findings and conclusions as set forth above, all other issues are moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rhonda Barnes,

Petitioner,

15IWCC0102

vs.

NO: 12 WC 18942

Southwest Airlines,

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 May 2, 2014 is hereby affirmed and adopted.

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

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

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

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

DATED: FEB 5 - 2015
KWL/vf
O-2/3/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0102

BARNES, RHONDA
Employee/Petitioner

Case# **13WC018942**

SOUTHWEST AIRLINES
Employer/Respondent

On 5/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% 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:

0307 ELFENBAUM EVERS & AMARILIO PC
KAROLINA M ZIELINSKA
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN 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
19(b)

15IWCC0102

Rhonda Barnes
Employee/Petitioner

v.

Southwest Airlines
Employer/Respondent

Case # 13 WC 18942

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **March 27, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☒ Were the 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, **10/30/2011**, 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 as it relates to her right shoulder and neck *is* causally related to the accident.

In the year preceding the injury, Petitioner earned $**42,159.19**; the average weekly wage was $**810.75**.

On the date of accident, Petitioner was **50** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of $**67,562.50** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**67,562.50**.

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 $540.50 per week for 125-4/7 weeks, commencing October 31, 2011 through March 27, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner's outstanding medical bills totaling $15,631.01 pursuant to the medical fee schedule.

Respondent shall authorize and pay for Petitioner's prospective medical treatment pertaining to the neck, including, but not limited to, C5-C7 anterior cervical discectomy and fusion surgery and related post-operative care and treatment as delineated by Dr. Hsu and provided by Section 8(a) of the Act.

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

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

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

Signature of Arbitrator

5/1/14
Date

ICArbDec19(b)

MAY - 2 2014

FINDINGS OF FACTS

At the time of the injury, Petitioner was a 50 year-old employee of Southwest Airlines working as a Customer Service Agent. Petitioner had worked for Respondent since May of 2002. As a Customer Service Agent, Petitioner's job duties consisted of checking in passengers, making reservations, working the ticket counter as well as the gate and checking in luggage/bags. In order to check in luggage, Petitioner had to lift the luggage in order to place it onto a conveyor belt. Petitioner testified the luggage usually weighed up to 50 pounds. At times, the luggage weighed as much as 70-80 pounds, at which point the customer was charged an additional baggage fee.

The parties stipulated to the occurrence of an accident on October 30, 2011. (Arbitrator's Exhibit 1).

Petitioner testified that in the afternoon of October 30, 2011, she was lifting a customer's bag when she felt pain in her neck and right shoulder. Petitioner provided that the scale showed the bag to weigh approximately 50 pounds, though she felt it may have been heavier than that. As she was lifting the bag to move it, she felt tightness on the right side of her neck as well as a sharp pain in her right shoulder. Petitioner testified her shoulder felt like it was out of socket. Petitioner testified she had never felt this type of pain in her neck or in her right shoulder before.

Petitioner testified she had been working full duty as a Customer Service Agent for at least a year prior to her injury on October 30, 2011. Petitioner testified she had medical care for her right shoulder and neck in the past, but was in good health and was not under any active medical care for her neck or right shoulder when she left for work on October 30, 2011. The medical records show Petitioner's last treated for right shoulder pain in 2010.

Petitioner testified that after the incident, she was unable to complete her shift and drove herself to MacNeal Hospital's Emergency Room. Records show she presented with complaints of a right shoulder injury after lifting a heavy piece of luggage while at work. Petitioner was evaluated by a doctor. X-rays were taken of her right shoulder. She was diagnosed with right shoulder strain, prescribed Vicodin for her pain and told to follow up the next day at the Clearing Clinic. (Px 2)

Petitioner presented to the Clearing Clinic the next day, October 31, 2011. (Px 3) Petitioner reported lifting a bag while working the kiosk machine at the ticket counter and injuring her right shoulder. (Px 3, p. 3-4) Petitioner testified that she reported pain in her right shoulder and pain in her neck. Petitioner was diagnosed with shoulder sprain and placed on restricted duty of no lifting over 10 pounds and no overhead work. She was also prescribed Dendracin Cream and advised to return in two days or sooner if needed. *Id.*

On November 2, 2011, Petitioner returned to the Clearing Clinic. (Px 3, p. 11) She complained of pain, tightness and a knot located in the right shoulder. The pain was noted as constant and moderate. Petitioner was placed on restricted duty of no lifting over 10 pounds and no overhead work and again prescribed Dendracin Cream. Physical therapy was ordered. *Id.*

On November 7, 2011, Petitioner presented for an initial physical therapy evaluation at the Clearing Clinic. (Px 3, p. 8) Petitioner reported pain in the right shoulder made worse by leaning on the right arm or reaching overhead or back. Petitioner filled out a patient questionnaire at this time. (Px 3, p. 18) At trial, Petitioner was shown the questionnaire. Petitioner testified she filled it out herself and signed and dated the form at the bottom.

Question number 3 on the questionnaire asked, "What is your injury (where is your pain)?" Petitioner wrote "upper right shoulder and neck." *Id.*

On November 8, she was seen by Dr. Bierman at Northwestern Medical Faculty Foundation complaining of shoulder pain following a work injury. Dr. Bierman assessed acute shoulder pain and referred her to orthopaedics. (Px 4, p.7-8)

On November 10, 2011, Petitioner presented to orthopedic surgeon, Dr. Matthew D. Saltzman, at Northwestern Medical Faculty Foundation for treatment regarding her right shoulder. (Px 4, p. 12) The notes indicate Petitioner injured her right shoulder at work when she was tagging a 50 pound bag and throwing it onto a conveyor belt. Dr. Saltzman ordered an MRI of the right shoulder. *Id.*

On November 11, 2011, Petitioner returned to the Clearing Clinic. (Px 3, p. 13). The notes indicate an MRI was ordered. Petitioner was kept on restricted duty and recommended to continue physical therapy. *Id.*

On November 18, 2011, Petitioner obtained the MRI of her right shoulder which demonstrated a "partial thickness tear of the distal supraspinatus tendon although extension to a full thickness tear cannot be adequately excluded. Irregularity and likely tear of the anterior/inferior labrum. Degenerative changes of the acromioclavicular joint." (Px 4, p. 28)

On December 1, 2011, Petitioner followed up with Dr. Saltzman to review the results of her MRI. (Px 4, p. 18) Dr. Saltzman administered a cortisone injection into Petitioner's right shoulder. Petitioner was kept off work for 4-6 weeks post injection. *Id.*

On January 12, 2012, Petitioner returned to Dr. Saltzman. (Px 4, pp. 24-25) Petitioner reported her injection helped her symptoms for about two weeks but her symptoms returned. Dr. Saltzman recommended a formal physical therapy program focusing on cuff strengthening and prescribed Diclofenac for pain. Dr. Saltzman opined that if Petitioner was still symptomatic in six weeks they should consider arthroscopic distal clavicle excision, subacromial decompression and rotator cuff debridement. *Id.* Petitioner began formal physical therapy at Accelerated Rehabilitation Centers on January 19, 2012. (Px 4, p. 26)

On February 16, 2012, Petitioner submitted to a Section 12 examination with Dr. Pietro Tonino at Loyola University Medical Center at Respondent's request. (Rx 1) In his report, Dr. Tonino opined Petitioner presented with a partial-thickness rotator cuff tear, a labral tear and acromioclavicular degenerative changes on the right shoulder. Dr. Tonino noted Petitioner's subjective complaints were in keeping with her objective findings and there was no evidence of symptom magnification. Dr. Tonino opined Petitioner's right shoulder condition was related to the injury she sustained at work on October 30, 2011. Dr. Tonino further opined that Petitioner was a candidate for right shoulder arthroscopy, possible labral repair and distal clavicle resection. The doctor added that she would not reach MMI until 4-6 months following surgery. *Id.*

On February 21, 2012, Petitioner returned to Dr. Saltzman for evaluation. (Px 4, pp. 33-34) The notes indicate Petitioner complained of weakness in her whole right arm and occasional numbness and tingling in both of her hands. Dr. Saltzman ordered a cervical spine MRI and noted Petitioner's symptoms of weakness and numbness were more consistent with a cervical problem that would need to be sorted out prior to her shoulder surgery. *Id.* The cervical MRI was completed on March 7, 2012 showing multilevel degenerative disc disease and facet arthropathy, with associated central spinal cord stenosis, neural foraminal narrowing. (Px 4, pp. 35-37)

On March 15, 2012, Petitioner presented to Dr. Saltzman. The doctor noted the cervical MRI showed moderate to severe bilateral foraminal narrowing at C5/6 and C6/7. Also noted were multiple degenerative changes. Dr. Saltzman opined that shoulder surgery would help Petitioner with her shoulder pain at the AC joint. He opined

that her weakness was more related to her neck than her shoulder. Dr. Saltzman recommended an evaluation by Dr. Wellington Hsu, a spine specialist, for Petitioner's complaints of weakness. (Px 4, p. 61)

On April 25, 2012, Petitioner presented to Dr. Wellington K. Hsu at Northwestern per referral by Dr. Saltzman. (Px 4, p. 70) Dr. Hsu noted Petitioner's primary complaints were bilateral posterior shoulder and neck pain. Dr. Hsu noted a history of work related injury six months prior when lifting a heavy piece of luggage. He further noted Petitioner developed neck pain about two weeks after the incident. She also reported occasional numbness and tingling in her fingertips following her work accident. Dr. Hsu examined Petitioner and reviewed her cervical MRI studies. Dr. Hsu's initial note indicate that he believed her symptoms were coming from the shoulder. The doctor recommended a cervical epidural steroid injection at C5-6 as a diagnostic and therapeutic injection. Dr. Hsu also recommended physical therapy for the cervical spine. (Px 4, p.p. 70-71) The Arbitrator notes that on July 30, 2012, Dr. Hsu amended his April 25th note indicating same was improperly dictated. The doctor provided that he believed Petitioner may either have pain from the shoulder or the neck itself. (Px 4, p. 70)

On May 9, 2012, Dr. Tonino conducted a record review and drafted a second report. (Rx 2) Dr. Tonino noted that cervical spine issues fell outside of his area of expertise and he could not comment on any connection with regard to the cervical spine. *Id.* Notwithstanding this opinion, Dr. Tonino noted he reviewed records from Dr. Hsu from April 25, 2012 and opined that Petitioner's "...condition is a shoulder condition and not a cervical condition, as indicated by Dr. Hsu." As noted above, Dr. Hsu's medical records indicated in an addendum created on July 30, 2012 that Petitioner's symptoms as of April 25, 2012 were coming either from the neck or the shoulder. (Px 4, p. 70) Dr. Tonino added "I do think that the type of injury she sustained, a traction-type injury to the right upper extremity, can sometimes cause pain which extends from the neck into the shoulder area, but the ultimate cause of these symptoms, I believe in this patient, are related to her shoulder." (Rx 2)

On June 19, 2012, Petitioner returned to Dr. Saltzman. The doctor noted Petitioner continued to have AC pain on the right side. Petitioner also reported spasms that start in her neck and radiated down both arms to both hands. Dr. Saltzman felt the spasms and radiating pain was probably more related from her neck. He didn't think the shoulder surgery would help with those symptoms. (Px 4, p. 110)

On June 27, 2012, Petitioner returned to Dr. Hsu and reported continuous neck pain. (Px 4, p. 124) Dr. Hsu noted Petitioner did not have any neck treatment since his initial visit. He also noted the physical therapy previously ordered had not been approved. Dr. Hsu again recommended physical therapy for cervical modalities to improve Petitioner's neck symptoms. (Px 4, p. 125)

On August 31, 2012, Petitioner submitted to a Section 12 examination with Dr. Babak Lami at the Illinois Spine Institute at Respondent's request. (Rx 3) Dr. Lami noted in his August 31, 2012 report that he based his opinions and impressions on his examination of Petitioner and his review of medical records. Dr. Lami indicated he reviewed medical records from the Clearing Clinic, Concentra, Northwestern and Accelerated. Dr. Lami specifically indicated he reviewed a November 29, 2011 note from MacNeal ER in which there were no cervical spine issues noted. Following physical exam, Dr. Lami noted Petitioner had right-sided axial neck pain as a part of her paraspinal muscles which believed was due to her shoulder dysfunction. Dr. Lami stated Petitioner required right shoulder surgery and opined the surgery was related to her work injury. Regarding the neck, Dr. Lami opined he did not appreciate any cervical spine issues and an epidural injection to the neck was not necessary as he felt Petitioner's neck pain was musculoskeletal. He also explained that Petitioner's reported mechanism of injury and initial records failed to show a cervical injury.. Dr. Lami recommended moving forward with right shoulder surgery and having post-operative physical therapy for the right shoulder and cervical paraspinal muscles at the same time. Lastly, Dr. Lami opined Petitioner could work with no lifting over 20 pounds and no overhead work. (Rx 3)

On October 9, 2012, Petitioner followed up with Dr. Saltzman for her right shoulder pain. Also noted was numbness, tingling and radicular symptoms which had improved with Gabapentin. Surgery was again recommended. The doctor further explained that the shoulder surgery would not help with any of the radicular symptoms or numbness and tingling. (Px 4, p.p. 141-142)

On November 9, 2012, Dr. Saltzman performed right shoulder surgery consisting of arthroscopic distal clavicle excision, arthroscopic debridement of partial thickness articular surface supraspinatus tear, proximal biceps mini open tenodesis and subacromial decompression with acromioplasty. The post-operative diagnosis was chronic biceps tendinitis, acromioclavicular arthritis and partial thickness rotator cuff tear. (Px 5)

On November 27, 2012, Petitioner followed up with Dr. Saltzman post-surgery. (Px 4, p. 156) Petitioner was advised to begin physical therapy and was kept off work for another 4 weeks. *Id.* Petitioner began physical therapy at Accelerated Rehabilitation Centers on December 11, 2012. (Px 6, p. 10)

On January 3, 2013, Dr. Saltzman advised Petitioner to continue physical therapy and kept her off work for another six weeks. (Px 4, p. 172) By January 14, 2013, Petitioner had attended 12 physical therapy appointments and noted she felt 45% improvement. (Px 6, p. 22) On January 18, 2013, Petitioner reported experiencing a locking sensation in her shoulders and neck. The therapist noted she has issues with her neck. (Px 4, p. 24) By February 13, 2013, Petitioner had attended 24 sessions and was recommended for additional physical therapy. (Px 6, pp. 46-49)

On February 14, 2013, Dr. Saltzman noted Petitioner's shoulder pain had largely improved and she was attending physical therapy three times per week. (Px 4, pp. 179-180) Dr. Saltzman recommended Petitioner complete her physical therapy and then progress to work conditioning with the goal of getting her back to work soon. Petitioner was to return in six weeks. *Id.*

By March 11, 2013, Petitioner had attended 33 physical therapy sessions for her shoulder. At that time it was recommended to transition to work conditioning. (Px 6, pp. 50-52)

On March 13, 2013, Petitioner began a work conditioning program at Accelerated Rehabilitation Centers. (Px 6, pp. 53-57). Petitioner testified she attended work conditioning every day for eight hours per day. She would lift and carry weights, push and pull various weights, screw in bolts and screws and place magnets on a board. Petitioner testified she would initially lift, carry, push and pull weights weighing about 10 pounds. As the work conditioning progressed, the weights increased up to 100 pounds. Towards the end of her work conditioning program, Petitioner was asked to walk around and carry weights weighing about 100 pounds.

By March 29, 2013, Petitioner had attended 9 work conditioning sessions at Accelerated and the functional progress note indicated she demonstrated the ability to perform 95.9% of the physical demands of a Customer Service Ramp Agent. (Px 6, pp. 88-91) It was noted at that time that Petitioner's goal of occasional two-hand floor to waist lifting up to 70 pounds was not met and her goal of occasional two-hand carrying up to 70 pounds was likewise not met. (Px 6, p. 89)

On April 1, 2013, Petitioner returned for her 10th work conditioning session and was discharged. Her 70 pound lifting and carrying goals remained unmet at the time of discharge. (Px 6, p.p. 95-96)

At trial, Petitioner testified that following her work conditioning session on April 1, 2013, she had increased tingling and numbness in her hands as well as increased stiffness in her neck. She also had swollen hands, felt burning in her fingers and could not touch anything without pain. Petitioner testified that work conditioning improved her right shoulder but caused increased pain in her neck and hands. Because of her increase in

symptoms, Petitioner complained to the physical therapist and was eventually sent to a doctor at a company clinic. Petitioner testified this doctor would not see her and told her to go and see her primary care doctor.

On April 1, 2013, Petitioner presented to her primary care doctor, Dr. Rachel L. Amdur, at Northwestern Medical Faculty Foundation. Petitioner's complaints were recorded as "after OT working with weights has tingling in fingers." (Px 4, p.p. 186) She returned to Dr. Amdur on April 4, 2013 with complaints of numbness and tingling in her fingertips bilaterally. Petitioner also reported noticing pain and burning of her neck on the right and finger swelling. Dr. Amdur noted Petitioner had an appointment with Dr. Saltzman that same day to address these complaints. (Px 4, pp. 213-214)

On April 4, 2013, Petitioner presented to Dr. Saltzman. (Px 4, p. 195) The note indicates Petitioner was in the process of completing work conditioning when she began having swelling, numbness and tingling in all of her digits in both hands as well as right neck pain and trapezial pain. The note further indicates Petitioner's shoulder felt much better. Dr. Saltzman recommended that Petitioner follow up with Dr. Hsu regarding her neck pain and numbness and tingling in her fingertips. Dr. Saltzman returned Petitioner to work from her shoulder standpoint with the limitation of no frequent power lifting or occasional power lifting and carrying. *Id.*

On April 8, 2013, Petitioner followed up with Dr. Hsu. (Px 4, p. 222) Petitioner reported that she was in the process of completing work conditioning for her right shoulder when she developed an increase in bilateral hand numbness, tingling and burning pains. Petitioner also noted occasional shooting burning pains localized to the medial aspect of her forearms bilaterally. Dr. Hsu ordered a new cervical spine MRI and kept Petitioner off work. *Id.*

Petitioner obtained a cervical spine MRI on April 11, 2013. (Px 8) The MRI report indicated that a direct comparison to Petitioner's March 7, 2012 MRI revealed progression of a disc herniation at C5-C6 as well as progression of the central canal stenosis at C5-C6. *Id.*

Petitioner returned to Dr. Hsu on April 15, 2013 for a post-MRI follow up. (Px 4, pp. 227-228) Petitioner complained of right-sided posterior neck pain as well as upper extremity numbness and tingling and burning pains. Petitioner reported that she did not have significant neck symptoms prior to her work-related injury while lifting luggage. Dr. Hsu noted Petitioner's cervical MRI demonstrated C5-C6 and C6-C7 disc herniations, left greater than right. Dr. Hsu opined Petitioner was a surgical candidate due to her physical exam, history and the fact that she failed conservative measures. Dr. Hsu recommended a C5-7 anterior cervical discectomy and fusion surgery. *Id.*

On May 22, 2013, Dr. Lami re-examined Petitioner at Respondent's request and drafted a second Section 12 report. (Rx 4) Dr. Lami noted that since his last examination Petitioner underwent right shoulder surgery followed by physical therapy and work conditioning and developed swelling in her fingers and sharp neck pain. Dr. Lami indicated his opinions were based on the review of medical records and listed all of the records he reviewed. Dr. Lami opined Petitioner's current symptoms of cervical radiculopathy were not documented in the medical records and opined that the medical documentation did not support a cervical spine injury. Dr. Lami noted in his report that when Dr. Hsu evaluated Petitioner in April 2012 he thought her symptoms were coming from her shoulder. Dr. Lami opined that Petitioner's cervical spine surgery was appropriate and acceptable but not related to the October 30, 2011 work injury. Dr. Lami indicated Petitioner required work restrictions of no lifting over 10 pounds and no overhead activities due to her cervical spine problems. *Id.*

On or about October 22, 2013, Dr. Hsu drafted a narrative report containing an outline of his treatment of Petitioner as well as his opinions regarding the cause of her cervical spine condition. Dr. Hsu noted that his opinions were based on the medical records as well as his own experience in treating Petitioner since April 25, 2012. Dr. Hsu opined that Petitioner's act of lifting a piece of luggage weighing approximately 50 pounds on

October 30, 2011 caused an aggravation of her pre-existing C5-6 and C6-7 spondylosis. (Px 1, p. 2). Dr. Hsu opined that this mechanism of injury was consistent with causing an aggravation that has led to the further development of symptoms over time. Dr. Hsu explained that the basis for his conclusion was that Petitioner's neck symptoms were sporadic and mild up to October 30, 2011, but following that date, her pain became much worse and required multiple modalities of conservative treatment. Dr. Hsu further opined that Petitioner's condition has since continued to progress and become worse to the point where her spinal cord requires decompression. Dr. Hsu opined that Petitioner would not necessarily have developed these symptoms but for the work-related injury. Dr. Hsu recommended surgery consisting of a C5-7 anterior cervical discectomy and fusion. (Px 1)

Petitioner testified she has not worked since the day of her injury, Sunday, October 30, 2011. Petitioner testified she has been kept on modified duty or off work status by her physicians at the Clearing Clinic and by Drs. Saltzman and Hsu at Northwestern Medical Faculty Foundation since her injury on October 30, 2011.

Petitioner testified she received $1,081.00 every two weeks from the workers' compensation carrier since her accident. The last time she received a check was on March 24, 2014, three days prior to trial.

Petitioner testified that workers' compensation never approved her cervical spine surgery recommended by Dr. Hsu. Petitioner testified that she has not been evaluated by Dr. Hsu since April of 2013 because she could not afford it and workers' compensation would not pay for it. Petitioner testified that she continues to experience tightness in her neck, numbness and tingling in her hands as well as her fingers. Petitioner testified she is currently taking medication for her neck prescribed by Dr. Hsu. Petitioner testified that if workers' compensation approved her cervical spine surgery, she would undergo that procedure. Petitioner further testified that she had not experienced any other incidents or accidents since October 30, 2011 that affected her right shoulder or neck or made it worse.

With respect to issue "F", whether Petitioners' current condition of ill-being regarding her right shoulder and cervical spine is causally related to the injury, the Arbitrator finds as follows:

After hearing the testimony of Petitioner and reviewing the exhibits submitted, the Arbitrator finds that Petitioner's current condition of ill-being with respect to her right shoulder and cervical spine is causally related to the injuries sustained on October 30, 2011.

Right Shoulder:

The Arbitrator finds that Petitioner's present condition of ill-being with respect to her right shoulder is causally related to the injury sustained on October 30, 2011. Causation in a workers' compensation case may be established by a chain of events showing prior good health, an accident and a subsequent injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96-97, 631 N.E.2d 724 (1994); *see also Darling v. Industrial Comm'n*, 176 Ill. App. 3d 186, 193, 530 N.E.2d 1135 (1988). In this case, the evidence shows Petitioner was not undergoing any active shoulder treatment before the accident and was able to work full duty as a Customer Service Agent prior to her injury. Moreover, Petitioner testified that she had not experienced any other incidents or accidents since October 30, 2011 that affected her right shoulder condition or made it worse. The Arbitrator finds that Petitioner's testimony was credible, and finds that the medical records from the Clearing Clinic, Dr. Saltzman, Dr. Amdur and Accelerated corroborate Petitioner's contention of causal relationship.

Moreover, the Arbitrator further relies on the opinion of Respondent's Section 12 examiner, Dr. Tonino. The doctor evaluated Petitioner on February 16, 2012 and opined that Petitioner's subjective complaints were in keeping with her objective findings and Petitioner's right shoulder condition was related to the injury she

sustained at work on October 30, 2011. Dr. Tonino also agreed with Petitioner's treating physician, Dr. Saltzman, and opined that Petitioner was a candidate for right shoulder arthroscopy, possible labral repair and distal clavicle resection.

Based on the opinions of Dr. Saltzman and Dr. Tonino, as well as Petitioner's credible testimony, the Arbitrator finds Petitioner's current condition of ill-being with respect to her right shoulder is causally related to her October 30, 2011 work accident.

Cervical Spine:

The Arbitrator additionally finds that Petitioner's present condition of ill-being with regard to her cervical spine is causally related to the injury sustained on October 30, 2011. Petitioner testified credibly that she did not have symptomatic neck pain or complaints at the time of her October 30, 2011 work accident and was not under any active treatment for her neck. This testimony is corroborated by the fact that Petitioner was able to work full duty as a Customer Service Agent prior to her injury.

Additionally, the Arbitrator puts greater weight on the opinions of Dr. Hsu than Dr. Lami. The Arbitrator notes that there are inconsistencies contained within Dr. Lami's reports. Dr. Lami provides that his opinions and impressions are based on his review of Petitioner's medical records. A review of the evidence shows Dr. Lami relies on medical evidence which was never presented in this case.

First, Dr. Lami notes in his August 31, 2012 report that he reviewed medical records from the Clearing Clinic, Concentra, Northwestern and Accelerated. A review of the records submitted demonstrates that Petitioner's medical records do not indicate she ever treated at Concentra for her October 30, 2011 injury. No medical records were introduced at trial from Concentra. Yet, Dr. Lami relies on these alleged Concentra records in forming his opinions. Similarly, Dr. Lami specifically indicates he reviewed a November 29, 2011 note from MacNeal ER in which there were no cervical spine issues noted. Again, the doctor provided he relied on a medical record that appears not to exist. Dr. Lami claims he reviewed notes from MacNeal indicating Petitioner had no complaints regarding her cervical spine when Petitioner's medical records do not indicate that she was ever treated at MacNeal on November 29, 2011.

The Arbitrator notes that Dr. Lami did not indicate he reviewed the November 7, 2011 physical therapy questionnaire in which Petitioner wrote that she had neck pain following her work injury. The Arbitrator assumes that Dr. Lami was not in possession of the full medical record at the time of his Section 12 exam. However, this questionnaire is significant as it demonstrates Petitioner was complaining of neck pain within a week after her work-related injury and is consistent with and corroborates Petitioner's testimony at trial. Dr. Lami did not or was unable to consider the entry in August 2012 when forming his opinions in this case and drafting his report.

Also of note is Dr. Lami's May 22, 2013 report. In May 2013, Dr. Lami opined Petitioner required cervical spine surgery, but the surgery was not work related because Petitioner's cervical spine injury and radiculopathy is not documented in the medical records and does not support a cervical spine injury. When stating this opinion, Dr. Lami again indicated in his report that his opinions were based on his review of medical records.
Unlike his previous report, Dr. Lami did indicate he reviewed the November 7, 2011 physical therapy note. However, Dr. Lami only summarized the note as it pertained to her right shoulder complaints. There is no reference that Petitioner actually wrote on the physical therapy questionnaire regarding her neck pain. Furthermore, Dr. Lami noted in his report that when Dr. Hsu evaluated Petitioner in April 2012 he thought her symptoms were coming from her shoulder. The doctor failed to mention Dr. Hsu's addendum of July 30, 2012, wherein Dr. Hsu amended his April 25th note indicating same was improperly dictated. Dr. Hsu provided that he

believed Petitioner may either have pain from the shoulder or the neck itself. As such, the Arbitrator is not persuaded by the Dr. Lami's causation opinion.

The Arbitrator relies on Dr. Hsu's treatment and opinions in this case. Dr. Hsu opined that Petitioner's lifting of a piece of luggage weighing approximately 50 pounds on October 30, 2011 caused an aggravation of her pre-existing C5-6 and C6-7 spondylosis. Dr. Hsu opined that this mechanism of injury was consistent with causing an aggravation that has led to the further development of symptoms over time. The medical records support Dr. Hsu's opinion. Petitioner complained of neck pain when asked to list the body parts she injured in her physical therapy questionnaire on November 7, 2011 – just seven days after her work accident. Additionally, Petitioner's complaints to Dr. Saltzman in February of 2012 regarding her neck and weakness in her whole right arm and occasional numbness and tingling in both of her hands were consistent with a neck injury. Finally, the progression of Petitioner's symptoms (which according to Dr. Hsu worsened to the point where Petitioner's spinal cord required decompression) is corroborated by medical records from Dr. Saltzman on April 4, 2013 and Petitioner's April 11, 2013 cervical spine MRI.

In conclusion, the Arbitrator finds that Petitioner met her burden of proof by a preponderance of the evidence that her condition of ill-being with respect to her right shoulder and cervical spine is causally related to her October 30, 2011 work accident.

With regard 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 as follows:

Petitioner alleges the following medical bills (Px 7) were outstanding at the time of arbitration:

MacNeal Hospital:	$894.55
Northwestern Medical Fac. Found.:	$733.00
Northwestern Memorial Hospital:	$8,908.39
AMIC Hyde Park Open MRI:	$3,581.00
Injured Workers Pharmacy:	$1,780.43
Total:	$15,897.37

Based on the Arbitrator's findings regarding causation, the Arbitrator finds that Petitioner's medical care was reasonable and necessary and finds Respondent liable for all of Petitioner's medical care and expenses as set forth above. Said bills are to be paid pursuant to the Illinois medical fee schedule.

With regard to issue "K", whether Petitioner is entitled to prospective medical care, the Arbitrator finds as follows:

Respondent's treating physician, Dr. Wellington Hsu, is recommending surgical repair for Petitioner's cervical spine consisting of C5-7 anterior cervical discectomy and fusion. Both Dr. Hsu and Respondent's Section 12 examiner, Dr. Lami, agree that surgery is reasonable and necessary to alleviate Petitioner's cervical spine symptoms. Petitioner testified she wishes to undergo the surgical procedure recommended by Dr. Hsu.

From the evidence presented, it is clear Respondent does not argue against the reasonableness and necessity of the recommended neck surgery, but rather, disputes liability on the basis of causal connection. Based on the Arbitrator's findings that Petitioner's cervical spine condition is causally related to her October 30, 2011 work accident, the Arbitrator adopts the opinion of Dr. Hsu that further treatment in the form of surgery is reasonable and necessary. Such treatment is considered to have been "incurred" as set forth in *Plantation Mfg. Co. v.*

Industrial Comm'n, 294 Ill. App. 3d 705, 691 N.E.2d 13 (1997). Respondent is therefore ordered to authorize and pay for Petitioner's prospective medical care, including the C5-7 anterior cervical discectomy and fusion, and related post-operative care and treatment.

With regard to issue "L", whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

Petitioner alleges 125-4/7 weeks of temporary total disability from October 31, 2011 through March 27, 2014.

Petitioner was placed on modified duty work status on October 31, 2011 by the physicians at the Clearing Clinic. (Px 3) Petitioner's physicians at Northwestern Medical Faculty Foundation have kept Petitioner off work since November 10, 2011. (Px 4) Dr. Saltzman, Petitioner's shoulder surgeon, kept Petitioner off work until April 4, 2013. On said date, Dr. Saltzman returned Petitioner to work from a shoulder standpoint only with the limitation of no frequent power lifting or occasional power lifting and carrying. (Px 4) Dr. Saltzman recommended Petitioner follow up with Dr. Hsu for her neck complaints. Dr. Hsu has kept Petitioner off work due to her cervical spine complaints pending her surgery. (Px 4) She remains off work as of the date of trial, March 27, 2014.

Based on the preponderance of the evidence, the Arbitrator finds that Petitioner's medical condition has not stabilized and she remains temporarily totally disabled due to her work-related injury. As such, the Arbitrator finds Petitioner was temporarily totally disabled from October 31, 2011 through March 27, 2014, the date of the hearing, for a period of 125-4/7 weeks.

Respondent has paid $67,562.50 in temporary total disability benefits and shall be given a credit for this amount.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Hegland,
Petitioner,

vs.

15IWCC0103

NO: 10 WC 13266

Federal Express,
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 arising in and out the course of employment, medical expenses, causal connection, prospective medical, temporary total disability, cervical injury and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 9, 2013, 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: FEB 5 - 2015
KWL/vf
O-2/2/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0103

HEGLAND, THOMAS
Employee/Petitioner

Case# **10WC013266**

FEDERAL EXPRESS
Employer/Respondent

On 4/9/2013, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4974 SHEA LAW GROUP
PATRICK M BROOKS
2400 N WESTERN AVE 2ND FL
CHICAGO, IL 60647

2912 HANSON & DONAHUE LLC
KURT HANSON
900 WARREN AVE SUITE 3
DOWNERS GROVE, IL 60515

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

- [ ] 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

15IWCC0103

Case # **10** WC **13266**

Consolidated cases: ____

Thomas Hegland
Employee/Petitioner

v.

Federal Express
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas J. Holland**, Arbitrator of the Commission, in the city of **Rockford**, on **March 19, 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. [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. [ ] 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 **1-6-10**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**34,195.72**; the average weekly wage was $**657.61**.

On the date of accident, Petitioner was **56** years of age, *married* with **2** dependent children.

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

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

Respondent shall be given a credit of $**54,174.96** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**54,174.96**.

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

ORDER

The Arbitrator finds that the Petitioner sustained a compensable accident at work on January 6, 2010, resulting in injuries to his lower back and right shoulder.

The Arbitrator finds that the Petitioner failed to prove a causal relationship between the accident of January 6, 2010 and his current condition of ill-being regarding his neck.

Respondent shall pay temporary total disability benefits of $438.41 per week for 75-3/7 weeks commencing January 14, 2010 to April 12, 2010 and May 5, 2010 to August 9, 2011, as provided in Section 8(b) of the Act. Additional claimed TTD benefits related to the unrelated neck condition are hereby denied.

Respondent shall be given a credit of $54,174.96 for previously paid TTD benefits, any future TTD benefits and any future PPD benefits.

Submitted medical expenses related to the unrelated neck condition are hereby denied.

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

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

Douglas J. Holland
Signature of Arbitrator

4-9-13
Date

APR 9 - 2013

The Petitioner was sent for an MRI of his shoulder, which revealed no new findings, and then was referred to Dr. Burnstine for additional consultation involving his neck. Dr. Burnstine recommended epidural injections for the cervical spine.

The Petitioner was ultimately sent for an MRI of his neck, and was then sent for an EMG study, which revealed a C5 radiculopathy, a change from the prior EMG. (Pet. Ex. 2) Thereafter, the Petitioner was referred to Dr. Jonathon Citow for further consultation.

Dr. Citow first examined the Petitioner on May 25, 2012, and after reviewing the diagnostic studies and performing an examination, recommended surgery in the form of a cervical fusion for the Petitioner. (Pet. Ex. 4) Dr. Citow suggested a causal relationship between the Petitioner's reported work accident and the neck condition, based on a history that the right arm radiating pain occurred with the accident. (Pet. Ex. 4)

The Petitioner was seen for an independent medical evaluation with Dr. Avi Bernstein on October 1, 2012. Dr. Bernstein felt the Petitioner's MRI scan revealed a neuroforaminol stenosis that may be responsible for the Petitioner's symptoms of a right C5 radiculopathy, but Dr. Bernstein felt that the scan revealed routine degenerative changes and the Petitioner should undergo a CT myelogram for a more definitive diagnosis. But Dr. Bernstein felt that any radiographic findings would not be the result of the Petitioner's reported work accident in 2010. (Res. Ex. 1)

After review of the Petitioner's updated EMG, Dr. Bernstein noted there were symptoms of a radiculopathy. (Res. Ex. 2) But on the issue of causation, he felt the current symptoms were unlikely to be related to the Petitioner's initial work accident. Dr. Bernstein noted that although the Petitioner had symptoms and features of a cervical radiculopathy early on, he recovered after a shoulder surgery and completed an FCE indicating that he was able to perform unrestricted activity. Dr. Bernstein noted that it was only in 2012 that the Petitioner had worsening symptoms and a positive EMG study, suggesting aggravation at a later date unrelated to his initial work incident. Dr. Bernstein concluded that the Petitioner's symptoms were likely the result of chronic degenerative change. (Res. Ex. 2)

The Petitioner ultimately underwent the recommended CT myelogram on December 21, 2012.

Upon further review, Dr. Citow did not change his recommendations for surgery.

Dr. Bernstein issued an addendum report following a review of the CT myelogram which he felt supported a diagnosis of a right-sided neuroforaminol stenosis consistent with a right C5 radiculopathy. But Dr. Bernstein continued to indicate that he does not believe there was a medical causation with the original accident, as his review of the casc medical records suggested that the Petitioner's condition of the right-sided radiculopathy after at a time removed from the Petitioner's reported work accident. (Res. Ex. 6)

The Petitioner was treated conservatively by Dr. Collins with physical therapy, and was ultimately allowed to return to work on April 10, 2011.

But the Petitioner's symptoms returned, and he was ultimately taken to surgery by Dr. Collins on May 14, 2010. Dr. Collins performed a arthroscopic rotator cuff repair to the right shoulder, with decompression/acromioplasty. Post-operative diagnosis was 80% partial thickness undersurface tear involving supraspinatous tendon. (Pet. Ex. 1)

The Petitioner still had complaints of tingling in the right hand post-operatively, and was sent for an EMG of his right upper extremity on June 11, 2010, which was interpreted as normal. No cervical radiculopathy was found. (Res. Ex. 4)

The Petitioner continued follow-up care with Dr. Collins, but testified that he was not improving after surgery. Dr. Collins' chart note of August 18, 2010, indicates that the Petitioner was improving, but had developed an adhesive capsulitis or frozen shoulder post-operatively. At that time, the Petitioner complained of intermittent numbness going down the arm, which was not present on the date of examination. (Pet. Ex. 1)

When next seen on September 22, 2010, by Dr. Collins, the Petitioner still complained of some intermittent tingling extending down the arm to the fingertips, indicating that some days he would have none, and other days it may bother him more. The Petitioner continued to have range of motion problems with the shoulder. (Pet. Ex. 1)

Due to the issue with the frozen shoulder, the Petitioner underwent a second procedure by Dr. Collins on January 10, 2011, which involved a manipulation of the shoulder due to the adhesive capsulitis. (Pet. Ex. 1)

The Petitioner testified that after the second procedure his symptoms were worse. But he received physical therapy and then went to a work conditioning program.

Dr. Collins ultimately recommended a functional capacity evaluation, which the Petitioner underwent on July 8, 2011. Following the evaluation, the FCE recommended the Petitioner be allowed to return to full-time work without restrictions. (Pet. Ex. 5)

The Petitioner testified that he was subsequently seen by Dr. Collins, who released him to return to full duty work but with a restriction of no lifting greater than 70 pounds. The Petitioner returned to work in a part-time courier position with the Respondent, which he testified involved less packages and packages that were smaller.

While working, the right shoulder pain continued, including tingling in the right upper extremity. On December 12, 2011, the Petitioner was experiencing extreme pain in the right upper extremity and went to the Condell Hospital Emergency Room. (Pet. Ex. 6)

FINDINGS OF FACT

The Petitioner is a 59 year old male who was employed as a handler for the Respondent since 1993. His job duties included loading trucks, sorting packages and helping out couriers. He would drive from building to building loading different trucks. The packages ranged in weight, with some packages being light, but up to a limit of 75 pounds.

The Petitioner testified that on January 6, 2010, he was working an unusually heavy day, loading trucks in three buildings. The Petitioner had to load a truck in 20 minutes and deliver it to the airport. The Petitioner testified that he was unhappy about the fact that he had to load a truck in such a short time frame without assistance and he complained about the assignment.

The Petitioner testified that while performing that task, he experienced pain in his back and right shoulder. The Petitioner was not able to identify a specific package that he was lifting or a specific activity he was performing when he first experienced the pain.

The Petitioner did not seek any emergency medical care on that date and did not report any accident.

The following day, the Petitioner reported the pain in his back and obtained medical treatment at Condell Immediate Care Center. The initial presenting complaint at Condell indicates "patient complains of lower back pain, patient states hurt back loading truck last night, patient now complains of generalized aches." (Res. Ex. 5) Under the physician's entry of chief complaint mechanism of injury, the history indicates loading a package (lifting) 22 hours prior. The Petitioner was diagnosed with back pain and muscle spasm, and instructed to return the following day.

The Petitioner completed an accident report on January 17, 2010, indicating a date of injury of January 6, 2010. When describing how the injury occurred, the Petitioner indicated that he was "loading a truck, gave me only ten minutes to load." (Res. Ex. 3) When asked when he first realized he was injured, the Petitioner responded "when I was driving truck to airport." The Petitioner listed injuries to his lower back and right shoulder, and indicated that he reported the accident the following day. (Res. Ex. 3)

The Petitioner testified that his low back pain resolved while receiving treatment at Condell over the next month, but that his right shoulder complaints increased.

The Petitioner then sought treatment with Dr. Roger Collins on February 3, 2010 at which time he was sent for an MRI of his right shoulder.

The Petitioner testified that it was about this time, 30 days from the date of accident, at which time he first experienced complaints of pain tingling in his right hand bilaterally. The Petitioner denied experiencing neck pain at that time.

At present, the Petitioner testified that he remains disabled from working and wishes to undergo the prescribed surgery by Dr. Citow. The Petitioner testified that he previously had group health insurance available through the Respondent to which he could have submitted the surgical cost when it was first recommended, but he chose not to do so. The Petitioner testified that he currently has group health insurance available through his wife, but that he had not submitted the proposed surgery for consideration through that coverage.

In support of the Arbitrator's decision relating to (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, the Arbitrator finds as follows:

On January 6, 2010, the Petitioner was performing his work activities as a handler loading packages into a truck. The Petitioner testified that it was an unusually heavy day and that he was required to complete a job task in a short period of time without assistance. While the Petitioner cannot identify a specific occurrence for the cause of injury to his right shoulder, low back and neck, he testified that he felt pain in his low back and right shoulder at or about that time.

The Petitioner reported the incident the following day and obtained medical treatment at Condell. When the Petitioner first reported for medical treatment the following day, he indicated that he had hurt his lower back the following day loading packages.

While the Petitioner is not able to identify a specific incident that led to his claimed injuries, the Arbitrator finds that the Petitioner complained of pain while completing a job task either during or shortly thereafter, which involved loading packages, and that his initial reporting of the incident was reasonably consistent.

As such, the Arbitrator finds that the Petitioner sustained an accident that arose out of and in the course of his employment by Respondent on January 6, 2010.

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 as follows:

The Petitioner testified that he initially felt pain in his low back, and somewhat in his right shoulder. When the Petitioner first obtained medical treatment the following day, his complaints mainly involved the low back, and there is a mention of right shoulder pain. The Petitioner testified at arbitration that initially his back pain was worse than the shoulder.

When the Petitioner completed the accident report on January 17, 2010, he only listed injured body parts as his lower back and right shoulder.

The Petitioner admitted at arbitration that he had no complaints of neck pain until later in the year of 2012 and that he had no complaints of tingling in his right upper extremity and fingertips until at least one month after his alleged injury.

The medical records of Advocate Condell Medical Center, which document the Petitioner's initial treatment from January 7, 2010 to February 7, 2010, detail an initial diagnosis of low back pain, changing to right shoulder pain with the low back pain resolving, but there are no documented complaints of any radiating pain in the right upper extremity or tingling in the fingertips, or neck pain.

The Arbitrator notes that there is no documented complaints of any tingling in the fingertips until the Petitioner was first seen by Dr. Collins on February 3, 2010.

Dr. Collins' treatment focused on the Petitioner's complaints of right shoulder pain, and he could not explain the complaints of pain involving the tingling in the fingertips. Dr. Collins performed surgery to the Petitioner's right shoulder on May 14, 2010, which revealed an 80% partial thickness undersurface tear of the supraspinatous tendon of the rotator cuff, clearly a basis for the Petitioner's right shoulder complaints.

After the surgery, the Petitioner obtained an EMG of his right upper extremity on June 10, 2010 which was interpreted as entirely normal.

The Petitioner continued treatment with Dr. Collins primarily for issues involving a lack of mobility with his right shoulder post-operatively, and the medical records of Dr. Collins reflect that while the Petitioner's complaints of tingling into his fingers continued, it was intermittently and sometimes not present.

After the Petitioner's second procedure to the right shoulder, involving a manipulation for adhesive capsulitis, the Petitioner was able to complete a functional capacity evaluation on July 8, 2011, which found that the Petitioner could return to unrestricted work in his former position. The Petitioner's testimony that his right shoulder pain did not improve after both surgeries is inconsistent with the medical documentation of Dr. Collins.

Thereafter, the Petitioner did return to work with the Respondent, albeit in a part-time position, which involved the same lifting requirements as his former position.

When the Petitioner had additional complaints involving tingling in his fingers in December of 2011, he was ultimately sent for a second EMG study in the Spring of 2012, which was interpreted as positive for a C5 radiculopathy, an objective change in the Petitioner's condition.

While the Petitioner's current treating physician, Dr. Citow, has issued an opinion indicating that he believes there is a causal connection between the Petitioner's original accident and his current recommendation for a cervical spine fusion, the Arbitrator notes that the doctor's opinion is predicated upon an inaccurate history that the Petitioner's

complaints of neck pain and tingling began at the time of the original accident, and continued unabated. It is clear from the records of Dr. Collins that the tingling in the fingers would wax and wane.

The Arbitrator relies upon the opinion of Dr. Bernstein, who found that there was no causal connection between the original alleged injury and the Petitioner's subsequent cervical spine condition, based upon the change in the EMG findings, the fact that the Petitioner appeared to recover from his shoulder surgery and was able to complete an FCE indicating that he could perform unrestricted activity, and the gap in time between the original accident and the Petitioner's subsequent complaints of tingling and later neck pain. Considering the Petitioner's age and the change in the diagnostic findings, the Arbitrator agrees with Dr. Bernstein that the condition may be the result of a chronic degenerative change versus an acute injury from January 6, 2010.

Most significantly, the Arbitrator finds that based upon the Petitioner's testimony and the treating medical records, the complaints involving the neck and fingertips did not occur until at least almost one month after the alleged accident. Based upon the lack of contemporaneous complaints involving the neck or fingertips at the time of the accident, a finding that the Petitioner's alleged accident either caused injury to the Petitioner's cervical spine or aggravated a pre-existing condition to the cervical spine is precluded.

Further, the Arbitrator finds it unlikely that the Petitioner sustained acute injuries to his neck, low back and shoulder on January 6, 2010 based upon the Petitioner's vague specifics regarding the original accident.

The Arbitrator finds that based upon the available evidence, the Petitioner's initial low back injury and subsequent right shoulder condition are causally related to his work accident of January 6, 2010.

In support of the Arbitrator's decision relating to (J) <u>Were the medical services that were provided to Petitioner reasonable and necessary?</u>, the Arbitrator finds as follows:

The Arbitrator finds that the medical bill submitted from Highland Park Hospital in the amount of $2,835, is related to current treatment related to the Petitioner's neck condition, and having herein found that there is no causal connection between the Petitioner's neck condition and his accident of January 6, 2010, this bill is hereby denied.

Further, the Petitioner seeks prospective medical care in the form of a cervical spine fusion as recommended by Dr. Citow for his neck condition. Having herein found that there is no causal connection between the Petitioner's cervical spine condition and his work accident of January 6, 2010, prospective medical care for the cervical spine condition is hereby denied.

In support of the Arbitrator's decision relating to (K) <u>What temporary benefits are in dispute?</u>, the Arbitrator finds as follows:

The Arbitrator awards TTD benefits relating to the Petitioner's injury for his low back and right shoulder, from a period of January 14, 2010 to April 12, 2010 and May 5, 2010 to August 9, 2011, totaling 75-3/7 weeks, or $49,602.60.

The Arbitrator finds that additional claimed TTD benefits after December 21, 2011 are related to the Petitioner's unrelated cervical spine condition, and hereby denied.

The Arbitrator notes the Respondent is entitled to a credit in the amount of $54,174.96 for previously paid TTD benefits.

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

NICK E. SULLIVAN,

Petitioner,

15IWCC0104

vs.

NO: 11 WC 046880

STATE OF ILLINOIS/MENARD CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of the nature and extent of Petitioner's permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator only to the extent that it reduces the benefits awarded under Section 8(e) of the Act. Petitioner had been found to have lost 17.5% loss of use of both his left arm and right arm following treatment for bilateral cubital tunnel syndrome. The Decision of the Arbitrator noted Petitioner continued to notice significant scar tissue pain that increases under certain circumstances as well as a dull throbbing pain in his elbows after performing excessive work or with any yard work. The Commission finds the infrequent occurrence of pain and the lack of treatment for said pain, when present, justifies its action.

Petitioner testified to noticing significant scar tissue pain but did not testify as to the frequency in which he experienced it. He only noted that resting his elbows in a chair in a certain way results in a very intense pain. He indicated this pain is not produced when he sits on a couch or a sofa. He claimed that "I don't do it all the time." This is interpreted as an indication that he does not sit in a chair all the time. In not sitting in a chair "all the time" would lessen the

frequency in which Petitioner would experience the claimed pain.

He also testified to experiencing, on occasion, a dull throb at the end of the day if he performs "excessive work or anything in the yard or anything to with the job a lot." Per Petitioner, the dull throb is not constant but occasional and appears to occur only with certain activities.

Petitioner acknowledged that he has returned to his usual occupation as a correctional officer and is working full duty. He also acknowledged that he is not taking an over-the-counter pain medication. His medical records reflect no current subscriptions for pain medication.

The Commission finds Petitioner successfully recovered from bilateral cubital tunnel treatment as evidence by his return to full duty and his lack of need for any pain medication. To the end, the Commission finds Petitioner sustained a 15% loss of use of his right arm, his dominant arm, and a 10% loss of use of his left arm.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $678.32 per week for a period of 37.35 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 15% loss of use of his right arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $678.32 per week for a period of 25.3 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 10% loss of use of his left arm.

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: FEB 5 - 2015
kwl/mav
O: 01/26/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0104

SULLIVAN, NICK E
Employee/Petitioner

Case# **11WC046880**

MENARD CORRECTIONAL CENTER
Employer/Respondent

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4852 FISHER KERHOVER & COFFEY
JASON E COFFEY
PO BOX 191
CHESTER, IL 62233

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JUN - 9 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0104

NICK E. SULLIVAN
Employee/Petitioner

Case # 11 WC 46880

v.

MENARD CORRECTIONAL CENTER
Employer/Respondent

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 **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Herrin**, on **April 3, 2014**. By stipulation, the parties agree:

On the date of accident, **October 31, 2011**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$58,788.08**, and the average weekly wage was **$1,130.54**.

At the time of injury, Petitioner was **32** years of age, ***single*** with **1** dependent child.

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

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

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

ORDER

Respondent shall pay Petitioner the sum of $678.32/week for a further period of 88.55 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the 17.5% loss of use to the right arm/elbow and the 17.5% loss of use of the left arm/elbow.

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

05/29/2014
Date

JUN 9 - 2014

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

NICK E. SULLIVAN
Employee/Petitioner

15IWCC0104

v.

Case # 11 WC 46880

MENARD CORRECTIONAL CENTER
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated that on October 31, 2011, Petitioner, Nick Sullivan, a 32 year old correctional officer, sustained injuries to both his right arm/elbow and left arm/elbow while working for Respondent, Menard Correctional Center. Respondent initially disputed the issue of accident at trial, but following the testimony of Petitioner, made an oral motion to amend the Request for Hearing Form (Arbitrator's Exhibit 1) indicating a stipulation that Petitioner suffered a work accident which manifested itself on October 31, 2011.

Petitioner underwent nerve conduction studies per Dr. Daniel Phillips on October 31, 2011, which demonstrated mild-moderate predominantly demyelinative bilateral ulnar neuropathies across the elbows. (Petitioner's Exhibit (PX) 1, p. 3). Following the nerve conduction studies, Petitioner was referred to Dr. David Brown, a hand surgeon. Dr. Brown first treated Petitioner for this issue on May 29, 2013, noting he previously treated Petitioner for bilateral carpal tunnel syndrome and released from him treatment in March 2010. Dr. Brown stated Petitioner began to develop a gradual onset of numbness and tingling along the ulnar aspect of both of his hands in his little finger, ring finger and occasionally the middle finger. (PX 2, p. 1). Dr. Brown felt Petitioner's new symptoms and physical examination findings were consistent with bilateral cubital tunnel syndrome and accordingly issued Petitioner elbow splints to wear at night and recommended he take a non-steroidal anti-inflammatory medication. (PX 2, p. 2).

Petitioner testified at trial to several job duties which he characterized as involving heavy gripping and grasping. The job duties included: bar rapping; repetitive turning of Folger-Adams keys; pulling/pushing on heavy cell doors; and cuffing and un-cuffing of inmates. Petitioner further testified he had no hobbies outside of his employment which were as hand-intensive as the job duties described.

Petitioner also testified about a prior work-related injury. Petitioner had made a previous workers' compensation claim for a repetitive trauma injury involving carpal tunnel syndrome. Petitioner stated the previous claim was resolved through settlement contracts, and Petitioner acknowledged the previous claim had nothing to do with his arms, and he received no monies for permanent partial disability to his arms in the prior settlement.

After a second nerve conduction study on August 5, 2013 showed deterioration of Petitioner' s condition as compared to the prior study of October 31, 2011, Dr. Brown recommended surgical intervention. (PX 2, p. 5). Dr. Brown performed a decompression of the ulnar nerve in the right cubital tunnel on December 13, 2013. (PX 2, p.

22). Dr. Brown also performed a decompression of the ulnar nerve in the left cubital tunnel on January 10, 2014. (PX 2, p. 28). Following these two surgical procedures, Petitioner remained off work at the recommendation of Dr. Brown and was paid temporary total disability (TTD) benefits by Respondent.

Petitioner underwent a course of physical therapy at the request of Dr. Brown at Apex Physical Therapy following both surgeries. (PX 3). Following the course of physical therapy, Dr. Brown released Petitioner to full duty with no restrictions on February 17, 2014. At his last visit with Dr. Brown, Petitioner noted swelling in his left elbow with overuse. (PX 2, p. 34). Petitioner was found to have good active range of motion of both elbows and Dr. Brown felt Petitioner had done very well and had no further specific recommendations. (PX 2, p. 34).

Petitioner testified that, since being released by Dr. Brown, he notices significant scar tissue pain, that if he sets his arm on a chair and hits a certain point he has very intense pain. However, he has also noticed the feeling coming back in his hands. Petitioner further testified when he performs excessive work or anything in his yard, he will feel a dull throbbing pain at the end of the day in his elbows.

CONCLUSIONS OF LAW

Petitioner's date of accident falls after September 1, 2011, and therefore Section 8.1b of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act") shall be discussed concerning the permanent partial disability (PPD) award being issued. It is noted when discussing the permanency award being issued that no PPD impairment report pursuant to Sections 8.1b(a) and 8.1b(b)(i) of the Act was offered into evidence by either party. This factor is thereby waived.

With regard to Section 8.1b(b)(ii) of the Act (Petitioner's occupation), Petitioner's is employed as a correctional officer. Petitioner's credible testimony indicated his job entails several repetitive duties involving his upper extremities. Further, Petitioner testified he feels a dull throbbing ache in his elbows with excessive work. Accordingly, the Arbitrator concludes that Petitioner's PPD will be larger based on this regard than an individual who performs lighter work, and therefore great weight is afforded this factor when determining the PPD award.

Regarding Section 8.1b(b)(iii) of the Act (Petitioner's age at the time of the injury), Petitioner was 32 years old at the time of manifestation of his repetitive trauma injuries. The Arbitrator considers Petitioner to be a younger individual and concludes that Petitioner's PPD will be more extensive than that of an older individual because he will have to live and work with the disability longer. Great weight is placed on this factor when determining the permanency award.

With respect to Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), there is no alleged future earning capacity issue in question, and no weight is therefore given in this regard.

Concerning Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), evidence of disability in Petitioner's treating medical records finds that Petitioner's bilateral cubital tunnel syndrome was treated surgically and has now healed. Dr. Brown noted swelling in Petitioner's left elbow with overuse. Petitioner testified he feels a dull throbbing pain in his elbows with excessive work. Great weight is placed on this factor when determining the PPD award.

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, applying Section 8.1b of the Act, Petitioner has sustained accidental injuries that caused the 17.5% loss of use of the right arm/elbow and the 17.5% loss of use to the left arm/elbow.

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

Robin Haynes,
Petitioner,

vs. NO: 13 WC 29626

15IWCC0105

Most Valuable Personnel,
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, current and prospective medical expenses and temporary total disability and being advised of the facts and law, with the exception noted below otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

If an employee refuses to submit him or herself to a medical examination in accordance with Section 12 of the Illinois Workers' Compensation Act, the Act allows for a temporary suspension of compensation payments until such an examination has taken place. In the above captioned claim, Respondent submitted evidence that on four separate occasions it properly requested Petitioner to submit herself to a Section 12 evaluation and it supplied the requisite expenses and notice related thereto. The first requested evaluation had been scheduled for December 23, 2013. It was not until March 27, 2014 that Petitioner actually attended the evaluation. As such the Commission finds that Petitioner's compensation payments should be suspended from December 23, 2013 through March 26, 2014. The Commission notes that while Respondent alleges it incurred a charge of $1,400.00 for Petitioner's failure to attend the evaluation, there is nothing in the Act that allows for a credit to be given to Respondent for the missed appointment and as such the Commission will not award the same.

IT IS THEREFORE ORDERED BY THE COMMISSION that with the exception noted above the Decision of the Arbitrator filed August 12, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's compensation payments shall be suspended from December 23, 2013 through March 26, 2014.

15IWCC0105

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 $18,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 6 - 2015

MB/jm

O: 1/22/15

43

Mario Basurto

David L. Gore

Stephen Mathis

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

HAYNES, ROBIN
Employee/Petitioner

Case# **13WC029626**

15IWCC0105

MOST VALUABLE PERSONNEL
Employer/Respondent

On 8/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4583 SOFFOETTO JOHNSON TEEGEN ET AL
DAVID J BAWCUM
74 E GRAND AVE PO BOX 86
FOX LAKE, IL 60020

4944 KOREY COTTER HEATHER RICHARDSON
NICHOLAS TATRO
20 S CLARK ST SUITE 500
CHICAGO, IL 60603

15IWCC0105

STATE OF ILLINOIS	)	☐ Injured Workers' Benefit Fund (§4(d))
	)SS.	☐ Rate Adjustment Fund (§8(g))
COUNTY OF Lake	)	☐ Second Injury Fund (§8(e)18)
		☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robin Haynes
Employee/Petitioner

Case # **13** WC **29626**

v.

Consolidated cases: ______

Most Valuable Personnel
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 Falcioni**, Arbitrator of the Commission, in the city of **Waukegan**, on **7/29/2014**. 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?

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

J. ☒ Were the 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 15IWCC0105

On the date of accident, **6/26/13** 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 **$1,151.23.00;** the average weekly wage was **$191.87.**

On the date of accident, Petitioner was **38** years of age, **Married** with **3** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $191.87 week for 52 5/7 weeks, commencing July 24, 2013, through July 29, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay all necessary, reasonable and related medical care, pursuant to the fee schedule, of $1,810.63, to Vista Corporate Health, $3,673.07, to Vista Medical Center East and $5,110.00, to American Center for Spine and Neurosurgery, as provided in Sections 8 (a) and 8.2 of the Act.

Respondent shall authorize and pay for prospective medical care, specifically the series of three epidural injections recommended by Dr. Citow, along with all related benefits.

Respondent shall pay to Petitioner penalties of **$0** as provided in Section 16 of the Act; **$0,** as provided in Section 19(k) of the Act; and **$0,** as provided in Section 19(l) of the Act.

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

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

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

Richard E. Dilm — Signature of Arbitrator

August 5, 2014 — Date

AUG 12 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robin Haynes	)	
Petitioner	)	
	)	
vs.	)	Case No.: 13 WC 29626
	)	
Most Valuable Personnel	)	
Respondent	)	

DECISION OF ARBITRATOR

FINDINGS OF FACT

On June 26, 2013, Petitioner, Robin Haynes ("Petitioner"), was employed by the Respondent, Most Valuable Personnel ("Respondent"), a staffing company with a branch office in Waukegan, Illinois, nearby where the Petitioner lived.

On such date, the Petitioner had been placed by the Respondent and was working at a factory in Pleasant Prairie, Wisconsin. Petitioner's duties there included working on an assembly line by placing aerosol cans and candles into boxes as they ran along the line. Petitioner testified that due to her lack of reliable transportation, each day she would walk from her home in Waukegan to Respondent's branch office, and from there would ride a bus that was provided by the Respondent from the Respondent's branch office in Waukegan to and from her factory job in Pleasant Prairie. Petitioner further testified that the Respondent was aware that she did not have reliable transportation from the time she began working for the Respondent.

Petitioner testified that on June 26, 2013, while performing her job on the assembly line, Petitioner, while attempting to catch a box that was falling off of the line, jerked and turned her body, causing her to feel immediate pain in her lower back . Petitioner immediately reported this accident to a male supervisor who provided Petitioner with a stool so that she could continue working. Petitioner testified that minutes later, she again had to jerk and turn her body to try and

catch another box that had fallen off of the line. This caused an increase in the pain whe was already experiencing and Petitioner again immediately reported this second incident to a supervisor and was then subsequently transported back to the Respondent's branch office in Waukegan where she was then taken to Vista Corporate Health Services at Vista East Hospital in Waukegan.

Petitioner's unrefuted testimony established that prior to these two incidents on that day, Petitioner had not had any prior problems or pain in her lower back, nor had she ever received or sought out any prior medical treatment or care for back pain or problems.

Upon presenting to Vista Corporate Health Services that same day, Petitioner was examined by a Dr. E. Estrella, M.D., to whom she reported pain to her right shoulder, the right side of her lower back and to her right leg. Petitioner was given light duty work restrictions and told to follow up on July 1, 2013. (Petitioner's Ex.#1).

Thereafter, Petitioner followed up at Vista Corporate Health Services for an additional five visits on July 1, 2013, July 8, 2013, July 15, 2013, July 22, 2013 and August 2, 2013. Petitioner continued to complain of low back pain/sciatica during each of those subsequent visits. During the course of these follow up visits, Petitioner's diagnosis was lumbar strain for which she was prescribed physical therapy and her light duty work restrictions were continued. At her last August 2, 2013, visit at Corporate Health Services, Petitioner was referred to Dr. Jonathan Citow, a board certified neurosurgeon, for further evaluation and treatment. (Petitioner's Ex. #1).

Pursuant to her physical therapy referral, Petitioner underwent physical therapy, also at Vista East Hospital, from July 23, 2013 through August 16, 2013, for a total of seven sessions. (Petitioner's Ex. #2). Petitioner's unrefuted testimony at trial established that such physical

therapy was authorized and approved by the Respondent. Petitioner reported to Vista that the PT actually made her feel worse.

Petitioner testified that on July 23, 2013, the Respondent instructed her that she was not to return to the Respondent's branch office in Waukegan to perform her light duty work. Petitioner further stated that she was instead instructed to report to Respondent's other branch office in Northbrook, Illinois. According to Don Vargas, this change was made due to Petitioner's bad attitude in performing the light duty tasks she was assigned, and was done to move her to a location with better supervision over her activities. According to Petitioner, since she began working for the Respondent, she lacked reliable transportation to and from her job at the Pleasant Prairie factory and that the Respondent was aware of this. Petitioner further testified that because she lacked reliable transportation, when she was offered the light duty position in Northbrook, she requested that the Respondent provide her transportation, otherwise she would not have a way to get to Northbrook. According to Petitioner, the Respondent refused to offer her transportation to Northbrook and have yet to offer her any other type of position which would accommodate her light duty restrictions.

At trial, Respondent's safety and risk manager, Dan Vargas, testified on Respondent's behalf. Mr. Vargas confirmed that Petitioner was sent home from her position at the Respondent's branch office in Waukegan because Petitioner was constantly talking on her phone and reading. He further testified that she was no longer allowed to work at the Waukegan branch office and that as a consequence, she was assigned to Respondent's other offices in either Northbrook or Prospect Heights. Mr. Vargas acknowledged that transportation was not made available to Petitioner by Respondent to either of these offices. He also stated that Petitioner's reassignment from the Waukegan branch office was for conduct unrelated to her work injury.

Pursuant to her referral from Corporate Health Services, Petitioner initially presented to Dr. Citow on September 25, 2013. Petitioner's unrefuted testimony at trial established that the delay between the August 2, 2013, referral and getting in to see Dr. Citow was due to waiting on the Respondent's authorization and approval of the visit. At that visit, Petitioner provided a history of the work accident on June 26, 2013, which resulted in back pain extending through both legs, right greater than left, to the calves with numbness, weakness and paresthesia. Examination demonstrated tenderness in the paraspinal musculature with range of motion limited secondary to pain and with a bilateral positive straight leg raise. Dr. Citow's assessment was lumbar spondylosis. Dr. Citow ordered Petitioner to undergo a lumbar MRI and provided her with light duty restrictions until further notice. (Petitioner's Ex. #3).

On October 7, 2013, Petitioner underwent an MRI of her lumbar spine at Dr. Citow's office. Impression from the radiologist, Dr. Louis Manquen, M.D., was: (1) disc herniation at L5-S1 with the disc extruding into the neural foramen bilaterally causing sever bilateral neural foraminal stenosis and mild bilateral neural foramen stenosis, (2) disc herniation at L4-L5 causing mild central stenosis and mild bilateral neural foramen stenosis, and (3) no compression fractures or spondylolisthesis. (Petitioner's Ex. #3).

Dr. Citow's assessment upon review of Petitioner's MRI was severe bilateral L5-S1 foraminal stenosis secondary to disc herniation for which he recommended Petitioner undergo an epidural steroid injection. (Petitioner's Ex. #3).

On November 4, 2013, Petitioner underwent an L5-S1 epidural injection performed by a Dr. Juan Alzate, M.D., at Dr. Citow's office. (Petitioner's Ex. #3).

Following the injection, Petitioner followed up with Dr. Citow on November 20, 2013, with continuing persistent pain extending through both legs towards the calves with numbness,

weakness and paraesthesias. She reported mild benefit from the epidural steroid injection. Following examination, Dr. Citow recommended she complete a series of three epidural injections and did not change her light duty work restrictions. (Petitioner's Ex. #3).

On March 27, 2014, Respondent had Petitioner undergo a Section 12 independent medical examination ("IME") of her lower back with a Dr. Alexander J. Ghanayem, M.D. In his IME report, Dr. Ghanayem states that Petitioner provided him a history that on June 26, 2013, she was boxing candles and aerosol cans when a display fell upon her causing her to be knocked down, landing on her knee and right arm. She also reported back pain as well. Dr. Ghanayem reported that during his examination of Petitioner, her lumbar spine revealed muscular discomfort to palpitation across the base. He notes that Waddell signs were equivocal. Dr. Ghanayem also reported that his review of Petitioner's MRI revealed: (1) degenerative changes at both L4-L5, (2) a broad disc ridge at the L5-S1 level that causes foraminal narrowing, but no central or lateral recess stenosis, and (3) no narrowing at the L4-L5 level. Dr. Ghanayem's impression was that Petitioner sustained a back sprain based on the mechanism of the injury and that the findings on her MRI scan are long standing in nature. He further testified that no additional medical care is warranted, that she is at MMI and that she may return to work at regular duty. (Respondent's Ex. #1)

Petitioner testified at trial that Dr. Ghanayem spent a total of 3-5 minutes performing his IME of her on March 27, 2014. She also denied telling him that the mechanism of her injury was simply from a box of candles and aerosol cans falling upon her; rather, as she testified at trial, her injury occurred while having to jerk and twist her body to catch the boxes that were falling off of the line.

As of the time of trial, Petitioner testified that Respondent has refused to authorize and approve the recommended series of three epidural injections recommended by Dr. Citow and that no other jobs or offers of employment, light duty or otherwise, had been offered to her by Respondent. She also testified that the bills stemming from her seven physical therapy sessions at Vista and her treatment with Dr. Citow, have not been paid to date, by Respondent. (Petitioner's Ex. #4).

CONCLUSIONS OF LAW

As it relates to issue (F), is Petitioner's current condition of ill-being causally related to her injury, the Arbitrator concludes as follows:

The Arbitrator finds that the Petitioner's present condition of ill-being, namely a lumbar disc herniation at L5-S1, is causally related to her June 26, 2013, accident at work.

The Arbitrator bases this decision on the Petitioner's credible testimony and consistent complaints, the temporal relationship between Petitioner's injury and the onset of the symptoms, Petitioner's lack of symptoms prior to June 26, 2013, and the opinions of board certified neurosurgeon Dr. Citow.

While the Arbitrator notes the findings and opinions of Dr. Ghanayem, the Arbitrator finds that the opinions of Dr. Citow were the most informed, reliable and credible. The Arbitrator also notes that Dr. Citow's opinion is bolstered and thereby validated by Dr. Louis Manquen, M.D., the radiologist who performed the October 7, 2013, MRI scan of Petitioner's lumbar spine, whose impression was also disc herniation at L5-S1 with severe stenosis.

Dr. Ghanayem's opinion that the findings on Petitioner's MRI scan are of long standing nature, even if taken at face value, do not relieve Respondent of liability in this case as

Petitioner's unrefuted testimony established that prior to this accident, Petitioner had not had any prior problems or pain in her lower back, nor had she ever received or sought out any prior medical treatment or care for back pain or problems and that since the date of accident herein she has had a continual chronology of L/S and radicular problems and treatment for same, thus leading to an almost inescapable conclusion that at the very least the accident as alleged herein made an already existent condition symptomatic, and therefore compensable.

Therefore, based upon the record as a whole, the Arbitrator finds that Petitioner's condition of ill-being at the time of trial as it related to her lumbar disc herniation at L5-S1, is causally related to her June 26, 2013, work accident.

As it relates to issue (J), were the medical services that were provided to Petitioner reasonable and necessary and has the Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator concludes as follows:

Having found for the Petitioner on the issue of causal connection, the Arbitrator finds that the treatment rendered to Petitioner has been reasonable and necessary in the treatment of her work related lumbar disc herniation at L5-S1. The Arbitrator bases these findings on the credible testimony of the Petitioner, taken together with the credible opinions and recommendations of Petitioner's treating physician, Dr. Citow.

Petitioner initially presented to and treated with Vista Corporate Health Services, the provider recommended, approved and paid for by the Respondent. Thereafter, as recommended and referred by Vista Corporate Health Services, Petitioner underwent seven physical therapy sessions at Vista East Hospital. Petitioner was then referred by Vista Corporate Health Services to Dr. Citow for treatment, who subsequently had Petitioner undergo an MRI and epidural

steroid injection. Petitioner's unrefuted testimony at trial established that all of the aforementioned treatment was first authorized and approved by the Respondent.

While Dr. Ghanayem does agree that a few months of physical therapy would be reasonable, he disagrees that any additional treatment would be warranted. For the reasons stated above in issue (F), the Arbitrator does not find such opinions of Dr. Ghanayem to be credible or persuasive on the issue of reasonableness and necessity of Petitioner's remaining medical treatment related to her low back injury.

Therefore, the Arbitrator orders that Respondent is required to pay for the reasonable and necessary medical treatment received by Petitioner. Specifically, the Arbitrator orders Respondent to pay $1,810.63, to Vista Corporate Health, $3,673.07, to Vista Medical Center East and $5,110.00, to American Center for Spine and Neurosurgery. The Respondent shall pay the aforementioned medical bills in accordance with the Act and the medical fee schedule. The Respondent shall be given credit for any amount it paid towards the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments.

As it relates to issue (K), is Petitioner entitled to any prospective medical care, the Arbitrator concludes as follows:

Having found for the Petitioner on the issue of causal connection, the Arbitrator finds that the Petitioner is entitled to prospective medical, namely, the series of three epidural injections recommended by Dr. Citow.

While the Arbitrator notes the findings and opinions of Dr. Ghanayem, the Arbitrator finds that the opinions of Dr. Citow were the most informed, reliable and credible. The Arbitrator also notes that Dr. Citow's opinion is bolstered and thereby validated by Dr. Louis Manquen,

M.D., the radiologist who performed the October 7, 2013, MRI scan of Petitioner's lumbar spine, whose impression was also disc herniation at L5-S1.

Therefore, in accordance with the Arbitrator's finding in issue (F) and in specific reliance on Dr. Citow's opinions, Respondent shall authorize and pay for Petitioner to undergo the series of three epidural injections recommended by Dr. Citow.

As it relates to issue (L), what temporary total disability benefits are in dispute, the Arbitrator concludes as follows:

Petitioner alleges entitlement to temporary total disability benefits ("TTD") from July 24, 2013, through July 29, 2014, the date of trial.

It is undisputed that on July 23, 2013, the Respondent instructed Petitioner that she was not to return to the Respondent's branch office in Waukegan to perform her light duty work. It is also undisputed that on such date, Petitioner was then instructed to report to another one of Respondent's other branch offices in either Northbrook, or according to Dan Vargas, Prospect Heights. The Arbitrator further finds that Petitioner testified credibly that Petitioner lacked reliable transportation to either of those locations and that Respondent was also unable to offer her transportation to those offices.

That despite Petitioner's own conduct being the cause of her relocation or reassignment from Respondent's branch office in Waukegan, Dan Vargas, Respondent's safety and risk manager, acknowledges that Petitioner's reassignment was unrelated to her work injury. Therefore, in accordance with our Supreme Court's decision in *Interstate Scaffolding, Inc., v. Ill. Workers' Comp. Comm'n.*, because Petitioner's medical condition has not stabilized and she has not reached maximum medical improvement, her discharge is irrelevant to whether she is

entitled to TTD benefits. *Interstate Scaffolding, Inc., v. Ill. Workers' Comp. Comm'n.*, 236 Ill. 2d 132 (2010).

In this case, Petitioner lacked reliable transportation to and from the Respondent's other branch office locations and the Respondent was unable to provide her with such transportation. Petitioner testified without contradiction that Respondent was well aware of this fact. Consequently, due to Petitioner's lack of reliable transportation, Respondent's reassignment of Petitioner to a distant location meant that Respondent was unable to offer Petitioner reasonable accommodations in light of her light duty work restrictions.

Based on the Arbitrator's above findings in issues (F) and (K), and the evidence presented, the Arbitrator finds that Petitioner is entitled to TTD from July 24, 2013, through the date of trial, July 29, 2014.

As it relates to issue (M), should penalties or fees be imposed upon Respondent, the Arbitrator concludes as follows:

The Arbitrator finds that the Respondent is not guilty of an unreasonable and vexatious delay in payment of TTD and medical benefits.

The Arbitrator finds that Respondent reliance on on Dr. Ghanayem's IME opinion(s) contained in his IME report to terminate benefits was not so unreasonable or vexatious as to warrant an award of penalties.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Grant Frederick,
Petitioner,

vs. NO: 11 WC 26799

15IWCC0106

Serv-All,
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, 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 April 22, 2014 is hereby affirmed and adopted.

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

DATED: FEB 6 - 2015

MB/mam
o:1/15/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FREDRICK, GRANT
Employee/Petitioner

Case# **11WC026799**

15IWCC0106

SERV-ALL
Employer/Respondent

On 4/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3078 GUMMERSON & RAUSCH LLC
NICHOLAS E ALEXANDER
101 S BENTON ST SUITE 201
WOODSTOCK, IL 60098

2912 HANSON & DONAHUE LLC
KURT HANSON
900 WARREN AVESUITE 3
DOWNERS GROVE, IL 60515

15IWCC0106

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

- [ ] 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

Grant Frederick
Employee/Petitioner

v.

Serv-All
Employer/Respondent

Case # **11** WC **26799**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **Waukegan**, on **February 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [ ] 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 [ ] 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 **4-1-11**, 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 $**17,682.60**; the average weekly wage was $**340.05**.

On the date of accident, Petitioner was **24** years of age, *single* with **0** dependent children.

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

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

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

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

ORDER

DENIAL OF BENEFITS

Because the Petitioner failed to prove an accidental occurrence, and a proper date of accident, based upon a lack of history of a work injury documented in the initial treating medical records, and contradictory testimony of Keith Feister and Dan Johnson, 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.

#01 George S Andros
Signature of Arbitrator

April 17th, 2014
Date

APR 2 2 2014

FINDINGS OF FACT 11 WC 26799

On April 1, 2011, Petitioner was a 24 year old male employed by the Respondent as a part-time driver. Petitioner's job duties involved driving and making deliveries, though the Petitioner testified that he was involved in occasional loading of delivery trucks with an order and also taking inventory within the warehouse.

The only loading that the Petitioner testified to was for a particular client which he would perform one to two times per week and the truck would require moving milk crates filled out with zinc die cast parts which would weigh up to 50 pounds. The milk crates would be moved a short distance from the pallet into the truck. Lifting and loading of the milk crates would be at chest level or below. The Petitioner testified that on April 1, 2011, while loading a milk crate, he felt a pain in his left shoulder. The Petitioner testified that he immediately reported the incident to his supervisor, Keith Fiester.

The Petitioner testified, inconsistently, that he sought treatment for his shoulder injury with Strelcheck Chiropractic following the accident, but also claimed that he did not seek treatment for the shoulder injury until first seen by Dr. Rolando Izquierdo on April 25, 2011.

The records from Strelcheck Chiropractic reveal that the Petitioner was treated for his left shoulder on April 4, 2011 and April 6, 2011, but that he did not inform that provider of a work injury. (Res. Ex. 3) In a Strelcheck Chiropractic Clinic note from April 4, 2011, reveals that the Petitioner reported that this past Friday, which would have been April 1, 2011, that his left shoulder started hurting and had become progressively worse. Chiropractor Peter Norton documented the Petitioner had new complaints and symptoms in his left shoulder. The Petitioner was seen again on April 6, 2011, complaining that he was doing worse since his last office visit. He was again diagnosed with an injury to his left shoulder. (Res. Ex. 3) A note from Strelcheck Chiropractic specifically indicates the Petitioner did not advise them of a work injury. (Res. Ex. 3) The Petitioner agreed that he continued working his normal full duty work activities with the Respondent through April 25, 2011.

Petitioner was seen by Dr. Izquierdo on April 25, 2011. Dr. Izquierdo had previously treated the Petitioner for a left shoulder condition, and had performed an arthroscopic surgery to the left shoulder in 2004. The Petitioner reported that he had no problems and had returned to normal activities. He complained that about two weeks ago he started having popping in his left shoulder and noticed some weakness, Dr. Izquierdo diagnosed a possible subscapularis tear of the left shoulder and recommended the Petitioner undergo an MRI arthrogram of the left shoulder. No history of a work injury is documented in the treatment records from that date. (Res. Ex. 4)The Petitioner testified that after seeing Dr. Izquierdo he reported to work and had a conference with his supervisor, Keith Fiester, regarding the reporting of the work accident. Dan Johnson, president of the Respondent, was also present for the meeting. Petitioner testified that he was not sure at that time on which date he had been injured, and that he and Mr. Fiester had a discussion concerning what the date of accident may have been.

The Petitioner testified at arbitration that he was certain the date was April 1, 2011. The Arbitrator notes the Petitioner's Application for Adjustment of Claim on file with the Commission indicates a date of accident of April 4, 2011.

Keith Fiester, a warehouse manager for the Respondent, and the Petitioner's immediate supervisor, testified that on April 21, 2011, the Petitioner advised that his left shoulder was hurting. Mr. Fiester indicated that Dan Johnson of the respondent was also present during that conference. Mr. Fiester inquired why the shoulder was hurting, and the Petitioner responded that he was not sure but advised that he had an old injury from his football days. Mr. Fiester testified that the Petitioner returned on April 25, 2011, advising him that he had seen a doctor about his shoulder, was then claiming he must have done it at work while lifting baskets.

Mr. Fiester completed an accident report documenting those conferences. (Res. Ex. 5)

Mr. Fiester further testified that prior to that time the Petitioner was working his regular work activities without complaint.Mr. Fiester indicated that all employees were instructed to immediately report any accident. If an accident was reported, the employee reporting the accident would be taken for medical treatment, if necessary, and an automatic drug test would be performed. At that point, Mr. Fiester does not have any dealings with the further administration of worker's compensation claims. In this case, the Petitioner was not directed for medical treatment, as he had already been seen by a doctor, and no drug test was performed.

Dan Johnson, president of the Respondent, was present during the April 21, 2011 conference with the Petitioner, when he reported that his left shoulder was hurting, as a result of an old football injury. Mr. Johnson later learned that the Petitioner was subsequently claiming that he was injured at work, and he had a follow-up conference with the Petitioner just after April 25, 2011, in which he questioned the Petitioner as to why he was now claiming he had hurt himself at work. Mr. Johnson testified the Petitioner could not provide him with any answer to that question and would not look him in the eye.

The Petitioner completed a Secura Insurance Workers' Compensation Employee's Report on May 1, 2011. On that date, the Petitioner indicated that the date and hour his trouble first started was approximately April 5, 2011. In that form, identified by the Petitioner at arbitration, he further indicated that he first saw a doctor for treatment on April 26, 2011. (Res. Ex. 6)

The Petitioner was seen by Dr. Izquierdo on May 2, 2011. The records from Crystal Lake Orthopedics contain a chart note from May 2, 2011, which documents that the Petitioner was seen on that date for a repeat evaluation of his left shoulder. Dr. Izquierdo reviewed the MRI arthrogram, and diagnosed a full thickness subscapularis tear of the left shoulder, and biceps instability of the left shoulder. He recommended arthroscopic repair. (Pet. Ex. 2, p. 14)

Dr. Izquierdo then authored a report, also dated May 2, 2011, which documents a claim that the Petitioner was seen for evaluation of his left shoulder following an acute injury that he suffered at work on April 5, 2011. The history indicates that the Petitioner was lifting 40 pound containers of zinc and felt a tearing sensation in his left shoulder. The Petitioner denied any problems with his left shoulder prior to that date. Dr. Izquierdo volunteered that the Petitioner's symptoms were directly related to an injury sustained while working Serv-All lifting 40 pound containers of zinc on April 5, 2011. (Pet. Ex. 2, p. 15)

The Petitioner was seen for an independent medical evaluation with Dr. William Heller on May 24, 2011. By history, the Petitioner reported that his left shoulder became painful on or about April 5, 2011. He admitted to a prior left shoulder arthroscopic surgical repair. The Petitioner reported that on April 5, 2011, while lifting 40 pound containers of zinc, that he felt a tearing sensation in his left shoulder. Dr. Heller reviewed the April 25, 2011 report of Dr. Izquierdo which did not contain a history of a work accident, and the reports from Strelcheck Chiropractic, which revealed no history of a work accident, and pain from April 1, 2011. Dr. Heller also reviewed the MRI arthrogram and the Petitioner's accident report. Dr. Heller diagnosed a scapularis rupture with retraction and biceps dislocation. Dr. Heller considered that there was no causation between the Petitioner's alleged accident and left shoulder condition, on the basis of the discrepancy with the histories of injury as well as the fact that the MRI arthrogram revealed findings that were not consistent with an acute injury, but rather a longstanding injury which would have predated April 1, 2011. (Res. Ex. 1)

The Petitioner continued working as a driver, without lifting, until he underwent surgical repair by Dr. Izquierdo on June 15, 2011. Dr. Izquierdo performed an open repair full thick subscapularis rotator cuff tear, an open biceps tenodesis and a left shoulder arthroscopic debridement of the glenohumeral joint. Post-operative diagnosis was left shoulder full thickness subscapularis tear, biceps instability, left shoulder and low grade partial articular sided tear of the supraspinatous tendon. (Pet. Ex. 2) Petitioner continued off-work until December 11, 2011, at which time he learned that his position with the Respondent had been filled.

Post-operatively, Dr. Izquierdo offered that the Petitioner's symptoms and subscapularis tear were from an acute injury, versus a chronic condition, and that all of the Petitioner's symptoms, and injuries, were directly related to the reported injury at the Respondent. (Pet. Ex. 2, p. 18)

Dr. Heller subsequently reviewed the operative report, and indicated that his opinions regarding causation were unaltered, due to the disparity in the history relating to the date of injury, as well as the pre-operative MRI appearance. (Res. Ex. 2)

Petitioner testified that he returned to Dr. Izquierdo for additional treatment with his left shoulder in February of 2012, and again in August of 2012, but that he has not been seen for any treatment for the left shoulder since that time. Petitioner complained at arbitration that the arm and shoulder were sore all the time, and that he had weakness in the left shoulder, with difficulty performing lifting tasks. The Petitioner was seen on September 13, 2012, at which time he reported that his left shoulder pain and discomfort had improved, and that he had no pain, no problems, no difficulties. Petitioner further reported "complete resolution of his symptoms." (Pet. Ex. 2, p. 99)

Petitioner testified that he had no problems with his left shoulder following his original surgery in 2004 and prior to April 1, 2011, although he admitted at arbitration that his left shoulder condition post-operatively prevented him from his goal of playing football in college.

CONCLUSIONS OF LAW

The Arbitrator adopts the above findings and material facts in support of the following conclusions of law:

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

While the Petitioner testified that he injured his left shoulder on April 1, 2011, lifting a basket with die cast parts, the initial treating medical records from Strelcheck Chiropractic and Dr. Izquierdo do not contain a history of a work accident, and based on the contradictory testimony of Keith Fiester and Dan Johnson, which is consistent with the initial course of medical treatment, the Arbitrator notes sufficient evidence by the totality of the evidence that the Petitioner did not sustain an accidental injury on April 1, 2011 arising out of and in the course of his employment by Respondent.

Further, the initial treating medical records do not document a work accident occurring on April 1, 2011, and since the Petitioner initially was not sure of the date of accident, claiming an accident occurring on or about April 5, 2011, coupled with the fact that the Petitioner's Application for Adjustment of Claim asserts a date of accident of April 4, 2011, the Arbitrator finds based upon the totality of the evidence that the Petitioner failed to prove an accident date of April 1, 2011.

In support of this determination, the Arbitrator notes that when the Petitioner was first seen at Strelcheck Chiropractic on April 4, 2011 and April 6, 2011, he failed to claim any work accident, reporting a progression of left shoulder pain.

Further, when the Petitioner was first seen by Dr. Izquierdo on April 25, 2011, he provided no history of a work accident occurring on April 1, 2011, but rather an approximate two week progressing left shoulder pain, which would date to April 11, 2011. It was not until the Petitioner was seen a second time by Dr. Izquierdo, that he provided any history of a work accident, and when he did so, he reported an accident date of April 5, 2011. The Arbitrator finds it noteworthy that Dr. Izquierdo's chart note of May 2, 2011 does not document a history of a work accident, but a letter provided to the Petitioner on that date with a history of a work accident occurring on April 5, 2011, which is not documented anywhere else previously in his chart.

Additionally, the Petitioner himself admits that he did not put in a worker's compensation claim until after he had been seen by Strelcheck Chiropractic and Dr. Izquierdo. The testimony of Keith Fiester and Dan Johnson is consistent with the Petitioner's actions in this case, i.e. report of a work accident after being seen by Dr. Izquierdo. Also, their testimony that the Petitioner reported that it may have resulted from a prior left shoulder injury is consistent with the fact that the Petitioner did indeed sustain a prior left shoulder injury which required surgical repair.

Finally, the Petitioner himself completed the Secura Workers' Compensation Report on May 1, 2011, and identified a claimed accident date of April 5, 2011.

The Arbitrator finds it noteworthy that the accident statement which was contemporaneously prepared by Mr. Fiester documents that no work injury was reported until April 25, 2011, after the Petitioner was seen by Dr. Izquierdo, and that before the Petitioner did not know how he was injured. Further, it is significant to note that prior to that time the Petitioner was working full duty apparently without complaint.

The facts reveal that the Petitioner first claimed a work accident AFTER he was seen by Strelcheck Chiropractic and Dr. Izquierdo, without providing notice of a work accident to either, and AFTER advising the Respondent he did not know how he was hurt (perhaps from an old football injury?), and AFTER he had continued to work full duty three weeks without medical disability or complaint.

For all of the foregoing reasons, and after careful consideration of all the evidence, the Arbitrator is persuaded by the absence of a description of the Petitioner's claimed accident in the contemporaneous initial treating medical records, as well as the issue as to what date any accident may have occurred.

Based upon the totality of evidence the Arbitrator finds and concludes as a matter of material fact and as a matter of law, that the Petitioner failed to prove by a preponderance of the evidence that he sustained an accident in the course and scope of his employment by Respondent on April 1, 2011, and failed to prove a preponderance of the evidence an accident date of April 1, 2011.

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?; K. What temporary benefits are in dispute? and L. What is the nature and extent of the injury?

Having herein found that he Petitioner failed to prove an accidental occurrence or proper date of accident, these issues are not reached.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darlene Barnes Annabi,
Petitioner,

vs. NO: 13 WC 15206
13 WC 15207

Clerk of the Circuit Court,
Respondent,

15IWCC0107

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, benefit rate, medical expenses, prospective medical expenses, non insurance under FEIN 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 30, 2013 is hereby affirmed and adopted.

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

DATED: FEB 6 - 2015

MB/mam
o:1/15/15
43

Mario Basurto

David L. Gore

Stephen Mathis

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

BARNES ANNAB, DARLENE
Employee/Petitioner

Case# **13WC015206**

13WC015207

15IWCC0107

CLERK OF THE CIRCUIT COURT
Employer/Respondent

On 10/30/2013, 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 0.08% 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:

BARNES ANNAB, DARLENE
7801 S CHAPPEL ST
APT 1
CHICAGO, IL 60649

0132 COOK COUNTY STATE'S ATTORNEY
ASA RICHARD CRUSOR
509 RICHARD J DALEY CENTER
CHICAGO, IL 60602

15IWCC0107

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)

Darlene Barnes Annabi
Employee/Petitioner

v.

Clerk of the Circuit Court
Employer/Respondent

Case # **13** WC **15206**

Consolidated cases: **13 WC 15207**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **09/27/2013**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [ ] Is Petitioner entitled to any prospective medical care?

L. X What temporary benefits are in dispute?
X TPD [ ] Maintenance X TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **06/07/2011**, 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. In light of this finding, the Arbitrator views the remaining disputed issues as moot.

In the year preceding the injury, Petitioner earned $**28,766.40**; the average weekly wage was $**553.20**.

On the date of accident, Petitioner was **38** years of age, *single* with **3** dependent children.

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

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

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to prove she sustained an accident on June 7, 2011 arising out of and in the course of her employment under a "mental-mental" analysis. The Arbitrator views the remaining disputed issues as moot. Compensation is denied.

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

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

Molly C. Mason
Signature of Arbitrator

10/30/13
Date

ICArbDec19(b)

OCT 3 0 2013

Darlene Barnes-Annabi v. Circuit Court of Cook County
13 WC 15206-7 (consolidated)

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner appeared pro se. Both of her claims are premised on a "mental-mental" theory of recovery. The claims were consolidated by agreement at the Section 19(b) hearing held on September 27, 2013.

Petitioner's first Application, numbered 13 WC 15206, alleges an incident of June 7, 2011 resulting in mental illness caused by discrimination and harassment. Arb Exh 2. The second Application, numbered 13 WC 15207, alleges an incident of January 18, 2012 and mental illness stemming from discrimination and a forced job transfer. Arb Exh 4.

Petitioner testified she was born on May 25, 1973. She began working for Respondent on a seasonal basis in May 2010. Her employment status changed to "permanent" two months later. As of 2010, she worked in Room 602 at the Daley Center as a Senior II data entry operator in Respondent's civil division. Her duties consisted of entering return dates and appearances.

Petitioner testified that, in December 2010, her "grade" classification changed. She was promoted to Grade 10 but continued to be paid at a Grade 9 rate. Petitioner offered into evidence payroll documents reflecting a budget grade of 10 but "actual pay" of 9. The Arbitrator sustained Respondent's hearsay objection to the admission of these documents.

Petitioner offered into evidence an interoffice memorandum from Hollis Healy, the chief deputy clerk of labor relations for Respondent, giving Petitioner a "verbal warning" following an investigation of an incident occurring on December 6, 2010 in which Petitioner allegedly photographed a co-worker without her permission. The memo reflects that the warning would become part of Petitioner's personnel file. PX 10. Respondent objected to PX 10 on the basis of hearsay and lack of foundation. The Arbitrator sustained these objections.

Petitioner testified her second Application is based on an involuntary transfer to Respondent's chancery division, where she was assigned to work in the vault, pulling files for members of the public and moving files.

Petitioner testified she asked Respondent for a personal leave of absence on June 7, 2011 because she was mentally exhausted due to the unfair treatment she was receiving. She completed FMLA paperwork on June 9, 2011. [She offered into evidence a letter approving an FMLA leave from June 9, 2011 through August 8, 2011. PX 11. Respondent objected to PX 11 on the basis of hearsay, relevancy and foundation. The Arbitrator sustained these objections.]

Petitioner testified she last worked for Respondent on June 13, 2011, at which point she was experiencing severe panic attacks.

She requested a meeting with Paula Weber and spoke with an assistant named Flores. Respondent's Employee Assistance Program referred her to Ricardo Lugo.

Petitioner testified she met with Betty Smith on June 8, 2011. Petitioner described Smith as a psychotherapist. Petitioner testified that, at this point, she was very anxious, could not sleep and was afraid of being fired or transferred. Petitioner offered into evidence as PX 18 certain questionnaires that Ms. Smith completed on her behalf in connection with a charge Petitioner filed with the Illinois Department of Human Rights. Respondent objected to PX 18 on the basis of lack of certification. The Arbitrator sustained this objection.

Smith's records (PX 18) reflect that she is a licensed clinical social worker. On January 26, 2012, Smith completed a questionnaire for the Illinois Department of Human Rights in connection with a charge Petitioner filed with that entity. Smith indicated she initially treated Petitioner between June 8, 2011 and September 20, 2011 for an adjustment disorder with mixed anxiety and depression. Smith indicated that Petitioner complained of insomnia, fatigue and an inability to focus. Smith stated that Petitioner experienced these symptoms "in reaction to conflictual and stressful workplace experiences." Smith did not describe these experiences. She indicated she restricted Petitioner from working from June 9, 2011 through August 31, 2011 due to her condition and symptoms. She also indicated that Petitioner's symptoms "diminished but never totally ceased." She stated that Petitioner resumed treatment on January 18, 2012.

On June 10, 2011, Petitioner wrote another letter to Richard Spencer (with copies to various other individuals) in which she summarized the work she had performed in the civil division and again expressed a desire to be cross-trained as a courtroom clerk.

Petitioner testified her claim for disability benefits was not approved. Her FMLA leave was due to expire on August 31, 2011. She contacted Katrick Scott in labor relations to discuss this. After her leave expired, she did not feel well enough to work and so applied for unemployment benefits.

On September 2, 2011, Petitioner came under the care of Eldin Dzudza, M.D. In a letter dated September 21, 2011, Dr. Dzudza indicated Petitioner had been "diagnosed with major depressive disorder, single, severe," for which she was taking Celexa and Klonopin. Dr. Dzudza indicated he had last evaluated Petitioner on September 16, 2011 and, in his professional opinion, believed Petitioner was able to return to work. Dr. Dzudza identified himself as a board certified psychiatrist. PX 15.

Petitioner testified that Respondent terminated her employment on May 1, 2012. She learned of the termination by letter.

Petitioner testified her illness has made it difficult for her to look for work. She continues to take medication prescribed by Dr. Dzudza. She takes Elavil for insomnia and

Seratline as needed. She has not returned to the doctor but has obtained prescription refills from him.

Under cross-examination, Petitioner identified RX 1 as a letter dated March 14, 2012 she received from Respondent's pension fund requesting she provide additional information in support of her previous claim for disability benefits. Attached to this letter is an "employer verification statement" reflecting that Petitioner applied for "ordinary" (i.e., non-work-related) disability benefits. Petitioner acknowledged that her signature appears on this statement, next to the date "7/7/11" but she objected to the admission of the statement on the basis that she did not complete the statement. The Arbitrator admitted RX 1 into evidence over Petitioner's objection. Petitioner acknowledged she received unemployment benefits from September 14, 2011 through December 23, 2011. She was involved with an entity called "Illinois Job Link" during this interval. She subsequently received a letter directing her to report to work in Respondent's chancery division on December 23, 2011. She returned to work and continued working until February 1, 2012. At some point in May of 2012, she resumed treatment through a trial study being performed at the University of Illinois. She testified she has been unable to return to work since February 1, 2012. Respondent terminated her for accumulating more than 200 points. Respondent did not terminate her due to job abandonment.

Darlene Barnes-Annabi
13 WC 15206-7 (consolidated)

Arbitrator's Conclusions of Law Relative to Both Cases

Did Petitioner establish a compensable "mental-mental" injury on June 7, 2011 and/or January 18, 2012?

In both of her claims, Petitioner seeks recovery for a psychological disability in the absence of physical injury. The claims thus fall into the "mental-mental" category.

Prior to the issuance of Pathfinder Co. v. Industrial Commission, 62 Ill.2d 556 (1976), mental disability was compensable under the Act only if it was precipitated by physical contact or injury. City of Springfield v. Industrial Commission, 291 Ill.App.3d 734 (1997). In Pathfinder, the claimant pulled a co-worker's severed hand out of a machine, fainted and subsequently developed psychological problems. The Commission found the claim compensable. In upholding the Commission's award, the Illinois Supreme Court established guidelines for the compensability of psychological disability absent physical trauma. The Court held that an employee who "suffers a sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained," 62 Ill.2d at 563.

In "mental-mental" cases, the claimant must be engaged in employment at the time and place of the precipitating cause of the injury and must prove that the injury occurred because of a work-related risk or because the employment placed the claimant at risk of exposure exceeding that of the general public. Baggett v. Industrial Commission, 201 Ill.2d 187, 195 (2002).

Petitioner, who appeared pro se, was afforded an opportunity to testify at length. Petitioner did not testify that she experienced an abrupt shock traceable to an event occurring on either or both of the dates alleged in her Applications. Rather, she testified she developed a disabling psychological condition as a result of various stresses experienced at the workplace. She described the following circumstances: 1) she was promoted from one pay grade to another but continued to be paid at the original grade; 2) against her will, she was transferred from a civil division clerk job to a file retrieval job within the vault at the chancery division; 3) Respondent imposed a 2% processing fee on employees, including her, whose wages were being garnished; 4) at one point, a Respondent employee responded to a garnishment-related inquiry by indicating that Respondent did not employ anyone named "Darlene Barnes"; and 5) she generally felt discriminated against in the workplace.

Petitioner offered a variety of documents, including medical records, into evidence in support of her claims. Respondent objected to a number of these documents based on hearsay, lack of foundation and/or lack of certification. The Arbitrator sustained Respondent's objections to a notification of a verbal warning (PX 10), E-mails in which Petitioner requested

cross-training for a courtroom position and uncertified records/questionnaire responses authored by a treating licensed social worker, Betty Smith. [The Arbitrator notes that Petitioner and Respondent's counsel appeared before her on several occasions prior to the hearing, with the need for record/bill certification being discussed on those occasions]. The Arbitrator notes that, even if she were to consider the rejected records from Dr. Smith, those records do not advance Petitioner's claims in that they reference only vague "workplace stresses" without further detail. Dr. Dzudza's letter of September 22, 2011 (to which Respondent did not object) does not link the stated diagnosis of "major depressive disorder, single, severe" to work or any event occurring in the workplace.

In short, even when evidence rejected at the hearing is given consideration, Petitioner failed to establish a sudden, severe "shock" traceable to a specific work-related incident. The Arbitrator finds that Petitioner failed to prove accident under a "mental-mental" theory of recovery in either of her two claims. The Arbitrator views the remaining disputed issues as moot. Compensation is denied in both 13 WC 15206 and 13 WC 15207.

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

BARNES ANNAB, DARLENE
Employee/Petitioner

Case# **13WC015207**

13WC015206

15IWCC0107

CLERK OF THE CIRCUIT COURT
Employer/Respondent

On 10/30/2013, 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 0.08% 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:

BARNES ANNAB, DARLENE
7801 S CHAPPEL ST
APT 1
CHICAGO, IL 60649

0132 COOK COUNTY STATE'S ATTORNEY
ASA RICHARD CRUSOR
509 RICHARD J DALEY CENTER
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Darlene Barnes Annabi
Employee/Petitioner

v.

Clerk of the Circuit Court
Employer/Respondent

Case # **13** WC **15207**

Consolidated cases: **13 WC 15206**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **09/27/2013**. 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. [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 X Maintenance XTTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **01/18/2012**, 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. In light of this finding, the Arbitrator views the remaining disputed issues as moot.

In the year preceding the injury, Petitioner earned $**28,766.40**; the average weekly wage was $**553.20**.

On the date of accident, Petitioner was **38** years of age, *single* with **3** dependent children.

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

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

ORDER

For the reasons set forth in the attached conclusions of law, the Arbitrator finds that Petitioner failed to prove she sustained an accident on January 18, 2012 arising out of and in the course of her employment under a "mental-mental" analysis. The Arbitrator views the remaining disputed issues as moot. Compensation is denied.

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

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

Molly L. Mason
Signature of Arbitrator

10/30/13
Date

ICArbDec19(b)

OCT 3 0 2013

Darlene Barnes-Annabi v. Circuit Court of Cook County
13 WC 15206-7 (consolidated)

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner appeared pro se. Both of her claims are premised on a "mental-mental" theory of recovery. The claims were consolidated by agreement at the Section 19(b) hearing held on September 27, 2013.

Petitioner's first Application, numbered 13 WC 15206, alleges an incident of June 7, 2011 resulting in mental illness caused by discrimination and harassment. Arb Exh 2. The second Application, numbered 13 WC 15207, alleges an incident of January 18, 2012 and mental illness stemming from discrimination and a forced job transfer. Arb Exh 4.

Petitioner testified she was born on May 25, 1973. She began working for Respondent on a seasonal basis in May 2010. Her employment status changed to "permanent" two months later. As of 2010, she worked in Room 602 at the Daley Center as a Senior II data entry operator in Respondent's civil division. Her duties consisted of entering return dates and appearances.

Petitioner testified that, in December 2010, her "grade" classification changed. She was promoted to Grade 10 but continued to be paid at a Grade 9 rate. Petitioner offered into evidence payroll documents reflecting a budget grade of 10 but "actual pay" of 9. The Arbitrator sustained Respondent's hearsay objection to the admission of these documents.

Petitioner offered into evidence an interoffice memorandum from Hollis Healy, the chief deputy clerk of labor relations for Respondent, giving Petitioner a "verbal warning" following an investigation of an incident occurring on December 6, 2010 in which Petitioner allegedly photographed a co-worker without her permission. The memo reflects that the warning would become part of Petitioner's personnel file. PX 10. Respondent objected to PX 10 on the basis of hearsay and lack of foundation. The Arbitrator sustained these objections.

Petitioner testified her second Application is based on an involuntary transfer to Respondent's chancery division, where she was assigned to work in the vault, pulling files for members of the public and moving files.

Petitioner testified she asked Respondent for a personal leave of absence on June 7, 2011 because she was mentally exhausted due to the unfair treatment she was receiving. She completed FMLA paperwork on June 9, 2011. [She offered into evidence a letter approving an FMLA leave from June 9, 2011 through August 8, 2011. PX 11. Respondent objected to PX 11 on the basis of hearsay, relevancy and foundation. The Arbitrator sustained these objections.]

Petitioner testified she last worked for Respondent on June 13, 2011, at which point she was experiencing severe panic attacks.

She requested a meeting with Paula Weber and spoke with an assistant named Flores. Respondent's Employee Assistance Program referred her to Ricardo Lugo.

Petitioner testified she met with Betty Smith on June 8, 2011. Petitioner described Smith as a psychotherapist. Petitioner testified that, at this point, she was very anxious, could not sleep and was afraid of being fired or transferred. Petitioner offered into evidence as PX 18 certain questionnaires that Ms. Smith completed on her behalf in connection with a charge Petitioner filed with the Illinois Department of Human Rights. Respondent objected to PX 18 on the basis of lack of certification. The Arbitrator sustained this objection.

Smith's records (PX 18) reflect that she is a licensed clinical social worker. On January 26, 2012, Smith completed a questionnaire for the Illinois Department of Human Rights in connection with a charge Petitioner filed with that entity. Smith indicated she initially treated Petitioner between June 8, 2011 and September 20, 2011 for an adjustment disorder with mixed anxiety and depression. Smith indicated that Petitioner complained of insomnia, fatigue and an inability to focus. Smith stated that Petitioner experienced these symptoms "in reaction to conflictual and stressful workplace experiences." Smith did not describe these experiences. She indicated she restricted Petitioner from working from June 9, 2011 through August 31, 2011 due to her condition and symptoms. She also indicated that Petitioner's symptoms "diminished but never totally ceased." She stated that Petitioner resumed treatment on January 18, 2012.

On June 10, 2011, Petitioner wrote another letter to Richard Spencer (with copies to various other individuals) in which she summarized the work she had performed in the civil division and again expressed a desire to be cross-trained as a courtroom clerk.

Petitioner testified her claim for disability benefits was not approved. Her FMLA leave was due to expire on August 31, 2011. She contacted Katrick Scott in labor relations to discuss this. After her leave expired, she did not feel well enough to work and so applied for unemployment benefits.

On September 2, 2011, Petitioner came under the care of Eldin Dzudza, M.D. In a letter dated September 21, 2011, Dr. Dzudza indicated Petitioner had been "diagnosed with major depressive disorder, single, severe," for which she was taking Celexa and Klonopin. Dr. Dzudza indicated he had last evaluated Petitioner on September 16, 2011 and, in his professional opinion, believed Petitioner was able to return to work. Dr. Dzudza identified himself as a board certified psychiatrist. PX 15.

Petitioner testified that Respondent terminated her employment on May 1, 2012. She learned of the termination by letter.

Petitioner testified her illness has made it difficult for her to look for work. She continues to take medication prescribed by Dr. Dzudza. She takes Elavil for insomnia and

Seratline as needed. She has not returned to the doctor but has obtained prescription refills from him.

Under cross-examination, Petitioner identified RX 1 as a letter dated March 14, 2012 she received from Respondent's pension fund requesting she provide additional information in support of her previous claim for disability benefits. Attached to this letter is an "employer verification statement" reflecting that Petitioner applied for "ordinary" (i.e., non-work-related) disability benefits. Petitioner acknowledged that her signature appears on this statement, next to the date "7/7/11" but she objected to the admission of the statement on the basis that she did not complete the statement. The Arbitrator admitted RX 1 into evidence over Petitioner's objection. Petitioner acknowledged she received unemployment benefits from September 14, 2011 through December 23, 2011. She was involved with an entity called "Illinois Job Link" during this interval. She subsequently received a letter directing her to report to work in Respondent's chancery division on December 23, 2011. She returned to work and continued working until February 1, 2012. At some point in May of 2012, she resumed treatment through a trial study being performed at the University of Illinois. She testified she has been unable to return to work since February 1, 2012. Respondent terminated her for accumulating more than 200 points. Respondent did not terminate her due to job abandonment.

Arbitrator's Conclusions of Law Relative to Both Cases

Did Petitioner establish a compensable "mental-mental" injury on June 7, 2011 and/or January 18, 2012?

In both of her claims, Petitioner seeks recovery for a psychological disability in the absence of physical injury. The claims thus fall into the "mental-mental" category.

Prior to the issuance of Pathfinder Co. v. Industrial Commission, 62 Ill.2d 556 (1976), mental disability was compensable under the Act only if it was precipitated by physical contact or injury. City of Springfield v. Industrial Commission, 291 Ill.App.3d 734 (1997). In Pathfinder, the claimant pulled a co-worker's severed hand out of a machine, fainted and subsequently developed psychological problems. The Commission found the claim compensable. In upholding the Commission's award, the Illinois Supreme Court established guidelines for the compensability of psychological disability absent physical trauma. The Court held that an employee who "suffers a sudden, severe emotional shock traceable to a definite time, place and cause which causes psychological injury or harm has suffered an accident within the meaning of the Act, though no physical trauma or injury was sustained," 62 Ill.2d at 563.

In "mental-mental" cases, the claimant must be engaged in employment at the time and place of the precipitating cause of the injury and must prove that the injury occurred because of a work-related risk or because the employment placed the claimant at risk of exposure exceeding that of the general public. Baggett v. Industrial Commission, 201 Ill.2d 187, 195 (2002).

Petitioner, who appeared pro se, was afforded an opportunity to testify at length. Petitioner did not testify that she experienced an abrupt shock traceable to an event occurring on either or both of the dates alleged in her Applications. Rather, she testified she developed a disabling psychological condition as a result of various stresses experienced at the workplace. She described the following circumstances: 1) she was promoted from one pay grade to another but continued to be paid at the original grade; 2) against her will, she was transferred from a civil division clerk job to a file retrieval job within the vault at the chancery division; 3) Respondent imposed a 2% processing fee on employees, including her, whose wages were being garnished; 4) at one point, a Respondent employee responded to a garnishment-related inquiry by indicating that Respondent did not employ anyone named "Darlene Barnes"; and 5) she generally felt discriminated against in the workplace.

Petitioner offered a variety of documents, including medical records, into evidence in support of her claims. Respondent objected to a number of these documents based on hearsay, lack of foundation and/or lack of certification. The Arbitrator sustained Respondent's objections to a notification of a verbal warning (PX 10), E-mails in which Petitioner requested

cross-training for a courtroom position and uncertified records/questionnaire responses authored by a treating licensed social worker, Betty Smith. [The Arbitrator notes that Petitioner and Respondent's counsel appeared before her on several occasions prior to the hearing, with the need for record/bill certification being discussed on those occasions]. The Arbitrator notes that, even if she were to consider the rejected records from Dr. Smith, those records do not advance Petitioner's claims in that they reference only vague "workplace stresses" without further detail. Dr. Dzudza's letter of September 22, 2011 (to which Respondent did not object) does not link the stated diagnosis of "major depressive disorder, single, severe" to work or any event occurring in the workplace.

In short, even when evidence rejected at the hearing is given consideration, Petitioner failed to establish a sudden, severe "shock" traceable to a specific work-related incident. The Arbitrator finds that Petitioner failed to prove accident under a "mental-mental" theory of recovery in either of her two claims. The Arbitrator views the remaining disputed issues as moot. Compensation is denied in both 13 WC 15206 and 13 WC 15207.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Rebecca Mills,
Petitioner,

vs. NO. 11 WC 38332

15IWCC0108

The H Group,
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 temporary total disability, medical expenses and prospective medical expenses and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on June 2, 2014 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.

15IWCC0108

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 9 - 2015

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

o-01/28/15
drd/wj
68

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

MILLS, REBECCA Case# **11WC038332**
Employee/Petitioner

12WC004946

THE H GROUP
Employer/Respondent

15IWCC0108

On 6/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

LAW OFFICE OF FOLEY & DENNY
TIM DENNY
PO BOX 685
ANNA, IL 62906

2593 GANAN & SHAPIRO PC
CASEY MATLOCK
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Rebecca Mills
Employee/Petitioner

v.

The H Group
Employer/Respondent

Case # **11** WC **38332**

Consolidated cases: **12 WC 004946**

15IWCC0108

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon, Illinois**, on **April 8, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

15IWCC0108

FINDINGS

On the date of accident, **02/02/2011 & 02/08/2011**, 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 $**8,877.35**; the average weekly wage was $**1116.07**.

On the date of accident, Petitioner was **45** years of age, ***married*** with **1** dependent children.

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

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

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

ORDER

Respondent shall pay petitioner temporary total disability benefits of $744.04 per week for a period 5 4/7 weeks from February 28, 2014 to the present.

Respondent shall pay causally related medical bills contained in Petitioner's exhibit 9 pursuant to sections 8(a) and 8.2 of the Act as the treatment rendered to the petitioner has been reasonable and necessary and causally related to the work accident. Respondent shall also authorize and pay for prospective medical treatment recommended by Dr. Davis and Dr. Brown.

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

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

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

Carl Dee
Signature of Arbitrator

6/2/14
Date

ICArbDec19(b)

JUN - 2 2014

FINDING OF FACT:

FINDING OF FACT:

The Petitioner filed two applications for adjustment of claim which were admitted into evidence as Arbitrator's Exhibit 2. The Petitioner was injured in the course of her employment in separate accidents wherein she fell on ice in the Respondent's parking lot on February 2, 2011 and on February 8, 2011. Accident was not disputed at Arbitration.

The Petitioner began working for the Respondent in January of 2011 as a Crises Clinician. She takes calls at hospitals, schools, jails, and detention centers when they had a client who needed an assessment for a treatment plan.

The Petitioner was first referred to Dr. Austin at Work Care by the Respondent. Initially her main concern was her shoulders and her neck because she had a prior disc replacement and thoracic outlet syndrome surgery. Dr. Austin recommended physical therapy, but the problems with her knee persisted. She discussed these issues with her supervisor Harold Jones, but delayed in following up with additional medical treatment. When the problem with her knee did not resolve she sought treatment with Dr. Davis.

The Petitioner underwent additional physical therapy and injections. The injections and the physical therapy did not resolve the problem and Dr. Davis discussed surgery. She was referred to Dr. Brown because Dr. Davis is out on medical leave. Dr. Brown performed surgery on February 28, 2014.

The post-operative physical therapy is going slow and painful, but she is making improvements. Her range of motion is improving and she can now sit without pain shooting through her knee, and she was able to do steps this week which she has not been able to do for several years. The Petitioner was also

very clear that prior to the falls on the ice in the Respondent parking lot in February of 2011, she did not have any problems or receive treatment for her knee.

When cross examined regarding the history in Dr. Davis' records about her bicycle riding, the Petitioner testified that she and her husband bought bicycles, but she only rode on one occasion in the summer of 2011 due to the pain in her knee. When asked about the rural health medical record of June 7, 2011 indicating she had popping in her knee in recent weeks, the Petitioner stated she was undergoing more training with the Respondent and taking on more cases, and the additional work load was aggravating her knee condition.

Medical records from Dr. Austin at Work Care were offered into evidence as Petitioner's Exhibit 1. The Petitioner was first examined on February 9, 2011 where she reported falling in a parking lot at work. The history states that last week she was bruised on the butt and knee with muscle spasms in the right arm. Dr. Austin's diagnosis also confirmed that the Petitioner's main concern was with her neck and upper back/shoulder area as she did have signs and symptoms of cervical radiculopathy. The physical therapy notes state February 9, 2011 also include a history of hitting her right knee. Dr. Austin discharged the Petitioner from care indicating she continues with over the counter medication as well as her Lidoderm patches and Tramadol.

Dr. Austin's records resume on October 20, 2011 with a diagnosis of follow-up on right knee injury, still painful and cannot rule out retro patellar internal joint derangement. The Petitioner continued under Dr. Austin's care for treatment of her right knee condition through December 5, 2011 wherein she was referred to "ortho."

Medical records from InMed Diagnostics were also admitted into evidence as Petitioner's Exhibit 3 and contain the MRI report stating there is joint effusion present and degenerative changes without definitive ligament changes. Medical records from Rural Health of Anna were admitted into evidence as Petitioner's Exhibit 4. The patient reported that her right knee has been popping in the recent three weeks and she denied any significant injury or similar popping before. She was referred to the Davis Orthopedic Group.

Medical records from the Southern Illinois Orthopedic Center were offered into evidence as Petitioner's Exhibit 5. The patient intake form from the Southern Illinois Orthopedic Center indicates complaints of right knee and lower back pain that began in February of 2011 and began to worsen in March, as a result of a fall on ice at work.

Dr. Davis made an initial assessment of patella femoral arthrosis and apparently stable OCD lesion on the lateral aspect of the medial femoral condyle. Dr. Davis recommended continued conservative measures and discussed arthroscopy in light of no obvious structural deformity on the scans. On January 25, 2012, Dr. Davis recommended viscosupplmentation injections combined with protective body mechanics, exercises, and physical therapy.

On June 4, 2012, Dr. Davis notes injections did well initially but are starting to wear off. On June 28, 2012, Dr. Davis discussed the limited benefit of predicted relief from surgery due to the lack of obvious mechanical source of pain. Dr. Davis also noted she has exhausted conservative measures and does not feel she can live with this condition. On August 20, 2012, Dr. Davis stated it is his opinion beyond a reasonable degree of medical certainty that her work injury has led to this position requiring surgery and that the surgery is reasonable and necessary to alleviate her symptoms and give her the best possible

chance of improvement. The medical records dated February 13, 2014 indicate that the patient was referred to Dr. Brown by Dr. J.T. Davis.

The operative note of February 28, 2014 indicates right knee osteochrondolesion of the patella femoral joint and mild tracking patella. Dr. Brown performed an arthroscopic lateral release as well as arthroscopic debridement of chondromalacia of the patella tracheal and medial femoral condyle. He performed a lateral release and indicated they removed the joint, evacuated all of the fluid and manipulated the patella to help invert it and further decompress the patella femoral joint.

On March 13, 2014 and Dr. Brown recommended a patella tracking brace and physical therapy.

The Evidence Deposition of Dr. J.T. Davis was offered into evidence as Petitioner's Exhibit 8. Dr. Davis is a Board Certified Orthopedic Surgeon. (PE 8, p.4). Dr. Davis noted that on January 25th the patient continued to have persistent knee pain and a feeling as if her kneecap were sliding around. (PE 8, p.6). Dr. Davis recommended viscosupplemental lubricating injections and began three sessions at the end of April. (PE 8, p.6). The injections contain a lubricating substance found naturally in the joints called hyaluronic acid which simply lubricates the joint in a rough area so the joint may slide easier. (PE 8, p.7). After the injections, Dr. Davis saw her again on June 4, 2012 and injections were starting to wear off he recommended additional physical therapy. (PE 8, p.7). By June 28, 2012 the Patient had undergone extensive conservative management consisting of over a year and a half of symptoms and he discussed diagnostic arthroscopy with chondroplasty and evaluation of the osterochondro lesion in the knee.

Dr. Davis testified that with respect to the arthritis he did not feel the injury caused her arthritis but likely exacerbated the complaints of pain that she has. (PE 8, p.9). With the osteochondro lesion there is really no clear way to decide with an MRI scan prior to injury whether this was caused or just aggravated by the underlying condition. (PE 8, p.9). Dr. Davis testified that when you talk about symptomatic arthritis or arthritis without pain or swelling the trauma can stir both and create inflammatory mediators to accumulate fluid in the joint which can in turn cause pain. (PE 8, p. 9-10). Dr. Davis testified that the surgery he has recommended would be the next treatment to make her knee better and it is related to the exacerbation and her condition from her work injury. (PE 8, p.11).

Dr. Davis further stated that you would need more information before you can decide any relevance with regard to the cycling relative to the injury. (RE 8, p.19). Dr. Davis further refused to alter his opinion based on hypotheticals and indicated he would need the specific information regarding the alleged cycling to alter his causal connection opinion. (PE 8, p. 21). When further questioned regarding the mechanism of injury, Dr. Davis stated a fall in and of itself, whether it is a twist or a direct blow can exacerbate these underlying conditions. (PE 8, p.25). Dr. Davis also indicated that he believes cycling is a reasonable therapy protocol and it is a low resistance spin and good way to keep a joint mobile. (PE 8, p.26).

Medical bills were offered into evidence as Petitioner's Exhibit 9.

Petitioner's Exhibit 10 consists of accident reports dated February 2, 2011 and February 8, 2011. The description of the February 2, 2011 accident report indicates that she was walking from her car towards the gate facing the right side when she stepped in snow and the ice underneath causing her feet to slip from underneath her, she hit her right knee and bounced onto her left hip and left three fingers. She

reported her knee and hip were hurting and she had a horrible bruise on her hip and knee. "Knee was purple." The accident report from February 8, 2011 indicates that the Petitioner got out of her car and went to the passenger side and when she shut the door fell on her right knee onto the ground and twisted her upper body. Photographs offered as Petitioner's Exhibits 10 and 11 reveal picture of the parking lot that have water pooling in areas.

The Respondent offered the Evidence Deposition of Dr. Richard Lehman as Respondent's Exhibit 1. Dr. Lehman is a Board Certified Orthopedic Surgeon who performed an Independent Medical Examination of the Petitioner on July 24, 2012. (RE 1, p.5). Dr. Lehman did not believe the degenerative arthritis or the breakdown of her kneecap in the right knee was traumatically induced. (RE 1, p.11). Dr. Lehman believed the Petitioner suffered a contusion of the right knee. (RE 1, p.12). Dr. Lehman did not believe that an arthroscopic procedure was the best way to treat the Petitioner's knee condition. (RE 1, p.14). The time he spends with IME patient is fifteen to twenty minutes.

By history Dr. Lehman agreed that there was a work accident that caused bruising of the Petitioner's knee. (RE 1, p.34). Dr. Lehman also confirmed he had not been provided any medical records or evidence of medical records that predate the February 1, 2011 injury pertaining to the right knee. (RE 1, p.34). Dr. Lehman has essentially diagnosed the Petitioner with a degenerative condition. (RE 1, p.35). Dr. Lehman also agreed that degenerative conditions can be caused and become symptomatic due to a traumatic event. (RE 1, p.35). Dr. Lehman also confirmed that he has diagnosed essentially similar degenerative conditions on examination in both knees but the left knee was not symptomatic at the time of his exam. (RE 1, p.37). When asked for an explanation as to why the right knee would coincidentally become symptomatic shortly after the traumatic incident, Dr. Lehman stated that there is a real question

whether it became symptomatic after the accident and when that was because there is a number of history given in the records. (RE1, p.37). Dr. Lehman also noted that she is likely to have pain at some point in her left knee due to the degenerative arthritis. (RE 1, p.37). When asked to distinguish his opinion from that of Dr. Bowen's opinion regarding the Petitioner's MMI status, Dr. Lehman simply responded he does not agree with Dr. Bowen. (RE 1, p. 40). Dr. Lehman further explained that treatment for the degenerative arthritis would not be unreasonable. (RE 1, p.41). When asked whether it would be his recommendation that Ms. Mills simply live with the pain rather to proceed with surgery, Dr. Lehman stated that he does not believe she should live with the pain and she should treat the pain in the most effective way she can which could include injections, anti-inflammatories, braces, but he did not agree with surgery as it would likely be a short term benefit. (RE 1, p.41).

The Evidence Deposition of Dr. Jimmy Bowen was offered into evidence as Respondent's Exhibit 2. Dr. Bowen is Board Certified in Physical Medicine and Rehabilitation. (RE 2, p.7). Dr. Bowen performed an IME of the Petitioner on September 14, 2011. (RE 2, p.10). Dr. Bowen opined that he did not believe the Petitioner was at maximum medial improvement and the mechanism report injury was consistent with the problems she had and recommended physical therapy. (RE 2, p.16). Dr. Bowen subsequently authored a supplemental report after review of additional records and the IME from Dr. Lehman. (RE 2, p.17). Dr. Bowen testified that he changed his causation opinion in the subsequent report due to the date of the injuries and her complaints are inconsistent with the pain. (RE 2, p.30).

On cross examination Dr. Bowen agreed that the Petitioner had a prior history with back and neck surgeries and that would cause him as an examining physician some concern with regards to the type of fall reported. (RE 2, p.33). Dr. Bowen also agreed that it would be a cause for his primary concern as he asks the patient to prioritize what they think is bothering them most and if it was the neck he would

certainly emphasize that. (RE 2, p.33). Dr. Bowen also confirmed that the crepitus reported after the fall was a new symptom for the Petitioner and he has not reviewed any records that would contradict that account. (RE 2, p.33).

Dr. Bowen confirmed his impression of a trendelenburg gait which is essentially a compensatory gait which is consistent with a hip injury if the Petitioner landed on it. (RE 2, p.35). Dr. Bowen also confirmed that it is a kinetic chain and it could affect everything from the ground up. (RE 2, p.36). When asked whether it was possible if that type of altered gait could affect someone's knee, Dr. Bowen indicated it does, and . . . altered gait could cause the knee to start hurting at a later date than immediately after the accident. (RE 2, p.36). When asked if it was his opinion that the work accident at least made the symptoms of the Petitioner's pre-existing condition worse, Dr. Bowen confirmed that he said it was an aggravation of her pre-existing condition, but he did not relate it necessarily to the work injury as he said the prevailing cause is the pre-existing condition. (RE 2, p.39). Dr. Bowen indicated it just means it is less than 50% and it could be 0 to 49%. (RE 2, p.39). Dr. Bowen further explained that he does not know in retrospect because of the timeline had occurred afterwards so he cannot say greater than 50% medical certainty that it is related. (RE 2, p. 40). Dr. Bowen also noted that the Petitioner was initially provided Tramadol by Dr. Austin which would help with the pain and it could account for the knee pain being relieved in the few weeks after the accident. (RE 2, p.41). He also agreed that the Tramadol could account for the lapse of reports in pain throughout the following weeks. (RE2, p.41). Dr. Bowen also indicated that he agrees with Dr. Davis' surgical recommendation to help alleviate the symptoms at this point. (RE 2, p.41). Dr. Bowen reiterated that if you continue to have unrelenting knee pain regardless of the cause, then surgery may be an option. (RE 2, p.42).

The September 14, 2011 IME report of Dr. Bowen was attached to his deposition. It states: "at this time I do not believe she is at maximum medical improvement. I do believe that her complaints of knee pain and right hip pain are related to her work place falls of February of this year. I believe the initial fall as described on February 1st is consistent with the mechanism of injury with an exacerbation of her complaints on February 8, 2011. Again, I do believe these are work related." The IME report further goes on to recommend conservative modalities including anti-inflammatories and physical therapy.

Dr. Bowen's June 24, 2013 IME report was also attached to his deposition. Dr. Bowen's supplemental report indicates on multiple occasions he believes the current pain or condition is an aggravation of a pre-existing condition. Most notably in paragraph 5 he indicates that: "I believe that her current condition is related to a pre-existing condition and the work place injury." Dr. Bowen also states in paragraph 2 of his opinion section that: "I do believe because of her unrelenting pain and per the recommendation of Dr. Davis surgery may be beneficial. "

CONCLUSION:

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

No evidence was provided at Arbitration that Petitioner suffered any problems with her right knee prior to the work accident. Most notable is that the Respondent's first IME Physician, Dr. Bowen clearly states in his supplemental report after a review of all of the available medical data believes that the Petitioner's current condition of ill-being was at least aggravated by the work accidents. Dr. Bowen's opinion is in line with that of the treating physician, Dr. Davis who also conceded there was a degenerative process in the Petitioner's knee that was aggravated by the work accident. The Respondent's other IME Physician, Dr. Lehman disagreed, but did not have an explanation of why the

right knee began hurting after the accident. The Arbitrator concludes the Petitioner's current condition of ill-being is causally related to the work accident.

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

While the Respondent's second IME Physician, Dr. Lehman did not believe surgery was appropriate for the Petitioner's condition, he also did not believe requesting the Petitioner to simply live in pain was reasonable. Both Dr. Davis and Dr. Brown who took over for Dr. Davis, who is on medical leave believe proceeding with surgery was a reasonable option. The Respondent's original Section 12 Examiner, Dr. Bowen, was also adamant that surgery was a reasonable option for the Petitioner due to the persistent nature of her ongoing pain. At Arbitration the Petitioner testified that although she is less than six weeks since surgery she has progressed through therapy to where she is at a point where she is able to do stairs which she had been unable to do since prior to the accident. A noted improvement within weeks of the surgical procedure, further highlights that it was a reasonable option in this case. Therefore the Arbitrator concludes the medical services provided to the Petitioner were reasonable and necessary.

K. Is Petitioner entitled to any prospective medical care?

The primary issue presented at Arbitration as whether the surgery performed by Dr. Brown was reasonable and necessary. Based upon the findings above, the Arbitrator finds that the surgery had been performed by the time of Arbitration was reasonable and necessary. The Petitioner is also entitled to prospective medical treatment recommended by her treating physician.

L. What temporary benefits are in dispute?

The TTD dispute at Arbitration was limited to benefits owed to the Petitioner from the date of the Petitioner's surgery on February 28, 2014 to the present. Based upon the present findings above, the Arbitrator finds the Petitioner is owed TTD Benefits from February 28, 2014 to the present.

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

Rhonda Nichols,
Petitioner,

vs. NO: 09 WC 21757

Cahokia School District #187
Respondent.

15IWCC0109

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 22, 2014, is hereby affirmed and adopted.

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

DATED: FEB 9 - 2015

o-01/28/15
drd/wj
68

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NICHOLS, RHONDA
Employee/Petitioner

Case# 09WC021757

CAHOKIA SCHOOL DISTRICT #187
Employer/Respondent

15IWCC0109

On 1/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2727 BRUNTON LAW OFFICES
MARY STEWART
819 VANDALIA (HWY 159)
COLLINSVILLE, IL 62234

0180 EVANS & DIXON LLC
ROBERT HENDERSHOT
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

STATE OF ILLINOIS)

)SS.

COUNTY OF **Madison**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

Rhonda Nichols
Employee/Petitioner

v.

Cahokia School District #187
Employer/Respondent

Case # **09** WC **021757**

Consolidated cases:

15IWCC0109

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Joshua Luskin**, Arbitrator of the Commission, in the city of **Collinsville**, on **November 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

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

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

G. [x] What were Petitioner's earnings?

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

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

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

K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

L. [x] What is the nature and extent of the injury?

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other

14IWCC0109

Findings

On **September 26, 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 not*** sustain an accident that arose out of and in the course of employment.

Timely notice of the alleged accident **was** given to Respondent.

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

In the calendar year preceding the injury, Petitioner earned $**6,496.16**; the average weekly wage was $**166.57 (given 39 weeks employment)**.

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

Petitioner has received all reasonable and necessary medical services.

Respondent is not liable for the charges for 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

For reasons set forth in the attached decision, benefits under the Act are denied.

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

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

[signature] Jan. 21, 2014

Signature of Arbitrator — Date

JAN 22 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RHONDA NICHOLS,)
)
Petitioner,)
)
vs.) No. 09 WC 21757
)
CAHOKIA SCHOOL DISTRICT #187,) 15IWCC0109
)
Respondent.)

ADDENDUM TO ARBITRATION DECISION

STATEMENT OF FACTS

The petitioner is a part-time library aide who worked at the school district from 1997 until November 2008. She testified she would usually work fifteen to twenty hours per week, at between $11.75 and $12.00 per hour, and would not work during the summers (usually mid-June to mid-August). The respondent submitted wage records into evidence; see RX6. Her usual duties included checking out and looking up books and reading stories to the younger students as well as showing films.

The petitioner testified she began to notice physical problems in approximately 2006 or 2007, with allergic symptoms including sneezing, coughing, and difficulty breathing. She related these to her work in the school library, asserting she would feel sick while working and have increasing symptoms in the library. She asserted the library carpet was filthy and dirty and that the environment was dusty and moldy.

The petitioner acknowledged she went on summer break in 2008 as normal. The school underwent renovation during the summer of 2008. She testified that when she returned in August 2008, the renovations were still incomplete and she could not work. A letter directed from the employer to the claimant dated August 28, 2008 indicates that the renovations had in fact been completed as of August 13, 2008 and she was instructed to return to work or face disciplinary action. RX5. The petitioner returned to work thereafter, but asserted a spike in symptoms thereafter and utilized a breathing mask. Shortly thereafter, the petitioner had a meeting with the principal in late September 2008. She asserted her employment was terminated by the respondent thereafter and she did not know the reason for such; the respondent produced letters indicating she had been terminated for "gross insubordination." She has never returned to work for the respondent since that time, and has never applied for or looked for any other job since.

The medical records introduced show that the petitioner presented at Memorial Hospital in November 2007 for pulmonary function testing. The petitioner apparently

asserted occupational exposure to asbestos fibers. However, no obstructive or restrictive abnormalities were demonstrated. RX2.

On February 3, 2008, the petitioner was hospitalized at Memorial Hospital for chest concerns; the history was significant for mitral valve prolapse, and the petitioner complained of chest pain, shortness of breath, cough and blood-streaked sputum. Chest X-rays and CT scan during February 2008 demonstrated no cardiac or pulmonary concerns. She was diagnosed with acute bronchitis and was noted to be anemic. Notably, the petitioner made no reference to mold, dust or any issue or concern relative to her employment. See RX2. Post-discharge notes from Dr. Bhutto and Dr. Khan noted diagnoses of acute bronchitis and rhinitis; again, no history of a work-related concern is present. RX3, RX4. The petitioner, at trial, disputed the records if no work relationship was asserted therein.

Following that time, the petitioner continued to treat with Dr. Bhutto and Dr. Jawad Khan. The petitioner did note other respiratory concerns including sleep apnea. RX3. On April 17, 2008, the petitioner told Dr. Khan that there had been a fire in her home and she was "exposed to smoke inhalation and is currently staying at a motel." She reported nasal bleeding, sneezing, sore throat and bloody spit. RX4. At trial, the petitioner admitted the fire, but denied any exposure to smoke.

On May 30, 2008, the petitioner was seen for testing of the esophagus, duodenum, and colon; she was noted to have a history of chronic GERD. PX2.

As noted above, the petitioner was not at work during the summer of 2008, but did continue to seek medical treatment for cough and chest pains during the summer months. In June 2008, she reported chest pains and on June 30, 2008 a chest x-ray showed no cardiopulmonary disease. RX2. On July 7, 2008, she saw Dr. Khan and noted productive cough with yellowish green phlegm. RX4. On August 13, 2008, another set of chest X-rays was performed for a clinical history of cough. Mild cardiomegaly was noted; no pulmonary abnormality was observed. RX2.

On August 14, 2008, the petitioner presented to Dr. Bhutto. He noted a history of cough with green sputum beginning three to four weeks prior. He noted the chest X-ray showed no lung infiltrates and again recommended that she test for obstructive sleep apnea, as she had not followed up on that prescription. No work relationship is asserted in this note. RX3.

On August 18, 2008, the petitioner called Dr. Bhutto's office and requested a letter from the doctor stating she was not to be exposed to dust. On August 20 Dr. Bhutto wrote a note indicating "due to [her] medical condition it is preferable to avoid dust exposure if possible." PX9, RX3.

On September 2, 2008, the petitioner saw Dr. Bhutto and noted improved symptoms with only residual dry cough. She was noted to have had a recent episode of

15IWCC0109

acute bronchitis, clinically improved. She was going to see the sleep apnea clinic. No work relationship is noted herein. RX3.

On September 22, 2008, the petitioner was seen by Dr. Patrick Win. She reported a "long-standing history of multiple upper airway symptoms involving the nose and eyes." She also noted symptoms consistent with sleep apnea and a history of recurrent bronchitis. She queried whether "her current work environment is contributing to her symptoms" and asserted her work environment was very dusty. Dr. Win noted nasal congestion and itching, postnasal drip and congestion. The occupational exposure noted was a recent remodeling project at work. Following examination he noted she had allergic rhinitis, but observed normal spirometry and "I cannot cinch the diagosis of asthma" given that testing. See PX3. He noted testing showed allergies to various trees, grasses, weeds, and molds, among other things, and recommended ongoing use of various medications and inhalers for symptom control, as well as allergen avoidance.

The respondent commissioned an air quality study, which was admitted as PX8. It demonstrated results within EPA regulations and guidelines. Fungal spore testing within the library and hallway were compared to the outdoors; while some Pencillium and Aspergillus were identified in the library, overall fungal concentrations were reduced indoors as compared to outdoors. Moreover, the concentration of spores indoors "do not appear significant enough as expected with a potential microbial growth within these areas" suggesting there was no live organism present. See PX8, RX1.

On December 1, 2008, the petitioner presented to Memorial Hospital with another episode of bloody cough, with a history of productive cough over the last week. She noted a history of chronic bronchitis. A CT scan had been negative for pulmonary processes and she was assessed with acute bronchitis. Testing that day and the next demonstrated no changes since her prior testing and no substantial pathology. PX6.

The petitioner subsequently underwent a methacholine challenge test. On March 25, 2009, Dr. Win noted that he had not reviewed the results but apparently the petitioner reported that no evidence of reactive airway disease was observed. He noted the petitioner reported symptoms "if she doesn't take her medications" and that the petitioner "is extremely noncompliant with medications and takes them irregularly." In a subsequent opinion letter, Dr. Win noted that he had not received a report of allergen levels and was relying on the petitioner's description of the environment. He further noted that while exposure to allergens can provoke symptoms in an allergic individual, he "cannot verify that her environment 'caused' her respiratory problems." He placed no specific work restrictions on her at that time. See PX3.

On April 2, 2009, Dr. Bhutto noted the methacholine challenge test was unremarkable, as had earlier bronchoscopies. Dr. Bhutto indicated she "does not have any evidence of reactive airway disease or asthma." PX4. The petitioner continued to treat with Dr. Bhutto for periodic bronchitis and shortness of breath for the remainder of 2009. PX4.

15IWCC0109

The respondent commissioned a Section 12 evaluation with Dr. Thomas Hyers, a pulmonologist, who evaluated the petitioner on January 23, 2012. Dr. Hyers interviewed her and her husband, who had accompanied her. He obtained a medical and work history and noted that they were concerned about the possibility of exposure to asbestos. He also reviewed the medical records and the Environmental Consultant report. He observed the overall dust sampling was within EPA limits and the indoor mold sampling was below outside levels, and further noted slight elevation of Penicillium and Aspergillus in the library and hallway, but noted those molds were nonviable, or "not live, growing molds." His examination noted normal chest and lung findings, and spirometry was normal with no evidence of airway obstruction. He assessed her with allergic rhinitis (hay fever), with a possible assessment of mild asthma, though the latter diagnosis could not be confirmed given normal spirometry results. He opined this was an inherited and chronic condition, capable of being provoked by routine environmental triggers, which would have been common to any work or non-work environment. Moreover, he noted any such aggravation would have been temporary in nature, and given that the petitioner had not worked at the respondent's location in some years, he concluded any problems were not work-related in origin. Dr. Hyers testified in deposition in support of his findings and causation opinion on August 19, 2013. See generally RX1.

Dr. Win testified by way of deposition on August 26, 2013. See PX7. Dr. Win noted the petitioner is highly allergic to a variety of triggers and would expect such an individual to suffer symptoms "just by walking out in public areas." PX7 p.41. He noted that the petitioner was very sensitive to allergens and would likely suffer symptoms in "any environment, including work," where those allergens were present. PX7 p.26.

OPINION AND ORDER

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim, including that the alleged injury arose out of and in the course of employment. See, e.g., *Orsini v. Industrial Commission*, 117 Ill.2d 38, 44-45 (1987), *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1993). This, the petitioner failed to do.

The Arbitrator first notes that the petitioner's general demeanor and specific responses during her testimony were self-serving, occasionally belligerent, overly dramatic and prone to exaggeration, such as when she asserted dust was "inches thick" after all the renovations had been completed. She disputed the accuracy of her medical records when asked about the lack of a work history, denied being exposed to smoke as noted by her treating physician, acknowledged contacting Dr. Bhutto's office only after being confronted with his records, "if he said it," and denied recollection of aspects of her medical history. The overall impression from her testimony was of a general lack of both candor and credibility, which in turn informs the Arbitrator's findings as to each of the specific issues raised by the parties. The petitioner's husband testified in an attempt to bolster his wife's testimony; however, the Arbitrator notes the inherent bias a husband would show towards his wife and further notes that he asserted presenting at the school

during the construction – a period when the claimant was actually not at work. His testimony is provided little weight. Moreover, the Arbitrator notes that the Commission need not award compensation even if the claimant's version of relevant events is undisputed. *Smith v. Industrial Commission*, 98 Ill.2d 20 (1983).

The petitioner asserted her breathing problems began in approximately 2006 or 2007, though medical records do not begin until November 2007. At that time, the concern was due to exposure to asbestos, an assertion for which absolutely no evidence was introduced. Regardless, the testing at that time failed to reveal any abnormalities.

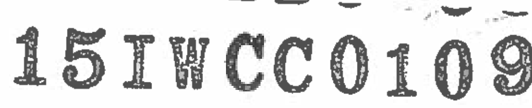
Months later, in February 2008, the petitioner again made numerous complaints, but the various lung scans and radiology studies produced normal and unremarkable results. Moreover, no history of any work exposure or concern is apparent – a fact the petitioner attempted to dispute at trial. Further undermining work as the provoking cause of her complaints is the ongoing symptoms and treatment during the summer months of 2008, when the petitioner was not at work. In addition to the multiple negative X-ray and CT scans, the petitioner has had multiple other benign testing, including spirometry, bronchoscopy and methacholine challenge testing.

The medical records do not support any evidence of lung or respiratory injury. The petitioner does indisputably have allergies to plants, dust, mold, and animals. However, these allergies appear by all credible evidence to be innate to the petitioner and neither created nor worsened by her employment. While her employment may have provoked symptoms, it appears quite clear that her work did so no more or less than any other environment. Dr. Win's testimony demonstrates patient advocacy, but his records clearly acknowledge greater skepticism, as when he stated he "cannot verify that her environment 'caused' her respiratory problems" as "the origins of her disease and when they first developed cannot be proven." See PX3.

The Arbitrator provides Dr. Hyers with substantial credence, especially given the fact that the objective studies support his assessment of the situation. His testimony was clear and the Arbitrator finds it highly likely that he is accurate in noting this is a longstanding, innate and most likely an inherited condition with triggers present in any work, social, private or public arena. The fact that the petitioner's complaints and symptoms persisted over the summer of 2008, when she was not working, and for years following her separation from her employment, further undermine any causal connection between her symptoms and her employment.

For the reasons stated above, the medical records, expert testimony, and evidence adduced at trial fail to credibly support her claim. The right to recover benefits cannot rest upon speculation or conjecture. *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977). The petitioner has failed to meet her burden of proof. Benefits are denied.

All other issues are rendered moot by the above findings.



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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gina Wicks,
Petitioner,

vs. NO: 10 WC 09057

15IWCC0110

Dillard's
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, permanent partial disability, medical expenses and penalties and attorneys' fees and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof..

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 2014, is hereby affirmed and adopted.

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

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: FEB 9 - 2015

Daniel R. Donohoo

o-01/27/15
drd/wj
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WICKS, GINA
Employee/Petitioner

Case# **10WC009057**

DILLARD'S
Employer/Respondent

15IWCC0110

On 4/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

1433 McANANY VANCLEVE & PHILLIPS PC
NICHOLAS KLUMB
515 OLIVET ST SUITE 1501
ST LOUIS, MO 63101

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

GINA WICKS
Employee/Petitioner

v.

DILLARD'S
Employer/Respondent

Case # 10 WC 9057

15IWCC0110

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Herrin**, on **January 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 4, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$22,440.60**; the average weekly wage was **$431.55**.

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

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

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

Respondent shall be given a credit of **$5,466.49** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,466.49**.

Respondent is entitled to a credit for all medical bills paid under Section 8(j) of the Act.

ORDER

Petitioner's current condition of ill-being is not causally related to the accident, and therefore Respondent is not liable for any additional medical, temporary total disability or permanent partial disability 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

03/17/2014
Date

APR 4 - 2014

STATE OF ILLINOIS)
)ss
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

GINA WICKS
Employee/Petitioner

v. Case # 10 WC 9057

DILLARD'S
Employer/Respondent

15IWCC0110

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner's Testimony

Petitioner, Gina Wicks, prior to working as a sales associate with Respondent, Dillard's, worked at a medical office where she was a medical secretary, assistant, and OSHA coordinator. Petitioner stated that this involved being extremely organized, and she was involved in hiring and firing, as well as scheduling matters. Petitioner stated that she took a part-time job with Respondent while still working at the medical office. At some point in time, Respondent offered her a full-time job with a salary higher than what she was making at the medical office. As such, Petitioner quit her job at the medical office and began with Respondent full-time. Respondent is a retail clothing store.

Petitioner testified she had two divorces and four children. She said that she was often stressed prior to her accident and that she did receive treatment for depression and anxiety, but did not suffer from panic attacks. Additionally, Petitioner testified she had a great memory and did not suffer from memory loss prior to the accident. Petitioner stated that she was still able to perform all her job duties prior to the accident. Moreover, Petitioner was diagnosed with fibromyalgia and migraine headaches prior to the accident. Additionally, Petitioner admitted she had migraine headaches prior to the accident. However, she stated that her previous migraine headaches were different than the headaches she has experienced since the accident.

Petitioner testified that on December 4, 2009, she was working with Respondent when she was bent down on the floor. She stated there was half of a solid-wood mannequin on top of the glass countertop. While she was working, the neck of the mannequin fell off and struck her on the front right side of her head. At that point in time, Petitioner testified she lost consciousness. However, she did not go to the emergency room until the next day. As a result of the accident, Petitioner testified she had a laceration that was one to one-and-a-half inches long. She testified that she received butterfly stitches to close up the laceration.

Petitioner testified that, after the accident, she drove herself home and experienced headaches. Petitioner presented to Herrin Hospital the next day and, thereafter, treated with her primary physician, Dr. Bob Thompson. Petitioner testified that Dr. Thompson provided medications which did not help her symptoms. Petitioner stated her diagnostic tests came back as normal and unremarkable.

Petitioner testified she began treating with Dr. Lori Guyton in 2010, and that she is still seeing Dr. Guyton. Petitioner testified she sees Dr. Guyton once every three months to obtain medication, specifically, Nuedexta. Petitioner could not recall if Dr. Guyton provided her any other medication.

Petitioner testified that, after the accident, she started experiencing panic attacks and had problems with her memory, taking directions, communicating with other people, and fatiguing easily. She went on to testify that, before the accident, she was a very sociable person, but now she becomes agitated and has problems socializing. Additionally, right after the accident, Petitioner testified that she had problems with her perception and dizziness, but these problems have since resolved.

Petitioner testified she currently suffers from panic attacks and was diagnosed with Pseudo Bulbar Affect. Petitioner explained that the Pseudo Bulbar Affect is bouts of crying or laughing spells without any reason. Petitioner also stated that she experiences light sensitivity and headaches.

Petitioner indicated that at one point in time, Respondent was willing to accept her back at her position. However, she received a letter indicating that she had abandoned her job and was thus terminated. Petitioner testified that at this point in time, she was still receiving treatment and that is why she had not returned to her job. On July 21, 2010, Respondent sent a certified letter to Petitioner indicating her job was still available. (Respondent's Exhibit (RX) 6). As Petitioner did not respond to the July 21, 2010 letter, Respondent sent another letter to Petitioner dated August 3, 2010, indicating she has been terminated due to job abandonment. (RX 6).

Petitioner testified that, since the accident, she has not returned to work. She testified that she has not tried to find work. However, she has considered getting out more and trying to volunteer. Since June 13, 2010, Petitioner has not received any temporary total disability (TTD) benefits. Respondent paid Petitioner TTD benefits from February 1, 2010 through June 13, 2010. (RX 4; see also Arbitrator's Exhibit 1).

Petitioner admitted she worked for Respondent after the date of the accident. She explained that she thought she worked until the end of December and possibly into January 2010. Petitioner testified that in December, she might have come down with the flu and missed some time from work for that illness.

Petitioner additionally testified that she asked Dr. Thompson for an off-work slip. Petitioner testified that Dr. Thompson provided this slip. Further, Petitioner testified that in February 2010, she filled out a Request for Leave form. The Dillard's Request for Leave Form indicates the reason for her leave was because "[her] own serious health condition makes [her] unable to perform the essential functions of [her] position." (RX 5).

Petitioner admitted that she was taking medication for depression and anxiety at the time of her accident. She testified that she was taking Cymbalta at the time of the accident. Further, Petitioner admitted that she took medication for her headaches prior to the accident, including Zomig and Triptan. Additionally, Petitioner testified that she was taking narcotic medications prior to the work incident, including Norco.

Records of Herrin Hospital

On December 5, 2009, Petitioner presented to the Emergency Department of Herrin Hospital complaining of light-headedness and headache. It was noted that on December 4, 2009, Petitioner was struck on her head with a piece of a wooden mannequin. It was also noted that Petitioner was taking Zomig, Vicodin and

Valium. CT Scans were performed of Petitioner's head and brain. Both scans were unremarkable. Further, it was noted Petitioner had a one centimeter laceration on her head. She was diagnosed with a head concussion and discharged that same day. (PX 1).

Records of Dr. Bob Thompson

Dr. Thompson was treating Petitioner prior to her December 4, 2009 accident. According to Dr. Thompson's records, on September 2, 2009, Petitioner was treated for depression, fibromyalgia, chronic pain syndrome and other conditions. Dr. Thompson prescribed various medications, including Valium. (PX 3).

Petitioner did not present to Dr. Thompson after the accident until December 22, 2009. Dr. Thompson indicated Petitioner had a work accident when she was struck on the head with a piece of a mannequin on December 4, 2009. He indicated Petitioner returned to work on December 7, 2009. Dr. Thompson again prescribed several medications, including Valium and Lexapro, among others. He diagnosed her with cerebral contusion, secondary confusion, and chronic anxiety. (PX 3).

Dr. Thompson also drafted three additional notes. The first note indicated Petitioner was off work December 16 through December 18, 2010. The second note stated Petitioner suffered a concussion on December 4, 2009, which caused confusion and headaches. The third note indicated Petitioner was "under a lot of stress," and should have a 30-day leave of absence "due to the anxiety." The third note does not indicate the leave of absence is a result of the December 4, 2009 accident. (PX 3).

On January 25, 2010, Petitioner returned to Dr. Thompson. He prescribed her a refill of her inhaler, as well as Zomig for her headaches, Norco, Valium, Stadol and Pristiq. She was diagnosed with depression, cerebral contusion, fibromyalgia, and chronic anxiety. (PX 3).

On January 29, 2010, Petitioner asked Dr. Thompson for an off work slip due to stress and anxiety. Dr. Thompson provided the off-work slip, which indicated Petitioner needed a 30-day sick leave due to acute and chronic anxiety. The off-work slip does not indicate the leave of absence was a result of the work accident. (PX 3).

Petitioner returned to Dr. Thompson on February 10, 2010, indicating that she wanted to be referred to Dr. Guyton. Moreover, Petitioner indicated she was still having problems relating to her work accident. Dr. Thompson filed out a form for FMLA and referred Petitioner to Dr. Guyton. (PX 3).

On March 1, 2010, Petitioner presented to Dr. Thompson complaining of panic attacks. Dr. Thompson noted Petitioner was the "same as before" and stated she was very depressed. He prescribed her various medications including Valium and Klonopin. Dr. Thompson also wrote another note indicating Petitioner was unable to return to work. (PX 3).

Petitioner continued to obtain treatment from Dr. Thompson throughout 2010 and 2011. In June 2010, Dr. Thompson was contacted by the Pain Management Center and informed that Petitioner was "double dipping" on her prescription of Norco. Dr. Thompson called CVS, Kroger, Walmart and Walgreens to cancel the prescription of Norco. (PX 3).

According to Dr. Thompson's records, he last treated Petitioner on May 17, 2011. On that date, Dr. Thompson noted Petitioner cries a lot, is depressed and has anxiety and cannot handle stress. He diagnosed Petitioner with PTSD, chronic anxiety, and depression, bipolar disorder, and fibromyalgia. (PX 3).

Records and Deposition of Dr. Lori Guyton

Petitioner first saw Dr. Guyton on April 28, 2010. Dr. Guyton noted Petitioner was diagnosed with a head concussion after the accident and that she received treatment at Herrin Hospital, including CT scans, which were normal. Dr. Guyton also noted that, prior to or at the time of her accident, Petitioner was taking eight medications, including Lexapro, Cozaar, Proventil, Prilosec, Zomig, Norco, Klonopin, and Robinul Forte. (PX 4; PX 5, p. 31). Dr. Guyton performed a neurologic examination, with Petitioner receiving a "mini mental exam" score of 28/30. (PX 4). Dr. Guyton testified that the mini mental exam tests memory and other parts of the brain. (PX 5, pp. 33-35.). Dr. Guyton further testified that a person with mild memory problems would score around a 21, and a person with moderate problems would score 10-20 and sever would score below 9. (PX 5, p. 35). Dr. Guyton noted Petitioner's score of 28 was well above the mild level. (PX 5, p. 35). Moreover, Dr. Guyton testified she would defer to a neuropsychologist for issues with memory and recall. (PX 5, p. 35).

Dr. Guyton noted Petitioner had a history of migraine headaches and fibromyalgia. She indicated Petitioner's concussion would improve with time, but that she was concerned with Petitioner's significant cognitive slowing, difficulty with attention, and concentration. Dr. Guyton indicated it would be unusual for those conditions to be a continuation of a concussive syndrome. Further, Dr. Guyton expressed concern over the amount of narcotic medicine Petitioner was taking, indicating it may cause some cerebral cognitive slowing. (PX 4). At her deposition, Dr. Guyton testified Petitioner had headaches that had been going on for years, and that she was concerned about Petitioner's medication use. (PX 5, pp. 7, 9). Additionally, Dr. Guyton testified Petitioner had been treating for several years for depression, anxiety and fibromyalgia. (PX 5, p. 29).

On October 26, 2010, Petitioner returned to Dr. Guyton and indicated she was not doing any better. However, Dr. Guyton noted Petitioner was sleeping well. Dr. Guyton told Petitioner to physically exercise 15-20 minutes a day, as well as told her the importance of exercising her brain at least 30 minutes per day. (PX 4).

On January 24, 2011, Petitioner returned to Dr. Guyton. Dr. Guyton noted Petitioner had complaints including headaches and decreasing memory. However, Dr. Guyton indicated Petitioner was suffering from migraines, head pain, memory difficulties and fibromyalgia. She also noted Petitioner was not exercising as recommended, and told Petitioner she needed to increase her activity and exercise, and become more structured. (PX 4).

On May 26, 2011, Petitioner again returned to Dr. Guyton. Dr. Guyton indicated Petitioner was suffering from Pseudo Bulbar Affect, or PBA. This was the first mention of PBA in the records. However, Dr. Guyton noted that overall, Petitioner felt better. (PX 4).

Petitioner continued to see Dr. Guyton through 2013. On August 3, 2011, Dr. Guyton noted Petitioner was doing much better. A month later, Dr. Guyton noted Petitioner had increased stress, as her husband left her, and that Petitioner was not doing well. (PX 4). Dr. Guyton testified that Petitioner's husband had an effect on Petitioner's symptoms. (PX 5, pp. 42-43).

In January 2012, Dr. Guyton noted Petitioner was "grieving for her old self." Dr. Guyton told Petitioner to maintain a routine and encouraged Petitioner to increase her activity and interaction. Five months later, Dr.

Guyton noted Petitioner was still having headaches, but they were not as bad as before. Dr. Guyton again told Petitioner to increase her activity, including exercising and interaction. (PX 4).

Petitioner returned to Dr. Guyton on September 10, 2012. It was noted that Petitioner recently underwent an inguinal hernia repair. However, it was also noted that her headaches had been getting better for a while. Again, Dr. Guyton indicated Petitioner needed to get out more and exercise. (PX 4).

On June 26, 2013, Dr. Guyton noted Petitioner was not having panic attacks and that her headaches would come and go. At that time, Dr. Guyton indicated Petitioner needed something to do and encouraged her to find work or volunteer. Petitioner's last visit with Dr. Guyton was on September 10, 2013. Dr. Guyton noted Petitioner was walking for daily exercise. Additionally, Dr. Guyton indicated Petitioner was doing better, but she still needed a job and to increase her activity and exercise. (PX 4).

Dr. Guyton testified that Petitioner's problems related to weakness and dizziness were not something she would expect Petitioner to have over two years after her accident. (PX 5, pp. 29-30).

Dr. Guyton testified that there were two conditions in Petitioner that she believed were related to the December 2009 work accident: 1. She believed that Petitioner's migraine headaches were exacerbated by the injury; and 2. The history of concussion. (PX 5, p. 14). The main medication Dr. Guyton prescribed Petitioner was Nuedexta, and that was for the PBA. (PX 5, p. 16). Dr. Guyton testified that PBA is a condition where people will have uncontrollable laughing and crying episodes. (PX 5, p. 17). Dr. Guyton testified that her final diagnosis of Petitioner was chronic headache, dizziness, memory changes and history of PBA. (PX 5, p. 20). The doctor further testified that Petitioner still also had a diagnosis of concussive syndrome. (PX 5, p. 20). Dr. Guyton testified that the memory problems could be due to Petitioner's underlying and longstanding depression, the history of longstanding fibromyalgia, the history of head trauma, and the effect of some of her medications. (PX 5, p. 20).

Records and Deposition of Dr. David Peeples

Dr. Peeples, a board-certified neurologist, evaluated Petitioner on May 3, 2010, and noted she had prior diagnoses of fibromyalgia, migraines, chronic low back pain, anxiety and depression, mild asthma, and hypertension. (RX 2, p. 5; RX 2, Dep. Exh. B). On examination, Petitioner was alert and oriented, with no problems with concentration, memory, flow of thought or other aspects of cortical function. Dr. Peeples stated it was more likely that her situational factors and underlying medical conditions were the prominent cause in her ongoing subjective complaints. He noted Petitioner had no limiting functional neurologic deficits and that Petitioner may work without specific restrictions. (RX 2, Dep. Exh. B).

Dr. Peeples testified that Petitioner's exam was entirely normal, with normal memory, normal praxis and no frontal release signs. (RX 2, pp. 9-10). Further, Dr. Peeples testified Petitioner's response to her accident was atypical and unexpected. (RX 2, p. 14). Dr. Peeples further testified Petitioner could return to work without restrictions. (RX 2, p. 16).

Records and Deposition of Dr. Michael Oliveri

Dr. Oliveri, a board-certified neuropsychologist, evaluated Petitioner on July 31, 2010 and November 7, 2012. (RX 1, Dep. Exhs. 2 and 3). Dr. Oliveri noted Petitioner's prior diagnoses, including depression and

anxiety, as well as fibromyalgia and vascular headaches. However, Petitioner did complain of headaches, sadness, panic-like symptoms, forgetfulness and anxiety at the time of the evaluation. (RX 1, Dep. Exh. 2).

During testing, Dr. Oliveri noted Petitioner was alert and demonstrated appropriate focused attention, with no significant dysphoria or anxiety. Additionally, he noted Petitioner's thought process was organized and goal directed and she readily understood task instructions. (RX 1, Dep. Exh. 2). Dr. Oliveri testified Petitioner had the highest rating possible for her Glasgow Coma Score, which is a neurologic rating of fundamental responses. (RX 1, p. 12).

Overall, Dr. Oliveri found no valid indications of an acquired neuropsychological disorder, with positive indicators of symptom magnification and response bias. He stated Petitioner's clinical history, notable for becoming more symptomatic over time, was inconsistent with the natural history of uncomplicated mild head injury. Further, Dr. Oliveri noted the level and pattern of results are not in keeping with the chronic residual manifestations of mild traumatic brain injury or persistent post-concussive syndrome. (RX 1, Dep. Exh. 2).

The doctor also stated that Petitioner's subjective complaints could not be taken at face value due to indications of symptom magnification, particularly as it related to nonspecific somatic/cognitive symptomology. However, Dr. Oliveri stated Petitioner would benefit from formal mental health management, but due to preexisting conditions. (RX 1, Dep. Exh. 2).

Petitioner returned for a follow-up evaluation on November 7, 2012. At that time, Petitioner stated a litany of complaints including cognitive problems, becoming increasingly overwhelmed, persistent forgetfulness, fatigue, and a panic disorder, among others. Additionally, Petitioner told Dr. Oliveri she had a "frontal lobe injury" and showed him a document entitled "*Lost and Found: What Brain Injury Survivors Want You to Know.*" On examination, Petitioner exhibited anxiety and dysphoria, which dissipated over the interview. He further indicated Petitioner had basic task orientation and was responsive to directions. (RX 1, Dep. Exh. 3).

In regard to her memory complaints, Dr. Oliveri noted Petitioner's complaints exceeded neurologic reference groups, which correlates with suboptimal performance validity. Overall, Dr. Oliveri stated Petitioner's neurocognitive and psychological test data were generally inconsistent with a valid representation of residual brain-behavior dysfunction or acquired psychiatric disturbance referable to her work accident. He further stated that Petitioner's neurocognitive decline was entirely incompatible with the natural course of recovery after mild traumatic brain injury. (RX 1, Dep. Exh. 3). Dr. Oliveri found that Petitioner had no valid indicators of an acquired neuropsychological disorder specific to the work accident, but rather positive indicators of response bias and symptom magnification. He additionally diagnosed Petitioner with pre-existing depressive disorder. (RX 1, Dep. Exh. 3).

Records of Dr. Naeem Qureshi

Petitioner first received treatment from Dr. Qureshi on January 27, 2011, over a year after her accident. Petitioner complained of depression and panic attacks. At that time, Dr. Qureshi noted Petitioner was alert and orientated times four. He also noted her memory testing was okay, with some minimal deficits, but nothing overt. Additionally, Dr. Qureshi assessed Petitioner with panic disorder with agoraphobia and major depressive disorder. (PX 2).

Petitioner continued to see Dr. Qureshi through 2013. Throughout her visits, Dr. Qureshi prescribed Petitioner several medications including Xanax, Cymbalata, Seroquel, Propanolol, Alprazolam, Prozac, and

Zoloft. On December 16, 2011, Dr. Qureshi increased Petitioner's prescription of Zoloft and Xanax to deal with her anxiety. Further, throughout this treatment, Dr. Qureshi continually noted Petitioner had a pleasant and cooperative mood with normal speech, and unremarkable and normal thought content and process. (PX 2).

On May 23, 2012, Dr. Qureshi noted Petitioner's depression and anxiety somewhat resolved, but started her on a methylphenidate prescription. Dr. Qureshi increased Petitioner's methylphenidate prescription on July 23, 2012. Overall, Dr. Qureshi's records do not indicate or state Petitioner's symptoms and complaints were related to her December 4, 2009 accident. (PX 2).

CONCLUSIONS OF LAW

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

Petitioner's current condition and symptoms are not causally related to the work accident. As shown, Petitioner had extensive and significant pre-existing problems, including depression, anxiety, headaches and fibromyalgia, among others. Petitioner bears the burden of proving that a causal relationship exists between her present condition of ill-being and the work-related injury. *Peabody Coal Co. v. Industrial Comm'n*, 232 Ill. App. 3d 800, 596 N.E.2d 1287 (4th Dist. 1992). Petitioner has not met her burden.

A causal connection between a condition of ill-being and a work-related accident can be established by showing a chain of events wherein an employee has a history of prior good health, and, following a work-related accident, the employee is unable to carry out her duties because of a physical or mental condition. *B M S Catastrophe v. Industrial Comm'n*, 245 Ill. App. 3d 359, 365, 614 N.E.2d 473,477 (4th Dist. 1993).

Here, Petitioner had significant preexisting conditions. According to Dr. Thompson's records, Petitioner was treated for depression, fibromyalgia, chronic pain syndrome and other conditions, on September 2, 2009. Dr. Thompson prescribed various medications, including Valium. Dr. Thompson's records evidence the fact that Petitioner was treated for depression, anxiety, headaches, fibromyalgia and other conditions prior to her accident.

Dr. Guyton noted the same in regard to Petitioner's prior conditions. Prior to or at the time of her accident, Dr. Guyton indicated Petitioner was taking eight medications, including Lexapro, Cozaar, Proventil, Prilosec, Zomig, Norco, Klonopin, and Robinul Forte. Moreover, Dr. Guyton testified Petitioner had been treating for several years for depression, anxiety, fibromyalgia, and that she had a history of headaches. She indicated it would be unusual for those conditions to be a continuation of a concussive syndrome. Further, Dr. Guyton expressed concern over the amount of narcotic medicine Petitioner was taking, indicating it may cause some cerebral cognitive slowing. Additionally, Dr. Guyton testified that Petitioner's problems related to weakness and dizziness were not something she would expect Petitioner to have over two years after her accident.

Dr. Peeples also noted Petitioner had prior diagnoses of fibromyalgia, migraines, chronic low back pain, anxiety and depression, mild asthma, and hypertension. Dr. Peeples stated it was more likely that her situational factors and underlying medical conditions were the prominent cause in her ongoing subjective complaints, and testified that Petitioner's exam was entirely normal, with normal memory, normal praxis and no frontal release signs.

Like all the other doctors, Dr. Oliveri noted Petitioner's prior diagnoses, including depression and anxiety, fibromyalgia and vascular headaches. Overall, Dr. Oliveri found no valid indications of an acquired neuropsychological disorder, with positive indicators of symptom magnification and response bias. Moreover, he stated Petitioner's clinical history, notable for becoming more symptomatic over time, was inconsistent with the natural history of uncomplicated mild head injury. In regard to her memory complaints, Dr. Oliveri noted Petitioner's complaints exceeded neurologic reference groups, which correlates with suboptimal performance validity. Dr. Oliveri testified Petitioner's evaluation was incompatible with an acquired neuropsychological disorder due to the December 2009 injury, and that in all probability behavioral and motivational issues were contributing to not only the test results but what she was complaining of. Moreover he would not place any restrictions on Petitioner and he did not believe she was in need of additional psychological treatment in relation to her December 2009 injury.

Further, Dr. Qureshi noted that prior to Petitioner's accident, Petitioner had a history of anxiety and depression. Overall, Dr. Qureshi's records do not indicate or state Petitioner's symptoms and complaints were related to her December 4, 2009 accident.

It is uncontroverted that Petitioner had significant preexisting conditions prior to her accident. Even though Petitioner indicated her depression and anxiety were not significant prior to her accident, the medical records prove otherwise. At the time of her accident, Petitioner's medications included Lexapro (a medication treating anxiety and major depressive disorder), Zomig (a medication for headaches), Norco (a narcotic pain killer) and Klonopin (a medication for anxiety and panic disorders). In addition, prior to her accident, Petitioner was prescribed Xanax (a medication for anxiety and panic disorders) and Valium (a medication for anxiety and panic disorders).

Additionally, Petitioner is not credible in relation to her complaints regarding her memory. Dr. Peeples found that Petitioner's exam was entirely normal, with normal memory, normal praxis and no frontal release signs. Further, Dr. Peeples testified Petitioner's response to her accident was atypical and unexpected.

Dr. Oliveri stated Petitioner's subjective complaints could not be taken at face value due to indications of symptom magnification, particularly as it relates to nonspecific somatic/cognitive symptomology. In regard to her memory complaints, Dr. Oliveri noted Petitioner's complaints exceeded neurologic reference groups, which correlates with suboptimal performance validity. Dr. Oliveri stated Petitioner's neurocognitive and psychological test data were generally inconsistent with a valid representation of residual brain-behavior dysfunction or acquired psychiatric disturbance referable to her work accident.

Petitioner's current complaints and condition are not a result of the work accident. Petitioner had a minor traumatic head injury, causing a concussion in 2009. Prior to the accident, Petitioner had significant disorders including anxiety and depression. Petitioner indicated it was her own serious health condition that was the causative factor in taking her off work. She received initial treatment from Herrin Hospital, who did not place her on work restrictions. Dr. Thompson, who initially took her off work, indicated Petitioner was under a lot of stress and should have a 30-day leave of absence due to the anxiety. His off-work slip, written over a month after the accident, did not reference or indicate the work accident as a reason for her to be off work, nor did it indicate the cause of Petitioner's stress and anxiety was the work accident.

Additionally, Dr. Guyton initially stated she was concerned with Petitioner's medications and indicated her narcotic pain medication might cause some cerebral cognitive slowing and noted that her headaches may be a result of her fibromyalgia.

As shown above, Petitioner has not met her burden proving her current condition is causally related to her December 2009 work accident.

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

Under the Act, the employee also has the burden of proving the reasonableness and necessity of medical expenses. *R & D Thiel v. Ill. Workers' Comp. Comm'n*, 398 Ill. App. 3d 858, 867, 923 N.E.2d 870 (1st Dist. 2010). Under the Act, an employee is entitled to recover only reasonable medical expenses that are causally related to her work accident and that are determined to be required to diagnose, relieve, or cure the effects of her injury. *Homebrite Ace Hardware v. Industrial Comm'n*, 351 Ill. App. 3d 333, 341, 814 N.E.2d 126 (5th Dist. 2004).

As discussed *supra*, Petitioner did not sustain her burden of proving a causal relationship exists between her current state of ill-being and the accident. As such, Petitioner has not sustained her burden of proof.

Further, Petitioner was placed at maximum medical improvement by Dr. Oliveri in July 2010. Accordingly, any treatment provided after July 31, 2010 would not be causally related to her work accident and not be required to diagnose, relieve, or cure the effects of her injury.

Respondent paid medical expenses incurred prior to July 31, 2010. (See RX 4). Respondent is not liable for any additional medical expenses, as those expenses related to Petitioner's pre-existing conditions or were for treatment not causally related to her work accident.

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

When determining whether an employee is entitled to TTD benefits, the test is whether the employee remains temporarily totally disabled as a result of the work-related injury and whether the employee is capable of returning to the work force. *Interstate Scaffolding, Inc. v. Ill. Workers' Comp. Comm'n*, 236 Ill.2d 132, 923 N.E.2d 266 (2010).

Here, it is uncontroverted Petitioner was paid TTD benefits from February 1, 2010 through June 13, 2010. The competent evidence indicates Petitioner was not totally disabled after June 13, 2010, and she is not entitled to any additional TTD benefits.

Dr. Peeples, a board-certified neurologist, evaluated Petitioner on May 3, 2010. He provided his report to Respondent on June 17, 2010. In his report, Dr. Peeples stated it was more likely that situational factors and her other underlying medial conditions are the predominant cause of her ongoing subjective symptoms. He stated she was able to work without restrictions. The Arbitrator hereby adopts the opinions of Dr. Peeples.

Accordingly, Petitioner was no longer temporarily and totally disabled as a result of the work-related injury. As she was able to return to work without restrictions, Petitioner is not entitled to any additional TTD benefits.

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

In order to be eligible for permanent partial disability benefits under the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"), the injuries must be "serious and permanent" and result in permanent partial disability or impairment. *Archer Daniels Midland Co. v. Industrial Comm'n*, 99 Ill.2d 275, 458 N.E.2d 494, 497 (1983). As stated above, Petitioner's current ill-being is not a result of her December 2009 injury. It is uncontroverted that Petitioner sustained an accident on December 4, 2009, when a piece of a mannequin struck her on the head. However, Petitioner has not suffered any serious and permanent injuries as a result of the accident.

As indicated *supra*, Petitioner had significant pre-existing conditions, including depression and anxiety, fibromyalgia, and headaches. Although Petitioner initially suffered from some dizziness and perception issues, she testified those issues have since resolved.

Moreover, Petitioner is not credible in relation to her memory complaints. Both, Dr. Peeples and Dr. Oliveri both indicate Petitioner's evaluations were normal. In addition, Dr. Oliveri found Petitioner had several indications of symptom magnification and response bias.

As such, the evidence submitted shows Petitioner did not suffer any "serious and permanent" injuries which resulted in permanent partial disability or impairment. Accordingly, Petitioner is not entitled to permanent partial disability benefits, nor is she permanently and totally disabled.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Matt Vanderheiden,
Petitioner,

vs. No: 13 WC 07164

Township of Manito,
Respondent.

15IWCC0111

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and evidentiary issues, and being advised of the facts and law, affirms in part and reverses in part the April 8, 2014 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).

After hearing on February 20, 2014, Arbitrator Erbacci found that Petitioner did sustain an accident that arose out of and in the course of his employment with Respondent on March 20, 2012 when Petitioner stepped out of a wheel loader. The Arbitrator found that Petitioner did provide timely notice of the accident to Respondent and his current condition of ill-being with regard to the left knee was causally related to the accident. Petitioner's undisputed average weekly wage was $320.00. Respondent was ordered to pay reasonable and necessary medical services pursuant to Section 8(a) and 8.2 of the Act in the amount of $868.00. Respondent was further ordered to authorize and pay for prospective medical expenses associated with a left knee arthroscopy as prescribed by Dr. Phillips pursuant to Section 8(a) and 8.2 of the Act.

After considering the entire record, and for the reasons set forth below, the Commission affirms the findings of accident, notice and benefit rate and reverses the remainder of the April 8, 2014 decision of the Arbitrator.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. On March 20, 2012, Petitioner was employed as a driver/laborer for Respondent and his duties included maintaining roads, replacing road signs, weed eating, and plowing roads. Petitioner walked extensively when working on the roads and had to climb in and out of trucks and road equipment. On March 20, 2012, Petitioner was working on a road widening project and was getting one of the last loads out of the wheel loader for the day. He stepped off the last step and his left knee twisted when the sand gave way and his knee popped and gave out. Petitioner testified that he fell backwards and landed on his buttock and shoulder. At hearing, there was no dispute as to accident or timely notice of accident by Respondent. (AX1, Tr. 9-12).

2. Petitioner testified that the fall occurred on a Thursday and he was not scheduled to work on Friday or over the weekend. Over the weekend his knee swelled, turned black and blue, and would not support his weight. (Tr. 16). On cross-examination, Petitioner was shown that March 20, 2012 was a Tuesday and he testified that he may have worked the remainder of the week after the accident. (Tr. 55). After review of his timesheets, Petitioner withdrew his TTD claim. (Tr. 55-56).

3. Petitioner presented to the emergency department at OSF St. Francis on March 21, 2012 with left knee pain after stepping off his tractor the day before. On exam, the knee was noted to be swollen and red with bony tenderness at the lateral joint line and lateral collateral ligament. X-rays returned negative and he was given Ibuprofen, Norco and a knee immobilizer and crutches and advised to follow up with an orthopedist. (PX2).

4. Petitioner went to see Dr. Robinson at Great Plains Orthopedics on April 5, 2012. Petitioner was noted in the record as stating that he felt a pop in his knee with significant swelling that had mostly resolved by that time. Petitioner was still having problems with weight bearing. Dr. Robinson diagnosed left knee pain with possible internal derangement and an MRI of the knee was ordered for further evaluation of Petitioner's symptoms. (PX3).

5. An MRI of the left knee was obtained on April 10, 2012 and was read as normal. Dr. Robinson reevaluated Petitioner after review of the MRI on April 24, 2012 and noted that there was no effusion on exam, but Petitioner still had mild to moderate tenderness of the patellar facets and joint lines. Dr. Robinson recommended a course of physical therapy for motion and strengthening. Petitioner was also given work restrictions which Respondent honored. (PX3).

6. On May 15, 2012, Petitioner presented for follow-up with Dr. Robinson. Petitioner reported that since his last visit he had tripped over some laundry and fallen forward on both knees, which caused a temporary increase in pain. However, since the fall his knee pain had settled down to the previous level. Petitioner was given a steroid injection in the left knee for his complaints. (PX3).

7. On direct examination, Petitioner testified that a couple of weeks after his work injury he slipped getting out of the shower, because he didn't have adequate knee strength but he didn't fall hard on his knee (Tr. 35). Petitioner testified on cross-examination, however, that the incident occurred in May 2012 and was caused when he tripped over some clothes and fell directly onto his knees. He testified that he did seek treatment due to increased complaints after the fall. (Tr. 49-50).

8. In the July 17, 2012 office note of Dr. Robinson, Petitioner is noted to have regained most of the strength in his knee, but he continued to have some pain anteriolaterally when he first gets up in the morning and when he is on his feet for a few hours. Petitioner was to continue with physical therapy but was released to full duty work on this date. (PX3).

9. Petitioner's last treatment with Dr. Robinson was on August 29, 2012. At that visit, Petitioner was still complaining of tenderness along the inferior aspect of the lateral patellar facet with mild popping noted with flexion and extension of the knee. Dr. Robinson released Petitioner to return as needed and continue working full duty. (PX3).

10. Petitioner testified that between August 29, 2012 and February of 2013 he received no treatment for his left knee. (Tr. 28). He continued to work for Respondent full duty during that time performing his regular job functions. (Tr. 29).

11. Petitioner also testified that he worked in the summers for Myers Produce, driving delivery trucks and tractors and walking the fields picking watermelon and sweet corn. (Tr. 37-38). Petitioner further testified that he worked for Myers Produce in the summer of 2012 and he drove farm tractors with steps similar to the wheel loader on which he was injured in March 2012 while working for Respondent. (Tr. 40).

12. Petitioner also assisted his girlfriend with a paper route wherein he would have to get in and out of his car (Tr. 52-53).

13. Petitioner testified the last time he was called into work for Respondent was on December 13, 2013 to put up snow fences along the roads. (Tr. 47-48). Petitioner testified that he drove a truck and loaded and unloaded bundles of snow fence with a co-worker. Petitioner and the co-worker pounded posts into the ground and installed the fencing. (Tr. 48-54).

14. Mr. Sunderland, the Road Commissioner for Respondent and Petitioner's supervisor, testified at hearing. He testified that Petitioner was able to work after the accident and continued to work light duty for Respondent. When Petitioner was released to full duty work by Dr. Robinson, Petitioner was able to do his regular full duty work and did not make any complaints to Mr. Sunderland about knee pain. (Tr. 57-63).

15. Petitioner testified that he sought an opinion with an orthopedic surgeon, Dr. Clark, at Pekin Orthopedics, in February 2013, but Dr. Clark recommended no care after that one visit. (Tr. 29-30). Dr. Clark's record is not in evidence.

16. The next treatment record in evidence was at Great Plains Orthopedics on April 30, 2013 with Dr. Phillips. (PX3). At that time, Petitioner complained of progressive symptoms over the past year in the left knee including locking and catching sensation and retropatellar discomfort and swelling. Dr. Phillips opined Petitioner should restart Celebrex and found Petitioner to be a candidate for arthroscopic surgery on the left knee. (PX3).

17. Dr. Phillips testified by way of deposition on January 24, 2014. Dr. Phillips is a board certified orthopedic surgeon with a subspecialty in sports medicine, primarily focusing on the knees and shoulders. Dr. Phillips testified that he only examined Petitioner on one occasion in April 2013. He further testified that the MRI of the left knee he reviewed was completely normal, but admitted

that the results could be a false negative, as there are conditions that do not show up on MRIs. Dr. Phillips testified his diagnosis was a subtle meniscal tear, chondral issues or plica pathology. Dr. Phillips opined that if Petitioner had a meniscal tear, it would not be bad enough to have been picked up by the MRI. He further testified that plica pathology is usually seen in runners or in people who regularly squat, twist and turn. Dr. Phillips also emphasized that Petitioner's fall to his knees at home did not help. In terms of a formal causal connection opinion, Dr. Phillips stated that the mechanism of injury as described, a step down injury and a pop, is somewhat atypical. He could only say that there was a 50/50 proposition that the work accident caused Petitioner's condition of ill-being. He went on to state that given the absence of prior problems and Petitioner's timeline of complaints, that the work injury caused the condition which developed and necessitated the recommendations for treatment (PX1).

18. Both on direct and cross-examination, Dr. Phillips agreed that the only positive findings on exam were crepitus and joint line tenderness. He further confirmed that he did not know that Petitioner was released to return to regular duty work by Dr. Robinson in 2012 and that Petitioner had been working full duty. Dr. Phillips went on to state in his deposition testimony that his differential diagnosis could be from everyday activities and wear and tear.(PX1).

19. Dr. Walsh provided a Section 12 examination of Petitioner on July 26, 2013 and issued a subsequent report. Dr. Walsh provided testimony by way of deposition on November 12, 2013. Dr. Walsh is a practicing board certified orthopedic surgeon specializing in knees. After examining Petitioner and reviewing the treatment records, Dr. Walsh gave an opinion, to a reasonable degree of medical and surgical certainty, that Petitioner's subjective complaints were not casually related to the March 2012 injury. Dr. Walsh opined that if Petitioner had suffered an injury to the knee requiring surgical intervention, he would have had significant swelling and would not have been able to continue working. Further, the MRI scan would have showed some abnormality. While Dr. Wash agreed that MRIs can sometimes read as false positive or negative, the type of injury Petitioner sustained in March of 2012 would not develop chondral pathology and it was not reasonable to go forward after the passage of so much time with surgery without a repeat MRI given several physicians found no evidence of a meniscal tear. (RX1, RX2).

20. Dr. Walsh opined that Petitioner did not require any further medical treatment, including an arthroscopy of the knee. Dr. Walsh further opined that Petitioner did not require any restrictions and was at maximum medical improvement regarding the left knee by August of 2012, when he was released by Dr. Robinson. (RX1, RX2).

The Commission affirms and adopts the Arbitrator's findings that on the date of accident, March 20, 2012, Respondent was operating under and subject to the provisions of the Act and an employer-employee relationship did exist between Petitioner and Respondent. The Commission finds the Petitioner's undisputed average weekly wage in the year preceding the injury was $320.00 and on the date of accident, Petitioner was 29 years of age, single with no dependent children. The Commission further affirms and adopts the Arbitrator's finding that on March 20, 2012, Petitioner did sustain an accident that arose out of and in the course of employment and timely notice of the accident was given to Respondent.

The Commission finds the Petitioner's current condition of ill-being is not causally related to the March 20, 2012 work injury and therefore, reverses the Arbitrator's finding regarding causation. The Commission finds the opinions of Dr. Walsh regarding the causal connection between

Petitioner's complaints and the work injury credible and more persuasive then those of Dr. Phillips when viewed with the record as a whole.

Dr. Phillips and Dr. Walsh indicated that Petitioner's diagnosis was not one that would typically be related to the mechanism of injury sustained in the work accident of March 2012. Dr. Phillips testified that as far as a causal connection opinion, he could not give more than a 50% chance that the work incident caused Petitioner's condition of ill-being. Dr. Robinson did not provide a causation opinion. Dr. Walsh testified that Petitioner suffered a knee strain and did not require any additional medical care. Dr. Walsh's opinion is supported by the diagnostic testing, including Petitioner's MRI of the left knee, which was read normal by all physicians.

The Commission further notes that Petitioner continued to work full duty at two jobs prior to his release from care and he continued to do so after he was released by Dr. Robinson at maximum medical improvement on August 29, 2012. He continued to work on a farm, driving vehicles and walking on uneven ground in the summer of 2012. When he returned to work for Respondent at full duty in the fall of 2012, he continued to do his regular work, walking on uneven ground and getting in and out of heavy equipment and vehicles without voicing any complaints to his supervisor.

Petitioner also testified to at least one intervening accident that caused left knee complaints. On direct examination Petitioner testified he slipped in the shower a few weeks after the work accident. On cross-examination, he testified it was a trip over clothing on the floor of his home a few months after the accident. Petitioner testified that the trip over the clothing caused him to fall directly on his knee and resulted in increased symptoms and need for medical care. Petitioner further testified to an aggravating event after the March 2012 work accident when he was building a fence at home.

Petitioner has failed to prove that his current condition with regard to his left knee or leg is related to the March 20, 2012 work accident. Based on the Commission's finding regarding causation, the Commission reverses the Arbitrator's awards of medical expenses, prospective medical treatment, and temporary disability benefits.

The Petitioner claims unpaid medical bills as contained in Petitioner Exhibit 5 and prospective medical expenses as prescribed by Dr. Phillips. Respondent has paid reasonable and related medical expenses through Petitioner's release by Dr. Robinson in August of 2012. The preponderance of the evidence, including the credible medical opinion of Dr. Walsh, as well as the medical records in evidence, support the Commission's finding that Respondent has paid for all reasonable and necessary medical treatment. Any treatment rendered beyond August 29, 2012 is not related to the alleged work injury.

With regard to temporary total disability benefits, the Petitioner withdrew his petition for TTD benefits during hearing.

After considering the record as a whole, and for the foregoing reasons, the Commission finds that on the date of accident, March 20, 2012, Respondent was operating under and subject to the provisions of the Act and an employee-employer relationship did exist between Petitioner and Respondent. Petitioner did sustain an accident on that date that arose out of and in the course of employment and timely notice of the accident was given to Respondent. In the year preceding the injury, Petitioner earned an average weekly wage of $320.00 and on the date of accident, Petitioner

was 29 years of age, single with no dependent children. The Commission further finds Petitioner's current condition of ill-being is not causally related to the accident and Respondent has paid all reasonable and necessary charges for all reasonable and necessary medical services through August 29, 2012.

Consistent with these findings, the Commission affirms the Arbitrator's finding of accident, benefit rate, and notice, but reverses the remainder of the Arbitrator's findings including causation, medical expenses and temporary disability.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the April 8, 2014 Decision of the Arbitrator is affirmed in part and reversed in part.

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 Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injuries.

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.

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

DATED: FEB 9 - 2015

Daniel R. Donohoo

Ruth W. White

Charles J. DeVriendt

o-12/02/14
drd/adc
68

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

VANDERHEIDEN, MATT
Employee/Petitioner

Case# 13WC007164

TOWNSHIP OF MANITO
Employer/Respondent

15IWCC0111

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

4476 KELLY LAW OFFICE
JAMES M KELLY
4801 N PROSPECT RD SUITE 832
PEORIA HEIGHTS, IL 61616

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

- [ ] 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)

Matt Vanderheiden
Employee/Petitioner

v.

Township of Manito
Employer/Respondent

Case # 13 WC 7164

15IWCC0111

An *Application for Adjustment 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 **February 20, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On the date of accident, **March 20, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$16,640.00**; the average weekly wage was **$320.00**.

On the date of accident, Petitioner was **29** 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 reasonable and necessary medical services, pursuant to the medical fee schedule, of **$868.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay, pursuant to the medical fee schedule, the reasonable and necessary medical expenses associated with the left knee arthroscopy prescribed for the Petitioner by Dr. Phillips, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

April 3, 2014
Date

13 WC 7164
ICArbDec19(b)

APR 8 - 2014

FACTS:

The Petitioner testified that he began working for the Respondent as a driver/laborer in December of 2011. The Petitioner described his work as "heavy work" and he testified that he used many different types of tools including weed eaters, lawn mowers, dump trucks, wheel loaders, welders, grinders and chainsaws in the performance of that work. He testified that in the winter time, his primary responsibility was snow plowing and in the summer time, he maintained the roads. His work with the Respondent required the Petitioner to walk a lot while working on the country roads and to climb in and out of dump trucks and road equipment.

On March 20, 2012, the Petitioner sustained an undisputed accidental injury which arose out of and in the course of his employment with the Respondent. The Petitioner was working on a country road using a wheel loader to fill a dump truck. The Petitioner testified that at some time after his lunch break, he was getting out of the wheel loader and, as he stepped off the last step of the wheel loader, the sand under his left foot gave way and he twisted his left knee. The Petitioner testified that his knee twisted, popped and gave out altogether and he fell backwards landing on his back side and his shoulder. The Petitioner testified that after he fell he could not put weight on his left leg so he limped around hoping to just work it out or walk it off.

The Petitioner testified that there was only about an hour of work left that day so he finished his shift and went home. He testified that he did not report his injury that day and that, as it was the last day of his work week, he reported the injury to his supervisor, John Sunderland, "Tex", when he returned to work on the following Monday. The Petitioner indicated that March 20, 2012 was a Thursday which was normally the last day of his work week. The Petitioner testified that over that weekend his knee swelled up and turned black and blue and that on Monday he only worked a half a day and left early to seek treatment at the OSF St. Francis emergency room. The Petitioner testified he did not work the rest of the week and he reported back to work the following Monday.

After the Petitioner was shown his time cards and advised that March 20, 2012 was a Tuesday, the Petitioner acknowledged that he was injured on a Tuesday and worked a complete day the next day and finished out the week. The Petitioner reiterated, however, that he reported the injury to Tex the following Monday and then worked the entire next week.

The OSF St. Francis emergency room records demonstrate that the Petitioner was seen there at 7:33 in the evening on March 21, 2012. The history noted is: "The patient was getting off his tractor yesterday evening when his foot got caught while the rest of his body continued to fall. He landed on his right shoulder in the sand and had no pain, except that which was in his left knee. The patient awoke today to a very stiff left knee. The pain at rest is tolerable, but gets significantly worse with ambulation and weightbearing. He was able to get to work today with an ACE wrap, but presents tonight with difficulty getting through work today." Left knee x-rays were reported to be normal and examination revealed decreased range of motion, swelling, effusion and bony tenderness. The Petitioner was provided with pain medicine, anti-inflammatories, a knee immobilizer and crutches. The Petitioner was

directed to return in one week and to take Ibuprofen and Norco for pain. The Petitioner was directed to not operate machinery while taking Norco.

On April 5, 2012, the Petitioner sought treatment with Dr. Ryan Robinson at Great Plains Orthopedics. Dr. Robinson noted a history of a left knee injury while getting down from a tractor at work on March 20, 2012. Dr. Robinson noted complaints of pain with weightbearing and a "feeling of grinding or glass in the knee". Dr. Robinson noted left knee x-rays showed "a very slight lucency along the anterior tibial plateau" but he indicated that "this does not likely represent a fracture and if so, it is non-displaced". Dr. Robinson's assessment was "Left knee pain with possible internal derangement". Dr. Robinson prescribed an MRI and sit down work only. A left knee MRI was performed on April 10, 2012 and was reported to be a normal study.

On April 24, 2012, Dr. Robinson noted that the Petitioner continued to have complaints of pain in the knee as well as a painful popping of the knee. Dr. Robinson noted the normal MRI study and x-ray findings, and he prescribed physical therapy and work restrictions of no prolonged standing, walking, bending, stooping, or squatting. Dr. Robinson also prescribed a venous Doppler study of the Petitioner's left calf to rule out blood clots.

The Petitioner returned to Dr. Robinson on May 15, 2012. Dr. Robinson noted that the Petitioner reported that on May 10th he tripped over some laundry and fell forward onto both knees. The records states "He states that this caused some increased pain at the left knee. It sounds as if the symptoms have essentially though settled back to his previous level". Dr. Robinson's Assessment continued to be "Left knee pain and injury" and he injected the Petitioner's left knee with a corticosteroid.

The Petitioner continued to follow up with Dr. Robinson seeing him on June 19, 2012, July 17, 2012, and August 29, 2012. The Petitioner reported continuing left knee pain on each of those follow up visits. Dr. Robinson released the Petitioner to return to regular work as of July 18, 2012. Dr. Robinson also prescribed a patellar stabilizing orthosis for the Petitioner which the Petitioner reported was beneficial. Dr. Robinson's assessment on August 29, 2012 was "Left knee pain suspected due to patellofemoral syndrome". Dr. Robinson noted at that time that the only other treatment he could offer the Petitioner would be a potential repeat corticosteroid injection. He further noted; "Otherwise, we would have to refer him for surgical consultation for consideration of possible lateral release".

The Petitioner testified that between August 29, 2012 and February 2013 he received no medical care or treatment for his left knee. The Petitioner testified that he continued to have problems with his left knee locking up during that period but he continued work full duty for the Respondent, performing his regular job functions. The Petitioner testified that he continued to have knee pain, swelling, and locking throughout that winter, despite wearing a brace and modifying his activity. The Petitioner testified that sometime following August 29, 2012 he received a letter from Great Plains Orthopedics advising him that Dr. Robinson had left the practice.

15IWCC0111

The Petitioner testified that in February 2013 he sought a second opinion with a different orthopedic surgeon, Dr. Clark, at Pekin Orthopedics. The Petitioner testified that he saw Dr. Clark one time and that the doctor did nothing for him at that visit. Dr. Clark's records were not offered into the record and Dr. Clark's bill has not been submitted for payment by the Petitioner.

In April of 2013, the Petitioner sought treatment with Dr. Mark Phillips at Great Plains Orthopedics. The Petitioner testified that the knee brace was no longer working like he thought it would and he was having problems with his knee locking up. The Petitioner testified that when he was sleeping his knee would lock up and he would not be able to bend it when he woke up. He testified that sometimes when he laid down flat his knee would lock straight out and, other times, when he curled up he could not get his knee to open up because it locked closed. The Petitioner testified that he was taking over-the-counter ibuprofen and was continuing to have problems with his knee.

On April 30, 2013 the Petitioner returned to Great Plains Orthopedics and saw Dr. Mark Phillips. Dr. Phillips noted the visit as a referral from Dr. Robinson. Dr. Phillips noted ongoing and progressive symptoms for the last year with crepitation, retropatellar discomfort, swelling, locking and catching. Dr. Phillips noted the normal MRI, but also noted he was concerned about "subtle meniscus, chondral and plica pathology". Dr. Phillips noted that the Petitioner was a candidate for "EUA arthroscopy with expected articular cartilage debridement versus microfracture and/or meniscus and plica surgery". The Petitioner testified that Dr. Phillips referred him to Dr. Link for conservative handling pending approval of the arthroscopy.

On July 26, 2013, the Petitioner was examined by Dr. Kevin Walsh at the request of the Respondent. Dr. Walsh diagnosed the Petitioner as having "left knee pain" and he opined that it was unlikely that the Petitioner's subjective complaints of knee pain in July of 2013 were "closely related" to the described March 2012 work injury. Dr. Walsh opined that the Petitioner was at maximum medical improvement from his injury and did not require any additional orthopedic intervention as a result of the injury. Dr. Walsh further opined that the Petitioner did not require any restrictions and that he did not sustain any permanent partial disability as a result of his injury.

The Petitioner saw Dr. Greg Link on August 5, 2013. Dr. Link noted complaints of continuing left knee grinding and locking. Dr. Link diagnosed left knee derangement and prescribed ibuprofen and tramadol. The Petitioner followed up with Dr. Link's partner, Dr. Johnson who ultimately performed another injection to the Petitioner's left knee on October 11, 2013. The Petitioner last saw Dr. Johnson on December 23, 2013 for conservative management of his left knee pain, pending approval of the arthroscopy.

John Sunderland, the Respondent's road commissioner, testified that the Petitioner did not report a work accident to him on March 20, 2012 but he acknowledged that the Petitioner did report the injury to him the following Monday. Mr. Sunderland testified that the Respondent was able to accommodate the Petitioner's light duty restrictions and that, in the

summer of 2012, the Petitioner went to work for Myers Produce. Mr. Sunderland testified that when the Petitioner returned to work for the Respondent in the fall of 2012, he was returned to full duty work. Mr. Sunderland testified that the Petitioner worked full duty for the Respondent from the fall of 2012 to the present and that when the Petitioner last worked in December 2013 he was installing snow fences. Mr. Sunderland testified that the Petitioner did not make any complaints to him about his knee during any time period after returning to work full duty.

The Petitioner testified that he currently continues to take the pain medication prescribed by Dr. Link. The Petitioner acknowledged that he has been released to full duty work and that he continued to work for the Respondent through December 16, 2013. The Petitioner testified that when he was working, he noticed that his knee was better in the morning and, as the day progressed, his knee got more tender and sore and it would not support him as well as it did in the morning. The Petitioner testified that he continues to experience left knee symptoms on a daily basis, including locking and a constant throbbing on the outside of his knee, and that he now walks with a limp. The Petitioner testified he had no left knee injuries or problems prior to March 20, 2012 and he did not limp prior to March 20, 2012. The Petitioner testified that, other than the tripping incident in May of 2012 and an increase in his knee pain after putting up a fence at home, he has had no injuries or accidents involving his left knee since March 20, 2012.

The November 12, 2013 testimony of Dr. Kevin Walsh was admitted into the record as Respondent's Exhibit 1. Dr. Walsh opined that the Petitioner's subjective complaints were not causally related to the March 2012 injury. Dr. Walsh noted that the Petitioner's mechanism of injury did not result in significant effusion and he opined that if the Petitioner had suffered a significant injury to the knee that required surgical intervention, he would have had significant swelling and would not have been able to continue to work. Dr. Walsh also indicated that the Petitioner's MRI scan would have showed some abnormality. Dr. Walsh explained that there was no evidence of a meniscus tear, the Petitioner's MRI was negative, there was only trace effusion and the Petitioner was not diagnosed with a meniscal tear. Dr. Walsh agreed that it would have been reasonable for the Petitioner to receive initial medical care including an orthopedic consult and physical therapy but he opined that surgery was not necessary for the Petitioner. Dr. Walsh agreed that MRI's can have false positives and false negatives and opined that, given the amount of time that has passed, it would be reasonable for the Petitioner to have a repeat MRI performed before having surgery. Dr. Walsh opined that the Petitioner's twisting injury on March 20, 2012 did not lead to his current condition of ill-being and that the Petitioner's condition is not consistent with the mechanism of injury:

The January 27, 2014 testimony of Dr. Mark Phillips was admitted into the record as Petitioner's Exhibit 1. Dr. Phillips testified that the Petitioner's MRI was normal but he testified that a small percentage of MRI's are false negatives and that there are also conditions that are "not so dramatically abnormal that they would show up on a MRI." Dr. Phillips testified his diagnosis was either a subtle meniscus tear, chondral issues or plica pathology. Dr. Phillips testified that the MRI did not pick up the meniscus tear so it was either missed or it wasn't a "horrible" tear. Dr. Phillips testified that other intersubstance things like chondral or plica

15IWCC0111

pathology may not actually be seen on an MRI. Dr. Phillips testified that he wouldn't disagree with a repeat MRI as an avenue of treatment but he indicated that regardless of the outcome of the MRI, if the patient's symptomology was still the same, he would recommend consideration of the arthroscopy. Dr. Phillips opined that, given the Petitioner's lack of previous left knee problems and the history of his complaints and treatment thereafter, the Petitioner's work incident caused the condition which developed and resulted in his recommendation to consider arthroscopic evaluation of the Petitioner's left knee.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Petitioner sustained an undisputed accidental injury that arose out of and in the course of his employment with the Respondent on March 20, 2012. The Petitioner reported the injury the following day and sought treatment at the OSF St. Francis emergency room that evening. The Petitioner gave a history of left knee pain since falling while getting out of his tractor the previous day and he was provided with pain medicine, anti-inflammatories, a knee immobilizer and crutches.

On April 5, 2012 the Petitioner sought treatment with Dr. Robinson who noted a history of a left knee injury while getting down from a tractor at work on March 20, 2012, and complaints of pain with weightbearing and a "feeling of grinding or glass in the knee". Dr. Robinson's assessment was "Left knee pain with possible internal derangement". Dr. Robinson prescribed an MRI which was performed on April 10, 2012 and was reported to be a normal study.

The Petitioner continued to treat with Dr. Robinson for his left knee complaints through August 29, 2012. That treatment included an injection of corticosteroids and physical therapy. Dr. Robinson noted continuing left knee pain throughout his treatment of the Petitioner but he released the Petitioner to return to regular work as of July 18, 2012. Dr. Robinson also prescribed a patellar stabilizing orthosis for the Petitioner which the Petitioner reported was beneficial. Dr. Robinson's assessment on August 29, 2012 was "Left knee pain suspected due to patellofemoral syndrome". Dr. Robinson noted at that time that the Petitioner continued to have left knee complaints but the only other treatment he could offer the Petitioner would be a potential repeat corticosteroid injection or referral for a surgical consultation.

The Arbitrator notes that the Petitioner was clearly still symptomatic as of August 29, 2012 and that further treatment including physical therapy, injections and surgery was considered. It is clear that, while Dr. Robinson returned the Petitioner to regular work and released him to return as needed, Dr. Robinson did not specifically place the Petitioner at maximum medical improvement on August 29, 2012.

15IWCC0111

While the Arbitrator notes that the Petitioner did not seek any medical treatment for his knee between August 29, 2012 and February 2013, the Petitioner credibly testified that he continued to have knee pain, swelling, and locking throughout that period of time. When he was seen by Dr. Phillips on April 30, 2013, Dr. Phillips noted a consistent history of injury and ongoing and progressive symptoms, including crepitation, retropatellar discomfort, swelling, locking and catching, since that injury.

Dr. Phillips noted the normal MRI, but was concerned about subtle meniscus, chondral and plica pathology which could be missed by an MRI. Dr. Phillips suggested surgical intervention in the form of diagnostic arthroscopy with expected articular cartilage debridement versus microfracture and/or meniscus and plica surgery. Dr. Phillips opined that, given the Petitioner's lack of previous left knee problems and the history of his complaints and treatment thereafter, the Petitioner's work incident caused the condition which developed and resulted in his recommendation to consider arthroscopic evaluation of the Petitioner's left knee.

While the Arbitrator notes the opinions of Dr. Walsh, the Respondent's examining physician, the Arbitrator finds that the opinions of Dr. Phillips are sufficiently credible, reliable, and persuasive so as to satisfy the Petitioner burden of proof. Based upon the Petitioner's testimony, the histories and complaints noted in the Petitioner's medical records, and the findings and opinions of Dr. Phillips, the Arbitrator finds that the Petitioner's current condition of ill-being in his left knee is causally related to the work injury of March 20, 2012. The Arbitrator further finds that the arthroscopic evaluation of the Petitioner's left knee prescribed by Dr. Phillips is reasonable, necessary and causally related medical treatment for which the Respondent is responsible pursuant to Section 8(a) of the Act.

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:

The Findings and conclusions of the Arbitrator relating to the issues of causation and prospective medical treatment are adopted and incorporated herein.

The Petitioner introduced evidence of outstanding medical expenses totaling $868.00 for treatment rendered to the Petitioner by Dr. Link and Dr. Johnson on the referral of Dr. Phillips. Having adopted the opinions Dr. Phillips, on the issues of causal connection and prospective medical treatment, the Arbitrator finds that the treatment rendered to the Petitioner by Dr. Link and Dr. Johnson, and the charges therefore are reasonable, necessary and causally related to the Petitioner's work injury and are also properly awarded pursuant to Section 8(a) of the Act.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF CHAMPAIGN	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Beckom,
Petitioner,

vs.

NO: 13 WC 02302

15IWCC0112

State of Illinois
Department of Transportation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection 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 August 30, 2013, is hereby affirmed and adopted.

DATED: FEB 9 - 2015

o-01/27/15
drd/wj
68

Daniel R. Donohoo

Charles J. DeVriendt

Ruth W. White

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

BECKOM, LAWRENCE
Employee/Petitioner

Case# **13WC002302**

15IWCC0112

ILL DEPT OF TRANSPORTATION
Employer/Respondent

On 8/30/2013, 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 0.06% 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:

1816 LAW OFFICES OF FREDERICK W NESSLER
MATTHEW V KENNEDY
536 N BURNS LANE SUITE 1
SPRINGFIELD, IL 62702

0830 CMS BUREAU OF RISK MGMT
WORKERS COMPENSATION MANAGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

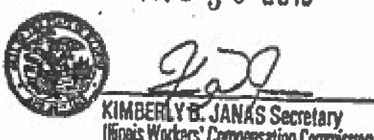
4390 ASSISTANT ATTORNEY GENERAL
ERIN DOUGHTY
500 S SECOND ST
SPRINGFIELD, IL 62706

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PKWY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

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

AUG 30 2013



KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LAWRENCE BECKOM
Employee/Petitioner
v.
ILLINOIS DEPT. OF TRANSPORTATION
Employer/Respondent

Case # 13 WC 2302

15IWCC0112

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Urbana**, on **July 22, 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

FINDINGS

On the date of accident, **January 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 alleged 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 **$50,460.00**; the average weekly wage was **$970.38**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

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

ORDER

The Arbitrator finds that Petitioner has failed to sustain his burden of establishing a work accident or that his condition of ill-being is related to his work with Respondent. Accordingly, benefits are hereby denied.

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

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

Signature of Arbitrator

08/27/2013
Date

ICArbDec19(b)

AUG 30 2013

STATE OF ILLINOIS)
)SS
COUNTY OF CHAMPAIGN)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LAWRENCE BECKOM
Employee/Petitioner

v. Case # 13 WC 2302

ILLINOIS DEPT. OF TRANSPORTATION
Employer/Respondent

15IWCC0112

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Lawrence Beckom, is a 53-year old former temporary highway maintainer for Respondent, the Illinois Department of Transportation (IDOT). Petitioner testified at hearing that on January 4, 2013, he was working in his capacity as a highway maintainer, clearing brush with his road crew. Petitioner claims that he has cut brush before while working for IDOT, but does not remember which month of this three-month employment stint whereby this work took place. Petitioner testified that he was clearing brush with a crew of three other IDOT employees: Mark Murphy, Dennis Yard, and Chuck Sale. Petitioner claims that Mr. Yard, Mr. Murphy and Mr. Sale were cutting down tree branches and he was feeding them into the "shredder" machine, or wood chipper. Petitioner testified that a tree hit him in the back while he was turned away. He did not see it fall. Petitioner stated that everything after the alleged impact was a blur. He testified that the impact knocked him off balance and forward onto his hand, that he stumbled, and that he immediately became dizzy, experienced pain in his left shoulder and back, and had trouble keeping his balance and walking. He did not fall down, however. Petitioner testified that he sat on a stool at the brush site while the crew completed their work, and that he finished the rest of the shift with his crew, which consisted of going to lunch (where he sat in the truck), and then picking up tractors and equipment in another town. He did not see a doctor that day.

At trial, Respondent called Michael Blain as a witness. Mr. Blain is the lead worker at the Litchfield IDOT yard, where Petitioner's road crew was dispatched on that date in question. Mr. Blain testified that he took the accident report from Petitioner at approximately 3:00 p.m. on January 4, 2013. He provided Petitioner with the necessary accident paperwork, and asked Petitioner if he was hurt and if he needed a doctor. Mr. Blain testified that Petitioner replied that he was fine and did not need medical attention. No ambulance was called to the Litchfield yard. After taking an oral statement from Petitioner, Mr. Blain called in the rest of the road crew and had them complete witness statement forms. As a result of the incident, Mr. Blain spoke to the crew about the safety expectations when cutting brush.

Mr. Blain also testified that he had received notice from his supervisors in Springfield that Petitioner was about to be placed on a three-day suspension. The suspension was for damage to vehicles, and was set to begin on January 8, 2013, and would end on January 10, 2013. The suspension would have required Petitioner to turn in his facility keys and identification badge.

At trial, Respondent also called Dennis Yard as a witness. Mr. Yard is also a temporary highway maintainer, and was working with Petitioner on the date of his alleged accident. He testified that he was running the chain saw on the date in question. According to Mr. Yard, he was sawing a limb when it came loose and started to fall toward Petitioner. Mr. Yard called out a warning, but misidentified Petitioner from behind and accidently shouted out Mr. Sale's name instead. Mr. Yard indicated the limb he felled was Y-shaped, consisting of a wider base that then split into two distinct branches toward what would have been the top of the limb. Mr. Yard testified that the split branches fell close to Petitioner, but did not strike him. According to what Mr. Yard saw, some twiggy debris of the upper limbs scattered around Petitioner, with branches approximately the size of a person's pinky finger. He saw Petitioner duck forward as the tree fell around him, but never saw him loose his balance. Mr. Yard approached Petitioner to see if he was injured, but he appeared to be fine. Petitioner never indicated to Mr. Yard that he was hurt. According to Mr. Yard, Petitioner sat off to one side to collect himself while he personally returned to cutting brush until lunch. Mr. Yard stated that the road crew took their lunch at their usual time.

Following the alleged accident, Petitioner was evaluated at Priority Care on January 5, 2013. According to the records of his first visit, Petitioner was experiencing no dizziness, no limb weakness, and had no trouble walking. He reported pain in his back, neck, and left shoulder. Petitioner underwent a lumbar spine x-ray at that time. It showed no acute findings. Petitioner also underwent a pelvis x-ray. It revealed no acute findings, and when compared to a previous x-ray, showed extensive degenerative changes. Petitioner also underwent an x-ray of the cervical spine. It showed no evidence of acute fracture, and no evidence of soft tissue swelling. Petitioner was given pain medication and was advised to consult with his primary care physician. (Petitioner's Exhibit (PX) 3).

Petitioner's primary care physician, Dr. Sheila Ayorinde, did not see him until February 6, 2013. At that time, Dr. Ayorinde did not conduct a physical examination of Petitioner's back to look for signs of impact, such as contusions or cuts. (PX 1, p. 27). Dr. Ayorinde testified that Petitioner suffers from a number of conditions, including schizophrenia and bipolar disorder. (PX 1, p. 27). She also testified that Petitioner is obese and a smoker, both of which can have a negative impact on spinal integrity, and can lead to the onset of arthritis and degeneration. (PX 1, pp. 28-29). Dr. Ayorinde reviewed the imaging ordered by Priority Care, and ordered a standing MRI for Petitioner's head and spine. (PX 1, pp. 29-30). The brain MRI was unremarkable, and the spinal MRI was relatively unremarkable, showing only a few benign and unrelated blood vessel clusters. (PX 1, Exh. 1B; PX 1, p. 31). Dr. Ayorinde believed that Petitioner's hip pain was radiating from his lower back. (PX 1, p. 19). Based on his medical records prior to the alleged accident, Petitioner had previously seen Dr. Ayorinde with complaints of hip pain, thigh pain, and decreased mobility. (RX 3). When asked if Petitioner's back pain ranging from the cervical through the lumbar spine was caused by being struck from a falling tree, Dr. Ayorinde testified that she believed "it's possible." (PX 1, p. 23). The doctor also thought it could be possible that Petitioner's back injuries could continue into the future. (PX 1, p. 24). Dr. Ayorinde also believed it was possible that Petitioner's bilateral hip and leg pain could have been caused from a tree falling on him. (PX 1, p. 24). The doctor further thought it was possible that any light-headedness and dizziness Petitioner experienced possibly could come from an impact from a tree. (PX 1, pp. 24-25).

Petitioner sought additional treatment from The Chiropractors of Springfield, where he reported on his medical questionnaire that his condition started on January 2, 2013, not the January 4, 2013 date of injury that he reported to his employers. Petitioner only attended a few appointments before discontinuing chiropractic treatment. (PX 2). Petitioner testified that he has undergone traditional physical therapy for his back, and aqua therapy at the recommendation of Dr. Ayorinde.

Petitioner has also been under the care of Dr. John Watson at the Orthopedic Center of Illinois since late January 2013. An additional MRI was taken, showing a mild C4-5 disc protrusion, which Dr. Watson could not relate to Petitioner's current symptoms. Dr. Watson added that he could not explain any of Petitioner's severe hip pain as coming from the spine. He recommended physical therapy and a surgical consultation with Dr. Joseph Williams. Dr. Williams also recommended physical therapy, and stated in his examination files that Petitioner's symptoms were "vague" and not explained by the MRI findings. Dr. Williams' diagnoses were cervical, thoracic and lumbar spondylosis and "questionable" cervical and lumbar strains. On February 25, 2013, Dr. Williams recommended that Petitioner was fit for light duty work. (PX 6). Petitioner remains off work, and still complains of pain. His vertigo has resolved.

Petitioner's Exhibit 22 contains three photographs. Petitioner testified that pages 1 and 3 of Petitioner's Exhibit 22 were taken by him immediately following the alleged accident via the camera on his cellular telephone. Petitioner testified that page 1 depicts the cut wood that remained after the tree job was completed. He testified that page 3 depicts the site of the work being performed immediately following the alleged accident. Petitioner testified that page 2 of Petitioner's Exhibit 22 are photographs taken by a person from his church sometime after the alleged accident, and depict the source of the limb in question that was cut.

CONCLUSIONS OF LAW

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

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

Petitioner has the burden of proving the issues of "accident" and "causal connection" by a preponderance of the evidence. *Franklin v. Industrial Comm'n*, 211 Ill.2d 272, 811 N.E.2d 684 (2004). Liability cannot rest upon imagination, speculation or conjecture. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 61, 541 N.E.2d 665 (1989); *see also Finch v. Ill. Workers' Comp. Comm'n*, 12 IWCC 638 (June 21, 2012). Two elements are required for a workers' compensation claim to be compensable: the injury must occur in the course of employment, and must arise out of the employment. *Caterpillar Tractor Co.*, 129. Ill.2d at 58. At issue in the instant case is the first element.

Based on the facts presented, the Arbitrator holds that there is insufficient evidence that an injury actually occurred on January 4, 2013. Petitioner's recollection of the incident is called into question due to credibility concerns and the frequent "memory lapses" he experienced at trial during cross-examination. Petitioner was combative during cross-examination, and offered testimony in an overly-protective fashion. Petitioner was unable to recall general and approximate information about his own life history, his previous forms of employment, his own medical treatment, and events leading up to or following his alleged injury. According to the credible testimony of Mr. Yard, Petitioner was not hit by a felled tree. Rather, the tree fell near Petitioner, who was swatted by some minor foliage and twigs. Neither of the other two IDOT crew members saw any accident. (See RX 1). Mr. Yard testified that Petitioner did not

indicate to him that he was injured. Petitioner himself testified that he completed the rest of the work day. Petitioner did not tell any of his crew members that he was injured. (See RX 1). According to the credible testimony of Mr. Blain, Petitioner did not tell his supervisor that he was injured when he reported the incident. Petitioner did not seek medical treatment until the following day, when three different x-rays were taken. None of the x-rays revealed any acute injuries. Petitioner's own orthopedic physicians are unable to explain how the current state of his spine could be causing the symptoms of which Petitioner complains. Petitioner testified that he has complained of some of his current symptoms before the date of his alleged injury. The prior medical records contained in Respondent's Exhibit 3 indicate prior complaints that are similar to the complaints following the incident. Respondent's Exhibit 3 is admitted into evidence over Petitioner's objection. The Arbitrator further finds it suspect that Petitioner was set to begin serving a suspension days after his date of alleged injury. As a result of the totality of this information, the Arbitrator holds that Petitioner has failed to meet his burden of proof and show that by a preponderance of the evidence, an injury arose out of the course of his employment on January 4, 2013.

The Arbitrator finds that the causation opinions of Petitioner's primary care physician, Dr. Sheila Ayorinde, are not compelling or persuasive. Dr. Ayorinde did not see Petitioner until more than a month after his injury. She admittedly did not conduct a physical examination on his back, and did not look for any lingering signs of contusion or impact. She was provided with x-ray results, all of which indicated that Petitioner showed no signs of acute injury on the day after his alleged accident. Dr. Ayorinde ordered two MRIs herself, neither of which showed any significant findings or acute injuries. She admitted that Petitioner possessed several significant risk factors for the development of degenerative back problems, including being overweight and being a smoker. She had also previously treated Petitioner for conditions that he attributed to his alleged injury on January 4, 2013, including lower extremity pain, and impaired range of motion. Further, Dr. Ayorinde's causation opinions (both in her letter and in the deposition testimony) only state that causality in the current matter is "possible." Based on this evidence, the Arbitrator finds that Dr. Ayorinde's statements are insufficient to establish a causative connection between Petitioner's condition of ill-being and his alleged accident. As such, the Arbitrator finds that Petitioner has not met the burden of proof to establish that his current condition of ill-being is causally connected to his alleged 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?; and

Issue (K): Is Petitioner entitled to any prospective medical care?

The Arbitrator finds that Petitioner's injury did not arise out of and in the course of his employment. Further, Petitioner has not established causation. As a result, the Arbitrator finds that Respondent is not liable for any of Petitioner's medical expenses related to the alleged date of injury, January 4, 2013, nor is Petitioner entitled to any prospective medical care at Respondent's expense.

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

The Arbitrator finds that Petitioner's injury did not arise out of and in the course of his employment, and further that Petitioner did not establish causation. As a result, the Arbitrator finds that Petitioner is not entitled to any temporary total disability benefits related to the alleged date of injury, January 4, 2013.

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

ANTONIO PEREZ,

Petitioner,

15IWCC0113

vs.

NO: 11WC19555

PACER CARTAGE, INC.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, employment, medical expenses, Respondent's credit, statute of limitations and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 16, 2013, is hereby affirmed and adopted.

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

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

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

DATED: FEB 9 - 2015
o1/14/15
RWW/rm
046

Charles J. DeVriendt

Daniel R. Donohoo

DISSENT

Perez v. Pacer Cartage, Inc. 11 WC 19555

I respectfully dissent from the majority. In this claim the fundamental issue before the Commission is whether Petitioner sustained his burden of proving an employee-employer relationship between himself and Respondent. I would have found that he did not and would have reversed the Arbitrator and denied compensation.

Petitioner testified that he entered into a contract with Respondent as a truck driver on April 19, 2010. The contract involved a lease of Petitioner's tractor. He used the tractor to pull trailers which had Respondent's name on them. A placard with Respondent's USDOT license number was affixed to his tractor when he was making deliveries for Respondent.

On cross examination, Petitioner testified the lease contract probably indicated it was intended to establish a principal/independent contractor relationship, but he did not read it. He also thought that the contract did not require that he work for Respondent exclusively. Petitioner did not always call the dispatcher when he was looking for loads; "he already knew what [he] would do." The dispatcher was "always contacting you" during his deliveries. When asked whether Respondent supervised the way he conducted his work, Petitioner answered it didn't happen to him, but it did with other people. Petitioner denied he chose his own routes in making deliveries, but then stated "they wouldn't tell you where to go through. If you were a driver you should know which way to go."

Respondent's Field Operations Manager testified Respondent hires employees who receive employment benefits, but it does not employ any diver/operators. Petitioner was an independent contractor from whom Respondent leased a tractor to deliver goods to Respondent's customers. Typically, the independent contractor would contact the dispatcher on a phone he leased from Respondent when he was available, and ask for work. One can also use the phone to request work through an app which did not require actually making a call. The independent contractor had the option of accepting or declining a job that was offered. In almost all cases the customer would be responsible for loading and unloading the trucks. The owner/operator would be required to do that work in about 1% of the cases and there must be prior approval and additional compensation from the customer.

The contract under which the parties operated provides that Petitioner is not to be considered an employee for any purpose whatsoever. It specifies that Respondent assumes complete responsibility for operation of the equipment only to comply with federal regulations and such assumption does not affect the relationship between the parties. Petitioner can decline any offered assignment and can work for others but only after the term of the agreement. Petitioner is not required to buy or rent anything from Respondent. Petitioner is not eligible for any benefits and must obtain workers' compensation insurance.

The contract also provides that Petitioner directs all operation of the equipment as long as it complies with law and requirements of customers. Petitioner determines the time of pickup and delivery and sets his own working hours. Petitioner is required to maintain insurance in the amount specified by Respondent, including workers' compensation insurance, but he did not have to purchase it through Respondent. Petitioner is required to get signatures of customers upon delivery to facilitate Respondent getting paid. The term of the contract is 90 days but it is automatically renewed unless either party notifies the other party that the agreement is terminated five days prior to expiration of the term. However, either party may terminate the contract for material breach in one day. The agreement specifies that Petitioner has "read and understand" the contract. Also admitted into evidence were directives in which drivers were informed of certain requirements of certain customers, directed to certain parking areas, and advised not to be "late" and to inform Respondent if they were unable to accept loads on certain days.

In my opinion it seems clear that it was the intention of the parties to enter into a principal/independent relationship through the contract they executed. Even Petitioner admitted that was "likely" the case. In such a situation, I believe the Commission should defer to such an intention of the parties unless there is convincing evidence that the respondent exerted substantial control over the job activities of the claimant. I do not believe such evidence was adduced in the claim now before the Commission. The facts that Petitioner had complete control over his equipment, could turn down assignments, could terminate the contract, could hire employees, and could work for other carriers all militate against a level of control necessary to establish an employer-employee relationship. In my opinion, all of the alleged "control" Respondent asserted basically involved the requirement that both entities abide by all applicable federal, state, and local laws and that Petitioner abide by the particular requirements of Respondent's customers. In my opinion such "control" is insufficient to establish an employment relationship.

For these reasons, I respectfully dissent.

O-1/14/15
RWW/dw
46

Ruth W. White
Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0113

PEREZ, ANTONIO
Employee/Petitioner

Case# **11WC019555**

PACER CARTAGE INC
Employer/Respondent

On 10/16/2013, 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 0.15% 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:

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

1454 THOMAS & ASSOCIATES
STEVEN COSTELLO
300 S RIVERSIDE PLZ SUITE 2330
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0113

ANTONIO PEREZ
Employee/Petitioner

v.

PACER CARTAGE, INC.
Employer/Respondent

Case # **11** WC **19555**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **GREGORY DOLLISON**, Arbitrator of the Commission, in the city of **NEW LENOX, IL**, on **JUNE 19, 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. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] 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?
[x] TPD [ ] Maintenance [ ] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **PROSPECTIVE CARE**

FINDINGS

On **MAY 4, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**62,146.76**; the average weekly wage was $**1,195.13**.

On the date of accident, Petitioner was **43** years of age, *married* with **1** children under 18.

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

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $796.75/week for 111 weeks, commencing May 5, 2011 through June 19, 2013, as provided in Section 8(b) of the Act.

Respondent shall be given no credit for benefits paid in this matter.

Respondent shall authorize payment for the follow-up visit prescribed by Dr. Atluri and the follow-up care for the left Achilles tendon prescribed at Metro South Medical Center.

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

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

10/15/13
Date

ICArbDec p. 2

OCT 16 2013

15IWCC0113

FINDINGS OF FACTS:

Petitioner testified that on April 19, 2010 he entered into a contract described as "Vehicle Lease and Independent Contractor Hauling Agreement" with Respondent. (PX1 and RX1). Per this contract he would lease his tractor to Respondent and then drive to pull trailers owned by Respondent or its customers. He was dispatched by Respondent and upon completion of a trip he would contact Respondent's dispatcher for his next assignment. He never hauled freight for another company during the pendency of the contract. Petitioner testified that he was required to display a sign on his truck with the name of Respondent and with the numbers assigned to Respondent by the United States Department of Transportation. Petitioner identified a photo of his truck which shows this required signage. (PX2).

Petitioner testified the compensation for the lease of the tractor and his services was a percentage of the revenue from the trip. There were no deductions for taxes or social security taken from his checks. The contract required him to purchase workers' compensation insurance. He paid all of the operating expenses for the tractor including fuel, license plates and maintenance. He was free to choose the routes used to complete his assignments.

On May 4, 2011 Petitioner fell from his truck while connecting a hose. He noted pain and swelling in his right elbow. He sought care that day at Metro South Hospital where x-rays failed to reveal any fractures. A mold splint was applied. Petitioner sought care on May 6, 2011 with Dr. Carl Dilella, an orthopedic surgeon. (PX4). Dr. Dilella noted pain and swelling in the area of the right distal triceps muscle. He ordered an MRI of the right elbow which revealed triceps tendonitis and a contusion to the humerus.

Petitioner also sought treatment at Work Right Occupational Health where he complained on May 9, 2011 of pain in his right elbow and right shoulder. A course of physical therapy, medication, activity restriction and a cortisone injection did not provide Petitioner any relief from right shoulder pain. On October 5, 2011, Dr. Ramsey referred Petitioner to Dr. Sam Biofora, an orthopedic surgeon, at Hand Surgery Associates. (PX3).

Dr. Biofora examined Petitioner on September 30, 2011 and found a decreased range of motion in the right shoulder. The Speeds, Yergason and cross-arm tests were all positive. Dr. Biofora reviewed an MRI of the right shoulder taken on July 21, 2011 which showed a small linear non-retracted full-thickness tear of the supraspinatous tendon with mild tendinopathy of the infraspinatus and subscapularis and also acromioclavicular arthritis. Dr. Biofora performed surgery to the right shoulder of Petitioner on November 30, 2011 at Metro South Medical Center. (PX6). Surgery consisted of a debridement of capsulitis and of a tear of the superior labrum, a partial acromioplasty, a distal clavicle resection and a biceps tenodesis.

Petitioner then underwent a course of physical therapy which afforded him some relief. Petitioner attempted a return to work as a truck driver on May 18, 2012 but returned to Dr. Birman (Dr. Biofora's partner) on June 1, 2012 complaining of pain and numbness over his right shoulder. A post-arthrogram MRI performed on June 30, 2011 showed a rupture of the long head of the biceps tendon and a possible a labral tear.

On September 28, 2012 Dr. Atluri performed a second surgery. Dr. Atluri noted that the biceps tendon long head was absent. The subscapularis tendon was torn. Dr. Atluri debrided abundant subcoracoid adhesions and extensive scarring in the subacromial space. He also further resected the clavicle, the acromium and the coracoid.

Petitioner underwent a course of physical therapy followed by work hardening. On February 13, 2013 Petitioner noted pain in his left heel while attempting to balance on his toes at work hardening. He went to Metro South Medical Center on February 19, 2013 where his injury was diagnosed as a partial tear of the left Achilles tendon (PX6). Petitioner was prescribed crutches and advised to follow up with an orthopedic surgeon. Petitioner testified that he has not received additional treatment due to a lack of insurance.

Petitioner resumed work hardening on April 15, 2013 but returned to Dr. Atluri on April 29, 2013 complaining of increased pain in his right shoulder. Dr. Atluri discontinued work hardening and ordered an FCE so as to determine permanent restrictions. (PX Group 5).

Petitioner underwent an FCE at ATI Physical Therapy on May 1, 2013. (PX9) The FCE demonstrated a Valid representation of Petitioner's present physical capabilities which were at the Light Physical Demand level. The examiner concluded that Petitioner's physical capabilities did not match the Medium Physical Demand Level required of truck drivers.

Petitioner never returned to Dr. Atluri following the FCE. His workers' compensation insurance policy provided compensation and medical benefits for 104 weeks. These benefits expired on May 4, 2013, the second anniversary of the accident. Petitioner testified that he received weekly disability benefits for 104 weeks.

Petitioner testified that he has not received any medical care for his right shoulder since seeing Dr. Atluri on April 29, 2013. He is right hand dominant. He notices pain, numbness, stiffness and a decreased range of motion in his right shoulder. He also has pain in his left heel.

Mr. Matthew Bahena testified that he was a field operations manager for Respondent at the McCook terminal. Bahena testified that Petitioner was considered to be an independent contractor per the contract and not the employee of Respondent. Petitioner would communicate regularly with Respondent's dispatchers using a text message phone which Petitioner leased, at his option, from Respondent. Bahena testified that Petitioner was free to accept or decline any assignment, choose his own route or drive for anyone else. Petitioner received activity based pay which varied from load to load. The mileage travelled was a factor in determining the compensation. Petitioner received a form 1099 and not a W-2 at the end of the year. Bahena testified that Petitioner could choose his work schedule and had to pay for his own insurance, fuel and other operating expenses.

On cross-examination Bahena testified that Respondent is in the transportation business and that Petitioner is a truck driver. Respondent currently has 123 owner-operators such as Petitioner at its McCook facility. The phone which Petitioner leased from Respondent had an application for load specific information and a direct connect feature. Petitioner however could have used his own cell phone. Bahena agreed that the contract (RX1) is open-ended with renewable 90 day terms and that the parties were operating under the original contract of April 19, 2010 on the date of accident. Bahena testified that Wayne, an employee of Respondent, would regularly be out in the yard inspecting the trucks of the owner-operators for compliance with safety regulations.

The parties each offered into evidence the contract and vehicle lease agreement which acknowledged that Petitioner was "experienced in the business of transporting cargo by motor vehicle" and that Respondent "was engaged in the transportation of property". (PX1 and RX1). The contract states that the relationship between the parties is to be that of principal and independent contractor with Respondent having no right to control the manner or prescribe the method of accomplishing the services rendered. The contract acknowledged

that Federal Motor Carrier Safety Act ("FMCSA") regulations required Respondent to "have exclusive possession, control and use of the equipment for the duration of the lease". (p. 2).

Per the contract, Petitioner could decline loads and Respondent did not guarantee a minimum number of shipments. Petitioner could work for others (p. 2 Sec 2) but his availability, efficiency and reliability were factors to be considered in assigning cargo to him. (p. 4). Petitioner had to give "reasonable advance notice" as to whether his vehicle was available. (p. 4). The vehicle had to pass Respondent's inspection, be in good working condition and be less than 15 years old unless Petitioner obtained a waiver of that requirement from Respondent. (p. 3)

According to the contract Petitioner controlled the loading and unloading of the truck, the routes, rest stops and where he purchased fuel. Petitioner bore all of the costs for licensing, fuel, maintenance and repairs. He was paid a percentage of the revenue for each load plus an occasional fuel surcharge. There was no tax or social security withheld by Respondent and Petitioner was not eligible for the fringe benefits Respondent provided its employees. In order to be paid, Petitioner had to submit the necessary paperwork obtained from Respondent's customers as well as his FMCSA logbooks. (p. 6). Respondent provided the necessary shipping documents and collected payment from its customers for the services rendered by Petitioner. (p. 5).

Petitioner had to report all accidents to Respondent within six hours. Respondent provided Petitioner with an accident kit consisting of a questionnaire and single-use camera. Petitioner was prohibited from transporting passengers or ride-alongs without Respondent's written permission. (p. 5). Petitioner was required to carry collision insurance coverage for his tractor in case it was damaged in an accident (p. 9). He also had to purchase workers' compensation insurance for himself. (p. 3). He was required to buy non-trucking or "bobtail" liability insurance for accidents occurring when he was not providing services under the contract. (p. 9).

The contract provided that it would expire in 90 days but would automatically renew unless either side gave five days notice on non-renewal. Either party could terminate the contract on 24 hours notice following a breach of the agreement.

With respect to issue (B.) Was there an employer-employee relationship, the Arbitrator finds as follows:

The Arbitrator finds that an employer-employee relationship existed between the parties on May 4, 2011.

The determination of whether an injured worker is an employee or an independent contractor is a fact-specific inquiry. No rule has been, or could be, adopted to govern all cases in this area. Henry vs. Industrial Commission 412 Ill. 279, 282 (1952). The courts have articulated a number of factors in making this determination. The term "employee" for purposes of the Act should be broadly construed. C.H.A. vs. Industrial Commission, 240 Ill App. 3d 820(1992).

The single most important factor is whether the purported employer has a right to control the actions of the employee. Ware vs. Industrial Commission, 318 Ill. App 3d 1117 (2000). Also of great significance is the nature of the work performed by the employee in relation to the general business of the employer. Additional factors are the method of payment, the right to discharge, the skill the work requires, which party provides the needed instrumentalities and whether taxes were withheld. A factor of lesser weight is the label the parties attach to the relationship. Ware (supra)

As stated above, the most important factor is the right to control. The actual exercise of control by an employer is strong evidence of the right to control. Only clear evidence that Respondent exceeded its control would overcome the conclusion that the right to control existed. Bob Neal Pontiac-Toyota vs. Industrial Commission, 89 Ill. 2d 403 (1982).

In this case, Petitioner drove exclusively for Respondent under an open-ended 90 day lease which had renewed itself four times prior to the accident. Respondent forbade Petitioner from carrying passengers or ride-alongs and his truck had to pass quarterly inspections by Respondent. Wally, a yard manager, checked Petitioner's truck on a regular basis for safety and equipment violations. Petitioner was required to display Respondent's name on his truck and he drove using the numbers issued to Respondent by the Department of Transportation. (PX2). Petitioner had no customers of his own and his work consisted entirely of servicing Respondent's customers. Respondent billed and collected for the services rendered by Petitioner.

The Arbitrator notes that the contract and the testimony of Bahena established that Respondent required Petitioner to cover himself with a policy of workers' compensation insurance. Under the Workers' Compensation Act, a self-employed independent contractor may decline purchasing a workers' compensation insurance policy for himself. Petitioner had no such option under the contract. Respondent also required Petitioner to purchase collision insurance to cover the replacement cost of his own tractor.

Finally, the lease gave "exclusive possession, control and use" of Petitioner's tractor to Respondent for the duration of the lease. Although such language in the contract is required by the FMCSA and Respondent was merely acting in compliance with the law does not diminish the fact that Respondent was exercising control over Petitioner. Ware (supra)

The second most important factor, the relative nature of Petitioner's work in relation to Respondent's business, also supports the conclusion that an employer-employee relationship existed. As stated in the "Recitals" section of the contract, Respondent is a trucking company and Petitioner is a truck driver. Bahena testified that Respondent has 123 owner-operators currently working under contracts similar to the contract offered into evidence. Petitioner's work as a truck driver was intimately related to the nature of Respondent's business as a cartage company.

Another consideration is determining the nature of the relationship is which party provided the instrumentalities needed to conduct business. Petitioner provided a tractor but Respondent provided the trailers hauled by Petitioner. Respondent also provided all of the paperwork such as seals, bills of lading and all shipping documents necessary to comply with the FMCSA. (See p. 4, paragraph E of PX1).

The right to discharge is another factor to be considered. As in Ware (supra) the parties in this case had an "at-will" relationship where either party, for whatever reason or no reason at all, could unilaterally terminate the agreement upon five days notice. As in Ware, Respondent had the right to terminate the contract for certain breaches by Petitioner. The right to discharge under these circumstances was held to be indicative of an employment relationship. Ware (supra)

Other factors may point toward a finding that Petitioner was an independent contractor but these factors are not persuasive. Although the contract identified Petitioner as an independent contractor, the label applied by the parties in a minor consideration. Ware (supra). The fact that Respondent did not withhold taxes from Petitioner's compensation is not a significant factor. The Court in Ware attached little weight to that factor.

The Arbitrator finds that a majority of the factors considered, including the two principal factors, supports the conclusion that an employer-employee relationship existed between the parties on May 4, 2011.

With respect to issue (C.) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner sustained an accident arising out of and in the course of his employment by Respondent on May 4, 2011.

Petitioner testified that on May 4, 2011 he fell from a height of five feet from his truck while connecting a hose. The accident occurred on Respondent's premises. Petitioner noted pain in his right arm and immediately reported the accident to Robert, Respondent's dispatcher. Respondent did not offer any evidence to rebut this testimony.

Petitioner sought medical care that day at Metro South Medical Center which recorded a consistent history (PX3). Petitioner complained of pain in his right elbow and shoulder from a fall at work two days later at Work Right Occupational and to Dr. Dilella. All of the medical records corroborate Petitioner's description of the accident.

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

Petitioner testified that he was working regularly and had no complaints relative to his right upper extremity or left foot prior to May 4, 2011. Petitioner sustained an injury to his right elbow and shoulder on that date. He began a course of medical care and disability which have continued to the date of arbitration. Petitioner further testified that he sustained an injury to his left foot on February 13, 2013 while attending work hardening as prescribed by Dr. Atluri. He was seen at Metro South on February 19, 2013 where he complained of the onset of pain in his left heel while attempting to balance on his toes at work hardening. (PX6). His x-rays revealed a partial rupture of the left Achilles tendon. Petitioner has had no further care to his left foot due to insurance issues. Respondent offered no evidence supporting a finding of no causal connection.

Based on the chain of events, the Arbitrator finds that there is a causal connection between the accident and the conditions of ill-being in the right arm, right shoulder and left foot of Petitioner.

With respect to issue (K.) What temporary total disability benefits are in dispute, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner was temporarily totally disabled from May 5, 2011 through June 18, 2013, a period of 111 weeks.

Petitioner received emergency care at Metro South Hospital on the date of accident (PX6). Petitioner came under the care of Work Right Occupational Health on May 6, 2011 which authorized him to be off work. Work Right referred Petitioner to Dr. Atluri who performed two surgeries to the right shoulder of Petitioner. Dr. Atluri advised Petitioner to stay off work completely for a period of time following the surgeries. Dr. Atluri subsequently released Petitioner to return to work on a light duty basis. Respondent made no showing that it had any light duty work available to Petitioner. On April 29, 2011, Dr. Atluri ordered Petitioner to return to see him for final restrictions after undergoing an FCE. The valid FCE on May 1, 2013 indicated that Petitioner did not meet the physical demands of his job as a truck driver. Petitioner did not see Dr. Atluri as requested

following the FCE for the imposition of permanent restrictions because his insurance coverage expired May 4, 2013. The permanent restrictions to be imposed on Petitioner remained undetermined at the time of arbitration. Petitioner is therefore not at maximum medical improvement for his right shoulder and he also requires treatment for his partially ruptured left Achilles tendon.

With respect to issue (N.) Is Respondent due any credit, the Arbitrator finds as follows:

The Arbitrator denies Respondent's claims for credit under Section 8(j) of the Act. Petitioner testified that he paid the premiums for the workers' compensation insurance coverage required by the contract. Respondent did not offer any evidence that it paid such insurance premiums in whole or in part as is required by Section 8(j) of the Act.

With respect to issue (O.) Prospective Medical, the Arbitrator finds as follows:

The Arbitrator finds that Respondent shall authorize the follow-up visit prescribed by Dr. Atluri and follow-up medical care for the partial rupture of the left Achilles tendon.

On April 29, 2013, Dr. Atluri prescribed a functional capacity evaluation and advised Petitioner to return for the imposition of permanent restrictions. Petitioner underwent the FCE (PX9) on May 1, 2013 but did not return to see Dr. Atluri due to a lack of insurance. Petitioner was advised by the emergency room doctor at Metro South to obtain follow-up care for the partial rupture of the left Achilles tendon. Petitioner again did not obtain follow-up care because his insurance policy had expired.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JIMMIE BOATRIGHT,

Petitioner,

vs. NO: 08 WC 43833

THE AMERICAN COAL COMPANY, **15IWCC0114**

Respondent.

DECISION AND OPINION ON REMAND FROM THE CIRCUIT COURT OF WILLIAMSON COUNTY

The Commission is in receipt of an Order of Remand from the Circuit Court of Williamson County, relative to the above captioned matter, under its case number 14 MR 8, by which it reversed the Decision of the Commission under its case number 13 IWCC 1087, finding that the Commission's Decision was erroneous as a matter of law.

As a result of the Circuit's Order of May 30, 2014, the Commission must find that the Petitioner sustained an exposure which occurred in the course and scope of Petitioner's employment with the Respondent. Based upon the Circuit Court's Order, relying upon Freeman United Coal Mining Co. v. Indus. Comm'n (Lefler), 188 Ill. 2d 243, 247 (Ill. 1999), the Commission further finds that Petitioner's condition of ill-being is causally related to said exposure. We further award Petitioner 20% loss of the person as a whole.

FINDINGS OF FACT

The Commission adapts certain of the findings of Arbitrator Gallagher as made in his November 28, 2012 decision. We restate and incorporate those findings below.

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a work-related occupational disease to his lungs and/or heart as a result of inhalation of coal dust, rock dust, fumes and vapors for a period in excess of 40 years. The date of last exposure alleged in the Application was September 23, 2008.

Petitioner was born in 1932 and, at the time of trial, was 79 years old. From 1965 to 1992 Petitioner worked as a coal miner for various coal companies. He retired from coal mining and began a landscaping business which remains in operation at this time. Petitioner went to work at Bombadier as a security guard in 1995, and in November, 2000, he began working for Respondent as a security guard because of better pay. Petitioner worked for Respondent in that capacity until November 8, 2007, when he was laid off. Petitioner returned to work for Respondent at the request of Bill Winters, Respondent's Chief of Security, on September 22, 2008. Petitioner only worked two shifts for Respondent and his last day of work for Respondent was September 23, 2008, the date of last exposure alleged in the Application.

Petitioner testified that his work as a security guard for Respondent caused him to be exposed to coal mine dust on a daily basis. Petitioner's job duties required him to patrol the area including the bathroom and wash room and drive people from one portal to another by bus. The last two days Petitioner worked for Respondent in September, 2008, he made the rounds in the parking lot and then inside the wash house. Petitioner never worked as a coal miner for Respondent.

Following Petitioner's layoff, he worked as a security guard at The Lighthouse Shelter in Marion, Illinois. Following the cessation of his work for Respondent, he became employed by IRA Detective Agency and worked as a security guard at Bombadier. Petitioner continued to work there up through and including the date this case was tried.

Petitioner testified that during his 12 hour shifts as a security guard for Respondent, approximately 80% of his time was spent away from the guard shack. He testified that while he worked in the coal mines, he experienced shortness of breath when walking. He first noticed this symptom in the late 1980's when he was working in the prep plants. Petitioner testified his breathing problems got a little bit worse from the time he first noticed them until he left coal mining. When he was working as a guard, his breathing problems would flare up when he had to climb stairs. He did not engaged in this activity the last two days he worked for Respondent. At trial, Petitioner testified he could walk about half a block before becoming short of breath and that he could climb ten to twelve steps before he would have to stop and rest. Petitioner testified that his breathing problems affected his activities of daily living and when this happened, he would either sit down or quit what he was doing for a while. Petitioner testified that, in spite of his breathing problems, he had no intention from retiring from work. Petitioner testified he smoked cigarettes starting at the age of 19 and quit on New Year's Eve, 1978. When he smoked, he smoked an average of a pack a day.

Bill Winters testified on behalf of the Respondent. Winters is the Chief of Security at Respondent and has been employed there for 31 years. Winters testified that Petitioner informed him that he was leaving his job with the Respondent because he did not want to work the 12 hour shifts or night shifts any longer. He did not complain to Winters about shortness of breath or any inability to perform his job.

Petitioner was examined by Dr. William Houser on February 12, 2009, at the direction of his attorney. Dr. Houser previously took the B-reader course and test to be certified as a B-reader; however, he failed the certification examination. Petitioner informed Dr. Houser that he had complaints of shortness of breath which occurred when walking one block on level ground or climbing two flights of stairs. He also complained of a slight cough which occasionally produced sputum. Petitioner informed Dr. Houser of his prior cigarette smoking and the fact that from 2000 to 2007 he worked for Respondent as a security guard. He further informed Dr. Houser that when he returned to work in September, 2008, he was unable to perform the job due to dust exposure and the physical demands of the job. Dr. Houser testified Petitioner had shortness of breath dating back to 2007. Dr. Houser further testified that there are numerous causes of shortness of breath including heart disease and deconditioning. Dr. Houser testified that given the fact that Petitioner was 76 years of age when he examined him and that he was obese and had heart disease which led to stent placement, that he was not shocked that Petitioner became short of breath after climbing two flights of stairs.

Dr. Houser's examination of Petitioner's chest was normal. Dr. Houser noted that a chest x-ray of July 31, 2008, revealed P/S opacities in all lung zones, category 1/0 pneumoconiosis. Dr. Houser testified that Petitioner's spirometry showed mild airway obstruction based on the FVC/FEV1 ratio but he did not know whether Petitioner's pulmonary function was any different prior to his employment with Respondent than when Dr. Houser measured it on February 12, 2009.

Dr. Houser testified that his diagnosis of coal workers' pneumoconiosis was based upon Petitioner's history of exposure to coal dust and a positive chest x-ray finding and that absent either one of those, he would not have diagnosed coal workers' pneumoconiosis in Petitioner. Dr. Houser testified that Petitioner could not have any further exposure to the environment of a coal mine without endangering his health. He further testified that the scarring and emphysema of coal workers' pneumoconiosis are permanent and they cannot perform the function of normal healthy lung tissue.

Dr. Henry Smith, a NOISH B-reader, interpreted a chest x-ray of May 13, 2008, as positive for pneumoconiosis with P/S opacities in the mid to lower lung zones bilaterally and profusion of 1/0. He interpreted a chest x-ray of July 31, 2008, as positive for coal workers' pneumoconiosis with interstitial fibrosis and P/S opacities in all lung zones with a profusion of 1/1. Dr. Smith interpreted a CT scan of May 13, 2008, as consistent with simple coal workers' pneumoconiosis with P/S opacities in the mid to lower lung zones bilaterally and a profusion of 1/0. Dr. Smith interpreted a chest x-ray of November 6, 2008, as early mild simple coal workers'

pneumoconiosis with P/P opacities in the bilateral mid to lower lung zones and a profusion of 1/0. He made a similar interpretation of a CT scan of that same date.

At the request of Respondent, Dr. Jerome Wiot, a B-reader, reviewed chest x-rays regarding Petitioner. Dr. Wio reviewed a chest x-ray and CT scan dated May 13, 2008, chest x-ray dated July 31, 2008, and a chest x-ray dated November 6, 2008, as well as a CT scan of that same date. Dr. Wiot found no evidence of coal workers' pneumoconiosis in any of these diagnostic studies. Dr. Wiot noted the study of May 13, 2008, revealed a non-calcified nodular density at the right base and a non-calcified nodule at the left base; however, he testified that those findings were not associated with Petitioner's dust exposure.

At the request of Respondent, Dr. Lawrence Repsher conducted a review of medical records and films regarding the Petitioner. Dr. Repsher is a certified NOISH B-reader. Dr. Repsher reviewed a chest x-ray dated July 31, 2008, a CT scan dated May 13, 2008, and found no evidence of coal workers' pneumoconiosis on these diagnostic studies. Dr. Repsher testified that the medical records he reviewed regarding Petitioner revealed the presence of heart disease and that this is the most common cause of shortness of breath. Dr. Repsher opined Petitioner has never suffered from coal workers' pneumoconiosis or any other respiratory disease or condition either caused or aggravated by the inhalation of coal mine dust. He further testified Petitioner has no functional limitation from the pulmonary standpoint based upon the testing he reviewed.

Petitioner underwent VATS resection of a benign necrotic tumor in the right lower lobe of his lung in June, 2008. Dr. Repsher testified there were no coal macules seen in the biopsy specimen from the right lower lobe. He testified that it would be very unlikely that there would be any coal macules elsewhere in the lungs.

Medical records of Dr. Albert Bledig were received into evidence. Petitioner had balloon angioplasty performed in February, 1991, for coronary artery disease and he described no shortness of breath at the time of the examination on January 18, 1993. On November 6, 1996, it was noted that Petitioner had occasional shortness of breath but he weighed 238 pounds at that time. Examination of the lungs revealed no rales. On a physical examination on November 27, 1997, Dr. Bledig noted Petitioner did not have shortness of breath. On the August 22, 2007, examination, Petitioner's lung were clear with no wheezing or crackles. Physical examinations conducted on September 20, 2010, and August 11, 2011, revealed Petitioner's lungs to be clear.

Medical records of St. Mary's Medical Center were received into evidence. These records included records from the Welborn Baptist Hospital. On February 20, 1991, Petitioner was hospitalized at Welborn with a three week history of chest pain associated with shortness of breath. The medical record there revealed Petitioner was a smoker having smoked a pack a day for over 30 years. Examination of Petitioner's lungs were clear. A CT of the abdomen taken on May 1, 2008, revealed a non-calcified pulmonary nodule at the base of the right lung. On June 4, 2008, Petitioner underwent a flexible fiber optic bronchoscopy for the right lower lobe lung nodule. The microscopic description of the pathology report noted a chronic nodule surrounded

by fibrotic hyalinized lung. The lung area remote from the nodule had scattered fibrosis, inflammation and emphysematous changes but no other specific findings. The discharge summary listed smoking as a diagnosis.

Further medical records of Prairie Cardiovascular were received into evidence. On June 25, 1999, Petitioner was admitted to St. John's Hospital with a complaint of unstable angina. It was at this time that Petitioner underwent a cardiac catheterization which revealed severe coronary artery disease. Petitioner successfully had performed on him a coronary stenting of the right coronary artery. It was noted in connection with that hospitalization that his lungs were clear. Subsequent examinations conducted on March 8 and August 22, 2001, revealed that his lungs were clear.

CONCLUSIONS OF LAW

Per direction of the Circuit Court, the Commission finds Petitioner sustained an exposure in the course and scope of his employment with Respondent as a matter of law.

Accordingly, we find that Petitioner's exposure is causally connected to his last employment. Petitioner worked for various coal companies for about 40 years, and as recently as 2008. While Petitioner admitted to smoking one pack of cigarettes a day for about 20 years, he quit smoking in the 1980s. He spent a significant amount of time surrounded by and exposed to coal dust and other associated hazards. Petitioner testified he worked above ground in the mining area. Even though he did not spend his days below ground in the mine itself, Petitioner was still exposed to all of the airborne hazards of a coal mine and inhaled coal dust and other particles that were brought to the surface by miners and equipment.

The Act provides a presumption that the cause of Petitioner's coal workers' pneumoconiosis was his work at the coal mines. The Act provides "If a miner who is suffering or suffered from pneumoconiosis was employed for 10 years or more in one or more coal mines there shall, effective July 1, 1973 be a rebuttable presumption that his or her pneumoconiosis arose out of such employment." 820 ILCS 310/1(d). Petitioner met that presumption and Respondent has failed to rebut it.

Further, we find Petitioner's average weekly wage was $457.18. Petitioner submitted evidence into the record that in 2007, the last year he worked for Respondent, he earned $23,773.31. When his salary of $23,773.31 is divided by 52 weeks, it equals $457.18.

IT IS THEREFORE ORDERED BY THE COMMISSION that Decision of the Commission filed on December 20, 2013 is reversed as stated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $274.31 per week for a period of 100 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the 20% loss of the person as a whole.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,500.00. 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: FEB 9 - 2015
TJT: kg
R: 12/2/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF DU PAGE	)		

☒ 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

Delilah Olan,

Petitioner,

vs. NO: 14 WC 11424

Wal-Mart/Sam's Club, 15IWCC0115

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, temporary total disability, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 30, 2014, 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.

15IWCC0115

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,500.00. 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: FEB 9 - 2015
TJT:yl
o 2/2/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b-1) DECISION OF ARBITRATOR

OLAN, DELILAH

Employee/Petitioner

Case# **14WC011424**

WAL-MART/SAM'S CLUB

Employer/Respondent

15IWCC0115

On 10/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ $337.68 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and

3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
KARIN CONNELLY
101 N WACKER DR SUITE 200
CHICAGO, IL 60606-7307

0560 WIEDNER & McAULIFFE LTD
BROOKE E TORRENGA
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-1)

Delilah Olan
Employee/Petitioner

v.

Wal-Mart/Sam's Club
Employer/Respondent

Case # **14** WC **11424**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **6/11/14; 8/5/14; 8/15/14**. Respondent filed a *Response* on **7/15/14; 8/14/14; 9/2/14**. The Honorable **Brian Cronin**, Arbitrator of the Commission, held a pretrial conference on **8/1/14** and a trial on **9/12/14** and **9/30/14**, in the cities of **Wheaton** and **Chicago.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **9/12/13**, 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 of her cervical spine *is not* causally related to the accident.

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

In the year preceding the injury, Petitioner earned $**16,900.00**; the average weekly wage was $**325.00**.

On the date of accident, Petitioner was **35** years of age, *single* with **2** dependent children.

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

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

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

ORDER

As he finds that petitioner's current condition of ill-being of her cervical spine is not causally related to the accident of September 12, 2013, the Arbitrator denies TPD benefits, TTD benefits, medical expenses and prospective medical care as it relates to petitioner's cervical spine.

The Arbitrator finds that petitioner is entitled to 4-3/7 weeks of TTD benefits, from 5/30/14 through 6/30/14, at a rate of $319.00/week, as it relates to petitioner's right shoulder condition.

Respondent has paid for all reasonable and necessary medical services.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $337.68 for the *final* cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

October 29, 2014
Date

OCT 30 2014

FINDINGS OF FACT

Petitioner is employed as a sales floor associate with respondent. (T. 7) Petitioner testified that on September 12, 2013, she "kind of yanked" a box of books that weighed approximately seven pounds and subsequently noticed "a little - - it was just a weird stinging feeling" in the top anterior part of her right shoulder. (T. 10-11) She testified that at that time, she reported the injury to her supervisor, Dan Gribble, and filled out an accident report. (T. 11-12)

An Associate Incident Report, which was completed and signed by petitioner, a triage report, a Form 45 and a Witness Statement, which was completed and signed by Dan Gribble, all indicate that petitioner did not report the accident until the next day, September 13, 2013. (RX1, 2, 3, 4) Dan Gribble indicated in his witness statement that petitioner informed him of the injury as she was leaving work on September 13, 2013, and further wrote that she was "going to see her own doctor." (RX4) All reports identify complaints of right shoulder/arm pain.

In the Associate Incident Report, petitioner described the events leading up to the accident as follows:

> "I was pulling RTU & went to lift boxes under books. I flet (sic) a little sting on my right arm. As the day went by there, my arm has been hurting."

On September 13, 2013, petitioner sought treatment with Arif Saleem, M.D., at Castle Orthopaedics & Sports Medicine. Four months prior, Dr. Saleem had released petitioner to return to work after he had performed right shoulder surgery on her on February 25, 2013. Upon presenting to Dr. Saleem on September 13, 2013, petitioner complained of anterior and lateral right shoulder pain after lifting something at work the day before. She felt a strain but did not feel a pop in the shoulder. (PX1, p. 26) Dr. Saleem diagnosed her with a right shoulder strain and released her to return to work with restrictions. On September 14, 2013, respondent began accommodating these work restrictions.

On September 27, 2013, petitioner saw Kristin Engle, PA-C, at Castle Orthopaedics & Sports Medicine. Ms. Engle wrote: "She did not have any sudden pain at the time of doing the activity but it was after the fact that her shoulder became very sore for her." Ms. Engle further noted that the pain has not improved but "is persisting" and that she "denies any feelings of instability." (PX1, p. 24) Petitioner underwent a right shoulder MRI arthrogram, which revealed distal clavicular osteolysis with no superior labral tear or rotator cuff tear identified. (PX1, p. 129-30)

Petitioner again saw Kristin Engle, PA-C, at Castle Orthopaedics & Sports Medicine on

November 13, 2013. Ms. Engle wrote that petitioner's right shoulder symptoms were improving. (PX1, p. 22) Apparently, Ms. Engle had previously recommended physical therapy for petitioner, but "due to insurance reasons, she has not been able to get into therapy yet." (PX1, p. 22)

For the next two months, Petitioner did not receive any treatment for her right shoulder. She initiated physical therapy on January 16, 2014. (PX1, p. 21) During the initial evaluation the therapist recorded that she "does not have any numbness or tingling in her fingers." Petitioner exhibited pain with palpation to the right supraspinatus and biceps, as well as to the right infraspinatus muscle. (PX1, p. 21) Petitioner underwent eight therapy sessions through February 13, 2014.

In a History & Physical Report #16, dated February 13, 2014, Physical Therapist Keith Champen wrote, in pertinent part, the following:

" . . . She reports that her shoulder is feeling a little better since last week. She reports that her pain rating is 5/10 on a VAS. The pain is not going down her arm as bad as it did last week . . . " (PX1, p. 19)

At a follow-up appointment with Dr. Saleem on February 14, 2014, petitioner complained of persistent pain and discomfort despite therapy. (PX1, p. 17) He found that she had pain with the Hawkins and Neer signs, as well as with the O'Brien's test. She also had mild biceps tenderness. Dr. Saleem recommended a right shoulder cortisone injection, which petitioner underwent on February 18, 2014. (PX1, p. 14)

A Nurse Note of Castle Orthopedics indicates that petitioner called the office on March 12, 2013, and stated that she received only minimal relief of her shoulder pain following the injection. Petitioner also reported that "since the weekend" the pain has increased and "goes to the neck." Petitioner reported that her shoulder got mildly better with the injection, primarily in regard to her ROM, but that the shoulder "now hurts like it used to." She experiences occasional numbness/tingling when her shoulder starts to ache. The nurse instructed petitioner to schedule a follow-up appointment. (PX1, p. 52)

On March 18, 2014, petitioner stated that the injection did help with some muscle tightness in the shoulder. (PX1, p. 11) On physical examination, she had mild pain with Hawkin's and Neer signs and tenderness over the trapezius muscle. Cervical range of motion was intact and Spurling Maneuver did not cause any radicular type symptoms down the arm. A cervical MRI was recommended "due to persistent pain and symptoms coming from the neck." (PX1, p. 12) A cervical MRI on March 28, 2014 revealed a right-sided herniation at C5-6 and a disc bulge at C3-4. (PX1, p. 105-106)

Petitioner came under the care of Thomas J. McGivney, M.D., on April 14, 2014. (PX1, p. 9) He noted that petitioner had a "convoluted history" including a prior labral repair and subsequent re-injury at work after lifting a box. He wrote that petitioner's shoulder MRI did not show abnormalities and "she subsequently started having worsening symptoms with pain radiating down the arm with numbness and tingling." Upon examining petitioner, he found a positive Spurling's sign and subjective complaints of pain radiating down the radial nerve

distribution of C6 to the thumb. He reviewed the MRI, diagnosed a disc herniation at C5-6 and recommended a total disc replacement at C5-6. Dr. McGivney concluded that it had been "8 months since the onset of the second injury" and that "therapy has failed." (PX1, p. 10)

Petitioner presented to the Rush Copley Medical Center ER on May 28, 2014, with complaints of chronic neck pain associated with numbness radiating down her arm. (PX3) She stated she injured herself at work eight months prior and since then had experienced chronic neck pain, which had worsened that morning. The radiologist interpreted a new cervical MRI as showing a broad-based disc protrusion at C6-7 with resultant abutment of the spinal cord.

On May 30, 2014, Dr. McGivney reviewed the May 28, 2014 cervical MRI report and stated that it showed a new disc herniation at C6-7 to the right that was "consistent with the patient's symptoms" that "had been there now for over eight months." (PX1, p. 4) He did not review the new MRI films at that time. Dr. McGivney stated that the prior MRI in March had showed a "small disk herniation at C5-6" but now it appeared petitioner had "two disks." On the basis of the MRI report alone, Dr. McGivney changed his surgical recommendation and suggested an anterior cervical discectomy, allograft arthrodesis and plating at C5-6 and C6-7. He stated that the procedure "is only FDA approved for two levels and the C6-7 disk is a new disk level." (PX1, p.5) He authorized petitioner off of work for the first time since the September 12, 2013 accident. (PX1, p. 4-5)

On July 7, 2014, petitioner again presented to Rush Copley ER with complaints of migraine headaches for the past 2 days as well as neck pain. (PX4) She stated she experienced headaches often but symptoms were worse than usual. She underwent a CT of the brain which was noted to be essentially normal. She was discharged with a diagnosis of migraine headaches.

On July 30, 2014, Dr. McGivney wrote a narrative report wherein he withdrew his recommendation for a two-level fusion at C5-6 and C6-7 and recommended a disc replacement or a discectomy/fusion at C5-6.

Petitioner presented to the Rush-Copley ER for a third time, on August 11, 2014. (PX5) At that time, she complained of right arm pain and swelling of the right forearm, hand, and fingers for the past two days. On physical examination, there was no swelling observed in the right forearm. A CT of the cervical spine revealed mild degenerative disc disease with posterior disc osteophytes at C4-5, with no gross canal stenosis. Interpreting physician Timothy O'Connell, M.D., noted that disc abnormalities are much better seen on an MRI. Petitioner was discharged with a diagnosis of right arm pain and neck pain.

Dr. Hoepfner's Opinions

At respondent's request, petitioner underwent an evaluation by Peter E. Hoepfner, M.D., a hand and upper extremity surgeon at Illinois Bone & Joint Institute, on June 30, 2014. (RX5) Dr. Hoepfner opined, based on his assessment and consideration of all of the available information in the case, that petitioner's symptoms appear to be related to the cervical spine. He

noted "moderate symptom magnification" during the exam, and stated that petitioner appeared to have a "pain focussed behavior" and "difficulty articulating specifics with respect to her symptoms." He further noted that she had difficulty identifying a specific dermatomal distribution. At that time, Ms. Olan stated that all the fingers on her right hand are numb, which Dr. Hoepfner found to be a non-dermatomal complaint.

Dr. Hoepfner also opined: "[T]he significance of Ms. Olan's initial complaints does have merit."

Dr. Hoepfner found that petitioner's right shoulder examination is essentially normal. His examination revealed a full range of motion, strength, and function without any positive provocative testing about the right shoulder girdle. By corroborating these exam findings with the recent post-surgical MR arthrogram of the right shoulder, Dr. Hoepfner confirmed that there is no anatomic abnormality.

Dr. Hoepfner opined: "With respect to Ms. Olan's right shoulder condition, there does not appear to be any causal relationship with the September 12, 2013, alleged incident and with any purported pathology affecting the right shoulder." He further opined, based upon his assessment that day and a consideration of all of the available information in this case, that Ms. Olan's symptoms appear to be related to the cervical spine. Although he deferred to a spine specialist regarding treatment for the cervical spine, he did state that based solely on a general orthopedic assessment, the current recommendation for a total disc replacement at C5-6 appeared premature in the sequence of treatment options. In this regard he noted that petitioner had undergone no diagnostic testing such as an EMG/NCV and no conservative care that could potentially obviate the need for surgery. He further stated that orthopedic literature reflected controversy surrounding disc replacement surgery.

Dr. McGivney's Opinions

In response to a request by petitioner's attorney, Thomas J. McGivney, M.D., a board-certified musculoskeletal specialist at Castle Orthopedics & Sports Medicine, S.C., reviewed the May 28, 2014 MRI films and authored a narrative report dated July 30, 2014. (PX2) He noted that petitioner's treatment since the accident had focused exclusively on the right shoulder until his initial evaluation on April 14, 2014.

In this narrative report, Dr. McGivney wrote, in pertinent part, the following:

"She [Kristin Engle, PA-C] felt there was possibility (sic) that the neck was a source of the pain and ordered an MRI of the cervical spine which was performed on March 28, 2014. MRI showed a right-sided disk herniation at C5-6 *** I felt that given the fact that she had normal disks at all other levels, that since the onset of symptoms started when she first saw Dr. Saleem for this back in September and although she had clinically no improvement with injections of the shoulder, therapy, therefore that herniated disk most likely was causing the symptoms of this patient for the entire time that Dr. Saleem was seeing her which was a total of eight months without relief *** I feel that she is having continuing neuropathic pain and that although the pain was never consistent (sic) as the same shoulder symptoms, that the pain is or directly caused

(sic) from the injury on September 12, 2013, and I do believe her current condition of ill-being is related to the cervical spine."

Dr. McGivney explained that although he had recommended a total disc replacement at C5-6 after his first evaluation, he had changed his surgical recommendation after reviewing the May 28, 2014 MRI report, which identified a disc herniation at C6-7. In this regard, Dr. McGivney stated: "I felt that given the fact that she now has a new disc herniation at 6-7 with a previous disc herniation at C5-6; it is not FDA approved to do a cervical disc herniation."

Dr. McGivney stated that he did not review petitioner's May 28, 2014 MRI films personally at the time of his May 30, 2014 examination. After reviewing the repeat MRI personally "on the date of this dictation," he did not appreciate a disc herniation at C6-7. Thus he felt the original diagnosis of a disc herniation at C5-6 was appropriate, and he disagreed with the Rush-Copley radiologist's reading of the May 28, 2014 MRI.

Dr. McGivney then opined that either an anterior cervical discectomy and fusion at C5-6 or a total disc replacement at that level was appropriate. He admitted that the benefits of a total disc replacement "have not been verified by medical studies as of yet." However, he felt that the "theory behind total disc replacement" rendered the surgical recommendation appropriate despite an admitted lack of any available clinical data to substantiate the theory.

Dr. Butler's Opinions

On August 13, 2014, petitioner was evaluated by Jesse P. Butler, M.D., C.I.M.E., a physician at Spine Consultants, L.L.C., at the request of respondent. (RX6) In addition to performing a detailed physical examination, he reviewed "a portion" of petitioner's medical records that included both cervical MRI reports, as well as both cervical MRI scans.

Dr. Butler wrote that petitioner's initial complaints with regard to her right shoulder are significant. He noted that petitioner actually felt she had injured her right shoulder with the incident of September 12, 2013. She sought treatment with her shoulder surgeon. Dr. Butler then opined: "The patient's complaints in my opinion are likely related to the shoulder." He then wrote: "The patient had additional diagnostic workup, which revealed no additional tear of the labrum. What is of concern is that the findings noted on the MRI in the region of the acromioclavicular joint. This was not discussed much in the independent medical exam. The partial response from the subacromial injection does provide some support that at least some component of her pain may emanate from the subacromial space and acromioclavicular joint."

Dr. Butler diagnosed petitioner with a resolving cervical disc herniation on the right at C5-6. Dr. Butler opined that the cervical disk herniation seen on the March 28, 2014 MRI was not caused by the September 12, 2013 work accident. He stated that the initial MRI of March 28, 2014, showed an acute herniated disc, and that the May 28, 2014 MRI scan showed partial resolution of this disc herniation fragment. Had the disc herniation actually occurred on the date of accident, Dr. Butler opined, an imaging study taken six months later would have shown some resolution of the fragment rather than an acute herniation.

Dr. Butler also noted that the mechanism of injury of lifting a ten-pound box would be inconsistent with the force necessary to create a cervical spine disc herniation.

Dr. Butler wrote that Ms. Olan reported to him that the radiating in her arm "has developed over time and was not acutely present [at the time of the accident], which would have been consistent with an acute herniated disc."

Given that the May 28, 2014 MRI showed at least partial resolution of the acute disc herniation, Dr. Butler did not feel that petitioner was a candidate for cervical spine surgery, noting the "benign findings" on the most recent MRI. He felt she did sustain a disc herniation at some point in the past year but that it seemed to be resolving on its own with non-operative treatment. He felt there was no causal connection between the work accident and the need for cervical treatment, and further stated that petitioner did not require restrictions.

CONCLUSIONS OF LAW

I. Accident/Causal Connection

Based on the Associate Incident Report, the Witness Statement and Dr. Saleem's September 13, 2013 chart note, the Arbitrator finds that on September 12, 2013, petitioner sustained an accident that arose out of and in the course of her employment.

The employee must prove by a preponderance of the evidence that a causal relationship exists between any condition of ill-being and the work injury. Parro v. Indus. Comm'n, 260 Ill.App.3d 551, 630 N.E.2d 860 (1st Dist. 1993)

The Arbitrator finds, by a mere preponderance of the evidence, that petitioner has failed to prove that her current condition of ill-being of her cervical spine is causally related to the September 12, 2013 accident. Petitioner claims that on that date, and as a result of the accident, she herniated her cervical disc at the C5-6 level. The Arbitrator relies on the opinions of Dr. Butler in finding that petitioner did not suffer an acute herniation of the C5-6 disc as a result of the September 12, 2013 accident. Dr. Butler wrote: "She states the radiating pain in her arm has developed over time and was not acutely present, which would be consistent with an acute disc herniation."

The petitioner has proven, however, that the current condition of ill-being of her right shoulder is causally related to the September 12, 2013 accident.

On February 25, 2013, approximately 6-1/2 months prior to the accident, petitioner underwent surgery that consisted of a right shoulder arthroscopic superior labral repair and a right shoulder arthroscopic clavicle resection. Dr. Saleem performed the surgery.

On May 16, 2013, petitioner returned to Dr. Saleem. He noted that she was doing well and was not having significant pain. She exhibited full active and passive range of motion of the shoulder without discomfort. Petitioner was asked to gradually advance her activities.

On September 12, 2013, while in the course and scope of her employment, petitioner lifted a box after which she complained of anterior and lateral right shoulder pain. The medical records document that several months after the accident, petitioner experienced symptoms down her right arm and later, into her neck.

A September 30, 2013, MRI arthrogram of petitioner's right shoulder showed distal clavicular osteolysis with no superior labral tear or rotator cuff tear identified.

A cervical MRI on March 28, 2014 revealed a right herniation at C5-6 and a disc bulge at C3-4.

Dr. McGivney causally related petitioner's C5-6 herniated disc to the accident of September 12, 2013.

Dr. Hoepfner opined that petitioner's current symptoms appear to be related to the cervical spine. He further opined that with respect to Ms. Olan's right shoulder condition, "there does not appear to be any causal relationship with the September 12, 2013, alleged incident and with any purported pathology affecting the right shoulder."

Dr. Butler opined: "The patient's current condition with respect to the cervical spine does not bear a causal relationship to the accident of September 12, 2013." Dr. Butler then opined: "The patient's complaints in my opinion are likely related to the shoulder."

Although petitioner told Kristin Engle, PA-C, on November 13, 2013 that her right shoulder pain had improved, petitioner voiced continuing complaints of right shoulder pain.

With regard to the onset of neuropathic/radicular symptoms, however, the Arbitrator finds that petitioner lacks credibility.

Petitioner testified that the numbness and tingling in her right arm began the day after the accident and progressively worsened. Yet, there are no documented complaints of right arm radicular symptoms for several months. During the physical therapist's initial evaluation of petitioner on January 16, 2013, he recorded that petitioner "does not have any numbness or tingling in her fingers." At that time, petitioner did exhibit pain upon palpation of the supraspinatus, infraspinatus and biceps muscles. On February 13, 2014, the physical therapist wrote that the pain is not going down her arm as bad as it did last week.

Furthermore, on May 28, 2014, a medical professional at Rush-Copley ER wrote, in pertinent part, the following:

"36-year-old female presents to the ED for evaluation of worsening chronic pain associated with numbness radiating down her right arm. 8 months ago, patient reports injuring herself at work. Since then, she has had chronic neck pain."

However, the Arbitrator notes that the first documented complaints of neck pain by petitioner are on March 12, 2013, which was six months after the accident.

Moreover, Dr. Hoepfner found that petitioner exhibited "moderate symptom magnification", appeared to have a "pain focussed behavior" and had "difficulty articulating specifics with respect to her symptoms." He further noted that she found it difficult to identify a specific dermatomal distribution. Additionally, Dr. Hoepfner found that petitioner did not give her full effort in the grip strength testing.

Dr. Butler wrote that petitioner's initial complaints with regard to her right shoulder are significant. He noted that petitioner actually felt she had injured her right shoulder with the incident of September 12, 2013. She sought treatment with her shoulder surgeon. Dr. Butler then opined: "The patient's complaints in my opinion are likely related to the shoulder." He then wrote: "The patient had additional diagnostic workup, which revealed no additional tear of the labrum. What is of concern is that the findings noted on the MRI in the region of the acromioclavicular joint. This was not discussed much in the independent medical exam. The partial response from the subacromial injection does provide some support that at least some component of her pain may emanate from the subacromial space and acromioclavicular joint."

Petitioner testified that she had no reason to believe that her symptoms were not being accurately documented by each of the providers with whom she came in contact at Castle Orthopedics & Sports Medicine.

The Arbitrator finds that petitioner's testimony with regard to the onset of cervical/radicular symptoms is less trustworthy than the contemporaneous medical histories taken shortly after the work accident. Sleeter v. Indus. Comm'n., 346 Ill.App. 3d 781, 784 (4th Dist. 2004)

In determining causation, the Arbitrator gives more weight to the opinions of Dr. Butler than those of Dr. McGivney.

The Commission is not required to give more weight to the opinion of a treating physician than that of an examining physician. Prairie Farms Dairy v. Indus. Comm'n, 279 Ill. App. 3d 546, 550 (5th Dist. 1996). Among the medical records that Dr. Butler reviewed, he looked at the MRI films and reports. He took a detailed history and conducted a thorough examination. The Arbitrator finds that Dr. Butler offered a well-reasoned assessment of the MRI films. In support of his opinion, Dr. Butler cites his findings on the MRI films, the lack of initial complaints of radiating arm pain and the non-traumatic mechanism of injury.

The Commission has found a treating doctor's opinion more credible where it was "gleaned from extensive examination of and contact with" the claimant. Edgcomb v. Indus. Comm'n. 181 Ill. App. 3d 398, 405 (3rd Dist. 1989)

The Arbitrator finds the opinions of Dr. Butler to be more persuasive than those of Dr. McGivney. Dr. McGivney has seen petitioner exactly two times, and his examination findings on each occasion were not nearly as extensive as those detailed in Dr. Butler's report. His initial examination of petitioner is not significantly more temporal to the date of accident than that of Dr. Butler, and, given that there is no evidence that he even reviewed petitioner's medical records. it cannot be said that he has greater familiarity with petitioner's symptoms since their

onset. Moreover, Dr. McGivney did not examine petitioner until April 14, 2014, which was seven months after the accident, and thus his opinion as to the age and origin of petitioner's disc herniation cannot be said to be more reliable than that of Dr. Butler. Please see Western Electric Co. v. Indus. Comm'n, 349 Ill. 139, 145-46 (Ill. 1932).

On May 30, 2014, Dr. McGivney reviewed the May 28, 2014 cervical MRI report and stated that it showed a new disc herniation at C6-7 to the right that was "consistent with the patient's symptoms" that "had been there now for over eight months." Yet, in his July 30, 2014 report, the doctor opined that that the Rush-Copley radiologist "is in error" and that C6-7 is a normal disc that does not require any surgery.

Dr. McGivney concedes that petitioner's neuropathic pain "was never as consistent as the same shoulder symptoms," but fails to explain how this fact led him to a different conclusion than Dr. Butler as to causation. (PX2) He makes no attempt to reconcile the lack of consistent cervical/neuropathic complaints or examination findings throughout the course of treatment prior to his evaluation. Furthermore, Dr. McGivney abruptly changed his surgical recommendation to a two-level fusion, apparently on the basis of a Rush-Copley MRI report, then withdrew his recommendation and prescribed either a C5-6 discectomy/fusion or a disc replacement. Dr. Hoepfner, in offering a general orthopedic opinion, felt that that cervical disc surgery is premature and that further diagnostic testing, such as an EMG/NCV, is reasonable. When Dr. Hoepfner examined petitioner on June 30, 2014, he found that petitioner had difficulty identifying a specific dermatomal distribution.

The Arbitrator also gives significant weight to his finding that petitioner is lacking in credibility.

II. Medical Expenses/Prospective Medical Care

Based on aforementioned findings and conclusions as to the issue of causal connection, the Arbitrator denies petitioner's claim for medical expenses for the May 28, 2014, July 7, 2014 and August 11, 2014 dates of service at Rush-Copley Medical Center as well as the balance due Castle Orthopedics & Sports Medicine. On the same basis, the Arbitrator denies prospective medical care, and the expenses associated with such care, for her cervical spine.

III. TTD Benefits

In his August 13, 2014 report, Dr. Butler opined: "The patient's complaints in my opinion are likely related to the shoulder." Dr. Hoepfner examined petitioner on June 30, 2014. At that time, and with regard to petitioner's right shoulder condition, he released Ms. Olan to return to work without restrictions. Accordingly, the Arbitrator finds that petitioner is entitled to TTD benefits from May 30, 2014 through June 30, 2014.

IV. TPD Benefits

The Arbitrator further denies petitioner's claim for temporary partial disability benefits (TPD). Petitioner offered no evidence that she suffered a temporary decrease in her wage-earning

capacity so as to be entitled to TPD during the period she worked light duty. Please see Mechanical Devices v. Indus. Comm'n, 344 Ill. App. 3d 752, 762 (4th Dist. 2003). No wage records for the period of September 13, 2013 through May 29, 2014 were introduced into evidence, and petitioner testified that she was paid her regular salary while being accommodated under restrictions. (T. 17) There is no basis for petitioner's claimed entitlement to TPD.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Bonifacio Ramirez,

Petitioner,

vs. NO: 12WC 7424

Axion Builders Co., d/b/a Enviricon1, LLC.,

15IWCC0116

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, temporary total disability, medical expenses, prospective medical care and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 13, 2014, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $64,000.00. 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: FEB 9 - 2015
o020515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

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

RAMIREZ, BONIFACIO
Employee/Petitioner

Case# **12WC007424**

AXION BUILDERS CO D/B/A ENVIRICON1 LLC
Employer/Respondent

15IWCC0116

On 8/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
JOSHUA E RUDOLFI
162 W GRAND AVE SUITE 1810
CHICAGO, IL 60654

0238 WOLFE & JACOBSON LTD
BILL JENSEN
225 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Bonifacio Ramirez
Employee/Petitioner

Case # 12 WC 7424

v.

Consolidated cases: -----

Axion Builders Co., d/b/a Enviricon1, LLC
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **6/4/2014**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **2/1/2012**, 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 regarding his lumbar spine, hip and knee are causally related to the accident.

In the year preceding the injury, Petitioner earned $**6,675.00**; the average weekly wage was $**983.97**.

On the date of accident, Petitioner was **53** 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 $**18,554.86** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**18,554.86**.

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $655.98/week for 110 weeks, commencing 2/1/2012 through 8/20/2012 and 11/12/2012 through 6/4/2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 2/1/2012 through 8/20/2012 and 11/12/2012 through 6/4/2014, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $18,554.86 for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $10,252.28, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,613.96 to ATI Physical Therapy, $6,833.62 to Athletico Physical Therapy, and $804.40 to Loyola University Medical Center, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services of $10,252.28, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $0.00 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.

Prospective Medical Care

Respondent shall authorize and pay for a series of lumbar epidural steroid injections as recommended by Dr. Alpesh Patel.

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.

Ketti Steffen
Signature of Arbitrator

8/13/14
Date

ICArbDec19(b)

AUG 13 2014

PROCEDURAL HISTORY

This matter was presented for a hearing pursuant to Sec. 19 (b) of the act before Arbitrator Ketki Steffen on June 4, 2014. Both parties were represented by counsel and have entered into several stipulations that are contained as Arbitrator's Exhibit No. 1 ("AX1") for the trial record.

FACTUAL HISTORY

Petitioner was 53 year old at the time of the accident which occurred on February 1, 2012. Petitioner testified in court with the aid of Spanish interpreter, Ms. Lapetina. The Petitioner worked for the Respondent for approximately 5 or 6 years performing demolition and construction of buildings. On February 1, 2012, Petitioner was gluing down paper on the roof of a building when the paper became unglued and the Petitioner slipped. The Petitioner fell approximately 10-12 feet and landed on his left side on the ground below. The ground was comprised of snow-covered dirt. The Petitioner testified that he felt pain all along the left side of his body from his waist and back down to his foot. The Petitioner's accident was properly reported and the Petitioner was transported to Adventist LaGrange Memorial Hospital in a company van. Accident and notice are not in dispute. (Arb. Ex. #1)

The Petitioner was admitted into the hospital at Adventist LaGrange Memorial Hospital on February 1, 2012 and was diagnosed with a left acetabular hip fracture after x-rays and a CT scan were taken. (Pet. Ex. #2) The Petitioner remained in the hospital until February 3, 2012, at which time he was transferred via ambulance to Loyola University Medical Center. (*Id.*)

On February 7, 2012 the Petitioner had surgery performed on his left hip at Loyola University Medical Center (hereinafter "Loyola") consisting of an open reduction and internal fixation of the posterior wall acetabular. (Pet. Ex. #3) The Petitioner was released from Loyola on February 9, 2012. (*Id.*) The Petitioner was unable to work during this time.

On February 14, 2012 the Petitioner reported to Loyola and complained of increased hip pain after feeling a "pop" in the joint over the weekend. (*Id.*) On February 15, 2012 the Petitioner followed up with Dr. Michael Stover out of Loyola at which time the Petitioner continued to complain of pain in his left hip. (*Id.*) The Petitioner followed up with Dr. Stover again on February 29, 2012 and complained of increasing pain in his left groin and left knee and physical therapy was recommended along with the use of crutches. (*Id.*) The Petitioner continued to follow up with Dr. Stover on March 4, 2012, March 28, 2012 and April 18, 2012, and was continued off work during all times while continuing to complain of pain. (*Id.*) The Petitioner testified that he did receive TTD benefits during this time.

The Petitioner had a course of physical therapy performed from July 2, 2012 through July 25, 2012 at Athletico Physical Therapy. (Pet. Ex. #5) On July 25, 2012, Dr. Stover ordered a functional capacity evaluation (FCE), which was performed at Accelerated Rehabilitation Centers on August 7, 2012. RX #2. Petitioner underwent an FCE at Accelerated Physical Therapy that was determined to be invalid. (Rsp. Ex. #2) The Petitioner testified that he "failed" this examination due to pain in his hip and low back.

The FCE therapist, Phil Rios, concluded that petitioner demonstrated inconsistent performance due to sub-maximum effort and was capable of greater functional abilities than he showed during the evaluation. *Id.* With respect to lifting, petitioner was able to lift up to 40 pounds from the floor to his waist, 30 pounds from twelve inches to waist, 30 pounds to shoulder height, and 30 pounds above his shoulder. *Id.* Mr. Rios noted petitioner self terminated the lifting activities despite no objective clinical findings to support his claim of pain. Id. Mr. Rios also noted that with stair and ladder climbing petitioner would ascend and descend stairs with weight bearing on his left leg, which was inconsistent with petitioner's diagnosis. *Id.* Mr. Rios concluded that petitioner's complaints of pain in the various tests performed were unreliable given the absence of a change in petitioner's heart rate while performing the tests. Id.

Petitioner returned to Dr. Stover on August 20, 2012. PX #4, P. 2. Dr. Stover noted petitioner's chief complaints included a left acetabular fracture along with left knee, hip and back pain. His notes document that he reviewed the results of the FCE and noted the inconsistencies and petitioner's lack of effort during the evaluation. *Id.* Dr. Stover discharged petitioner with a full duty release without restrictions and asked him to follow up in five months. *Id.*

Petitioner next sought treatment on October 25, 2012 when he was seen for a second FCE at ATI. Petitioner testified he was sent to ATI for the second FCE at the request of his attorney. This FCE was determined to be "valid" and placed the Petitioner at the "Light to Medium" physical demand level. (*Id.*) According to the report, the Petitioner's previous position as a "laborer" with the Respondent is considered a "Heavy" physical

demand level occupation. (*Id.*) The evaluator noted in his records that petitioner did not have a referral from a physician to conduct the evaluation. PX #6. In contrast to the first FCE, the therapist, Matt Hollens, concluded that petitioner's evaluation was reliable and documented restrictions. *Id.* With respect to the lifting tests, petitioner claimed to be unable to lift more than 25.8 pounds over his shoulder because of neck pain; more than 28 pounds from thirty inches to eighteen inches because of pain in his left hip and bilateral knees; and lifting 18 inches to the floor because of left hip and knee pain. *Id.* During the push testing, he limited his activity due to complaints of left hip and shoulder pain, and during the carrying testing he complained of leg cramps. *Id.* Following the second FCE, Petitioner returned to Dr. Stover on November 12, 2012 where he complained of left hip and groin pain. PX #4. Dr. Stover reviewed the second FCE and noted that it concluded petitioner could work at the medium duty level. *Id.* Dr. Stover ordered an MRI and a CT scan and placed petitioner under light duty restrictions. *Id.* Petitioner underwent a CT scan on November 20, 2012 that showed near anatomical alignment of the left acetabular column, and an MRI on November 23, 2012 that showed evidence of moderate gluteal, piriformis and obturator muscle atrophy. *Id.* Petitioner returned to Dr. Stover on December 20, 2012. Dr. Stover noted "I am uncertain as to why he has his continuing pain and weakness and ordered additional 6 weeks of therapy." *Id.*

The Petitioner followed up with Dr. Stover on November 12, 2012. (Pet. Ex. #4) The Petitioner continued to complain of pain in his left hip and left groin. (*Id.*) Dr. Stover recommended a CT scan of the left hip and released the Petitioner to light duty work. (*Id.*) A CT scan performed at Northwestern Memorial Hospital on November

20, 2012 revealed an unremarkable left hip and MRI of the left hip on November 23, 2012 was essentially unremarkable. (*Id.*)

The Petitioner followed up with Dr. Stover on December 17, 2012 and continued to complain of diffuse pain in his hip along with weakness. (*Id.*) The Petitioner was still ambulating with the assistance of a cane and had a noticeable limp. (*Id.*) Dr. Stover recommended physical therapy. (*Id.*) The Petitioner had a course of physical therapy performed at Athletico Physical Therapy from December 27, 2012 through February 6, 2013. (Pet. Ex. #5) The initial physical therapy intake from December 27, 2012 indicates that the Petitioner had continued hip pain and weakness in his legs. (*Id.*)

The Petitioner followed up with Dr. Stover on February 18, 2013. (Pet. Ex. #4) On that visit the Petitioner continued to complain of pain and also indicated again that he had lower back pain. (*Id.*) Dr. Stover states that he was unsure of the pain generator as the Petitioner's CT and MRI of his left hip were within normal limits. (*Id.*) Dr. Stover states that he was unsure if the back was the cause of the pain and referred the Petitioner to one of his spine-specialist partners. (*Id.*) Dr. Stover also indicated that the Petitioner was released to light duty in the past but that his employer has not been able to provide him with work. (*Id.*)

On February 20, 2013 the Petitioner saw Dr. Alpesh Patel, a spine specialist with Northwestern Medical Faculty Foundation. (*Id.*) The Petitioner reported the history of his accident and that he has been experiencing low back pain since the accident along with occasional numbness and tingling into the legs. (*Id.*) X-rays were taken of the Petitioner's lumbar spine that were unremarkable. (*Id.*) Dr. Patel recommended an MRI of the Petitioner's lumbar spine. (*Id.*) An MRI of the lumbar spine performed on

February 22, 2013 at Northwestern revealed a disk bulge at L4-5 with mild central canal stenosis and mild bilateral medial neural foraminal narrowing and a mild diffuse disk bulge at L5-S1. (Pet. Ex. #4)

On March 13, 2013 the Petitioner followed up with Dr. Patel. (*Id.*) Dr. Patel diagnosed the Petitioner with degenerative disk disease with foraminal stenosis. (*Id.*) Dr. Patel recommended a left sided transforaminal epidural steroid injection at the L5-S1 segment along with physical therapy. (*Id.*) The Petitioner was taken off work completely at that time. (*Id.*) The Petitioner had physical therapy performed at Athletico Physical Therapy from March 15, 2013 through April 16, 2013. (Pet. Ex. #5)

The Petitioner followed up with Dr. Patel on April 17, 2013 at which time it was noted that physical therapy was not helping the Petitioner's pain complaints. (Pet. Ex. #4) Dr. Patel recommended continued physical therapy and continued the Petitioner off work. (*Id.*)

The Petitioner followed up with Dr. Patel on October 16, 2013. (*Id.*) Dr. Patel noted that the Petitioner had not had additional treatment due to a lack of insurance approval. (*Id.*) Dr. Patel states in his report that the Petitioner has continued low back pain symptoms with radiation of pain in to the buttocks bilaterally consistent with diskogenic pain and that the Petitioner is currently on disability. (*Id.*) Dr. Patel addresses causation in stating:

> "I do not believe that the injury he had would have caused the degeneration, but it does seem based on the chronology of his symptoms and the nature of injury, the description of his symptom pattern today, his exam findings on repeat examination that his ongoing back pain symptoms are related to the fall that he sustained, resulting in both the fracture of left side leg as well as the low back pain that he is experiencing." (*Id.*)

The Petitioner was continued off work and injections were recommended. (*Id.*)

On October 28, 2013 the Petitioner followed up with Dr. Stover. (*Id.*) Dr. Stover states that the Petitioner continues to have pain in his hip and lower back. (*Id.*) Dr. Stover also recommends that the Petitioner undergo a lumbar epidural steroid injection in an attempt to alleviate his pain and then a hip injection if the back injection does not alleviate his pain. (*Id.*) Dr. Stover addresses causation in stating: "I do believe that it is indicated [back injection] and I believe that it is related to his work injury because it began following his accident." (*Id.*)

The Petitioner saw Dr. Patel on January 15, 2013. (*Id.*) Dr. Patel again stated the importance of having an epidural steroid injection. (*Id.*) Dr. Patel also reiterated his belief that the back pain was caused by the fall at work. (*Id.*)

The Petitioner testified credibly at trial. The Petitioner testified that he has not had the injection as recommended by Dr. Stover and Dr. Patel but would have it performed immediately if the Arbitrator were to award it to him. He further testified that he has not received TTD benefits August 20, 2012 and continues to receive medical bills in the mail. The Petitioner presented and walked in the courtroom with the assistance of a cane as prescribed by Dr. Stover. He testified that he does not use the cane all the time, but does use it the vast majority of the day. The Petitioner denied any previous injuries to his lower back and denied any lower back symptoms prior to the undisputed February 1, 2012 work related accident. The Petitioner testified that he has had low back pain since the date of accident. He testified that he has not returned to work since the accident, that the Respondent did not accommodate any of his light duty restrictions and that he has not looked for work due to his receiving Social Security

Disability at present. The Petitioner presently continues to take Lyrica and Ibuprofen in an attempt to alleviate his pain.

The Respondent produced an IME report from Dr. Steven Mash dated February 13, 2013. (Rsp. Ex. #1) Dr. Mash took a history from the Petitioner and noted that he complained of pain in his left hip and lower back with radiation into his legs. (*Id.*) Dr. Mash opined that the Petitioner was at MMI for his hip condition and that he has permanent restrictions are delineated in his FCE from ATI Physical therapy at the Light to Medium Demand level. (*Id.*) Dr. Mass further stated that the Petitioner "has good objective findings to support his subjective complaints." (*Id.*)

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 MAKES THE FOLLOWING CONCLUSIONS OF LAW:

The accident is not at issue. Petitioner was 53 year old at the time of the accident and has worked for the Respondent for approximately 5 or 6 years performing demolition and construction of buildings. Petitioner was gluing down paper on the roof of a building when the paper became unglued and the Petitioner slipped. The Petitioner fell approximately 10-12 feet and landed on his left side on the ground below. The ground was comprised of snow-covered dirt. The Petitioner testified that he felt pain all along the left side of his body from his waist and back down to his foot. The Petitioner's accident was properly reported, medical records document a a left acetabular hip fracture. The Petitioner remained in the hospital until February 3, 2012, at which time he was transferred via ambulance to Loyola University Medical Center. (*Id.*) where he

had surgery performed on his left hip at Loyola University Medical Center (hereinafter "Loyola") consisting of an open reduction and internal fixation of the posterior wall acetabular. (Pet. Ex. #3) The Petitioner was released from Loyola on February 9, 2012. (*Id.*) The Petitioner was unable to work during this time, underwent extensive physical therapy.

Petitioner continue complain of pain in his left hip and during physical therapy also had complains of pain in his back. (*Id.*) Petitioner claims that he the lumbar spine/back pain stems from his work accident and the Respondent argues that the back issues are not causally related to the accident. The Arbitrator finds that the back pain is causally related to the work accident for the following reasons:

- Petitioner testified credibly that he never had medical issues with his back prior to this accident. No evidence was produced to rebut this credible testimony
- The Petitioner's medical records document a consistent course of treatment since that time with consistent pain complaints in the left hip, groin and subsequently the lower back.
- Dr. Stover does not discount the Petitioner's back complaints and opines that he was unsure if the Petitioner's left hip was the origin of the Petitioner's pain and therefore referred the Petitioner for a consultation with a spine specialist, Dr. Patel.
- Both Dr. Stover and Dr. Patel believe that the work accident did not cause the degenerative condition in the Petitioner's lumbar spine, but rather based upon the chronology, the manifestation of symptoms, and the nature of the

accident, the Petitioner's current lumbar spine condition is related to the work accident.

- Dr. Mash notes that the Petitioner complained of low back pain at the time of his visit and opines that the Petitioner's objective medical findings support his subjective complaints. These medical opinions support a finding of causation.
- The nature of the accident, a 10-12 foot fall from the roof with a resultant hip fracture is consistent with Petitioner's back complains.
- The first FCE findings of invalidity are based on Petitioner's inconsistent performance due to sub-maximum effort. Mr. Rios, the FCE therapist also found the Petitioner's pain complains unreliable given the absence of change in Petitioner's heart rate during testing. The FCE also finds the the Petitioner back complains to be unrelated or not credible.

The Arbitrator finds that the Petitioner has reached MMI regarding his hip and knee condition. The Arbitrator finds that Petitioner's cervical spine issues are causally connected to the work accident. This finding is based in part upon Dr. Patel's opinion, the mode, mechanism and type of initial injury and an assessment of the Petitioner' credibility. The invalid FCE findings from the first FCE based on heart rate are not persuasive to the Arbitrator in light of the second valid FCE and the causal connection opinions from Medical doctors.

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 claims entitlement to payment for medical bills from (a) ATI in the amount of $2,613.96 relating to the second FCE, which was conducted on October 25,

2012; (b) Athletico in the amount of $6,833.62 for treatment provided from December 27, 2012 to April 16, 2013; and (c) Loyola University in the amount of $804.70 for treatment provided from February 10 to February 27, 2012 and April 18, 2012.

With respect to the ATI bill, the Arbitrator finds Respondent liable for the payment of this bill. This bill relates to the second FCE. Arguably, this second FCE was not medically authorized and was based on a referral of Petitioner's counsel. However, the second FCE became necessary when the first FCE was found to be invalid. The therapist found Petitioner's efforts, including his back complaints to be inconsistent. Arguably, Petitioner physical pain and limitations were caused in part by his work accident. Petitioner complained of shoulder, neck and bilateral knee pain. Petitioner testified in court that that he complained of lower back pain. The FCE report does not document back pain complaints.

Arbitrator discounts the findings of the first FCE and questions the heart-rate monitoring methodology. The second FCE was necessary and reasonable. It appears that the basis of the invalidity findings are Petitioner's subjective complains, including complains of back pain. All physicians, including Dr. Mash have found that objective findings of back problems supports Petitioner's subjective complain. Whether the back pain is caused by work accident or by arthritis, Petitioner's back pain complains should not have invalidated the the first FCE. The findings regarding heart rate are also not immensely persuasive. In light of the second valid FCE that supports Petitioner's position that he is limited to medium to light duty work, the Arbitrator finds that the second FCE was necessary and is compelling. The Arbitrator awards this bill.

With respect to the Athletico bill, the Arbitrator finds the Respondent liable for payment of this bill, because it was for treatment that has been found to be related to his work accident. With respect to the Loyola University bill in the amount of $804.70, the Arbitrator finds that Respondent is responsible for the payment of this bill pursuant to the negotiated rate, if applicable, or the lesser of the amount owed under the Fee Schedule or the actual charge. Payment of this bill should be made to the Petitioner and he will be responsible to pay the provider.

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 further treatment related to complaints of lower back pain. Specifically, he would like to undergo a lumbar injections recommended by Dr. Patel and Dr. Ihm. The accident is not at dispute. Petitioner fell 10-12 feet off the roof when he slipped during roof installation. He was hospitalized, suffered a fracture of his left acetabular and was hospitalized, underwent an open reduction and internal fixation. He subsequently underwent physical therapy.

Dr. Patel and Dr. Ihm recommend lumbar injections to relieve Petitioner's back pain. Dr. Stover initially could not determine the Petitioner's continued pain generator. He then referred the Petitioner to Dr. Patel in the belief that the Petitioner's back was causing all of his pain. Dr. Patel saw the Petitioner and opined, after diagnostic testing, that the Petitioner's low back is indeed causing him his pain and recommended lumbar epidural steroid injections. Dr. Stover agrees with this assessment. The Petitioner testified that he has not had these injections performed and that he would have them

performed immediately if awarded. There is no medical evidence contraindicating the reasonableness and necessity of these injections.

Based on the finding regarding causal connection and the validity of the second FCE, the Arbitrator finds that the Petitioner is entitled to prospective medical care recommended by Dr. Patel in the form of lumbar injections. Based on Petitioner's injuries and the course of treatment, this is a reasonable course of medical treatment and has a basis in the credible medical opinion of his treating physician.

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 Petitioner is awarded TTD benefits from February 1, 2012 to August 20, 2012 and from November 12, 2012 to June 4, 2014. The Petitioner was taken off work following his undisputed work accident on February 1, 2012. His medical records document that he was continued off work until August 20, 2012. On that date Dr. Stover released the Petitioner to full duty work following an invalid FCE dated August 7, 2012. (Pet. Ex. #4) Thereafter the Petitioner had another FCE performed on October 25, 2012. (Pet. Ex. #6) This FCE was determined to be valid and placed the Petitioner at the Light to Medium demand level. (*Id.*) The Petitioner's job title of laborer is in the Heavy demand level. (*Id.*) The Petitioner was returned to work with these restrictions on November 11, 2012 and his employer would not accommodate those restrictions. The Respondent's IME doctor also notes, along with the Petitioner's testimony, that the Respondent has not taken the Petitioner back to light duty work and that he continues to have these light duty restrictions. (Rsp. Ex. #1) Since that date the Petitioner has been released to work pursuant to the FCE or has been in an off work status per his

physicians. The Arbitrator awards the Petitioner TTD benefits from February 1, 2012 to August 20, 2012 and from November 12, 2012 to June 4, 2014. The Respondent shall receive the stipulated credit of $18,554.86 for TTD benefits already paid.

Ketki Steffen
Arbitrator, Ketki Steffen

8/13/14
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Katarzyna Kasprzycki,
Petitioner,

vs. NO: 12WC 38372

Kaczor & Associates, Ltd.,
Respondent,

15IWCC0117

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 accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 24, 2014, is hereby affirmed and adopted.

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

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

Bond for 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: FEB 9 - 2015
o020515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KASPRZYCKI, KATHARZYNA
Employee/Petitioner

Case# **12WC038372**

15IWCC0117

KACZOR & ASSOCIATES LTD
Employer/Respondent

On 6/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2197 RICHARDS MALLEN & ASSOC LTD
ROBERT J DARGIS
228 S WABASH AVE7TH FL
CHICAGO, IL 60604

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK RUSIN
10 S RIVERSIDE PLZSUITE 1530
CHICAGO, IL 60606

15IWCC0117

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

Katarzyna Kasprzycki
Employee/Petitioner

v.

Kaczor & Associates, Ltd.
Employer/Respondent

Case # **12** WC **38372**

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 **Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **June 2, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 9, 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.

In the year preceding the injury, Petitioner earned $**N/A**; the average weekly wage was $**N/A**.

On the alleged date of accident, Petitioner was **40** years of age, ***married*** with **3** dependent children.

Respondent shall be given a credit of $**12,350.04** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**12,350.04**.

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

ORDER

See attached findings.

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

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

Signature of Arbitrator

06·23·14
Date

JUN 2 4 2014

In support of the Arbitrator's decision relating to (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, the Arbitrator finds the following facts:

Respondent's business is an accounting and tax preparation firm. Their offices are located in an office building in Schaumburg, Illinois. The office building is shared with another tenant, a learning center. The businesses share common areas of the building which are used by employees of both companies, customers or visitors.

On January 9, 2012, Respondent's office was to be closed because employees were attending a training seminar. Petitioner reported to the office early in the morning and placed a sign in the office indicating the business was closed. Further, she checked e-mail and obtained a check to pay for the training seminar. Petitioner exited the office and walked to stairs in a common area of the building. Petitioner testified she was wearing flat dress shoes. She testified that when she got to the top of the stairs, the sole of her shoe caught on metal stripping on the stairs which caused her to fall. Petitioner specifically testified that she immediately knew the reason for her fall was metal stripping which caught her shoe. She immediately called her manager, Mr. Kaczor, and told him about the fall. However, she testified that she did not recall telling him the fall occurred because of her shoe being caught on metal stripping. She had left foot pain and her foot began to swell after the fall.

Petitioner sought emergency treatment at Northwest Community Hospital emergency room immediately following the incident. Petitioner testified that she told emergency room personnel about the fall and the fact that the fall occurred because her shoe caught on metal stripping. She was placed in a boot and referred to Dr. Kuesis, an orthopedic surgeon.

Petitioner saw Dr. Kuesis later that same day on January 9, 2012. She discussed the injury with him. She testified she told Dr. Kuesis how the injury occurred and specifically the fact that her shoe caught on metal stripping which was the cause of the fall.

Petitioner initially received conservative treatment under the care of Dr. Kuesis. She was diagnosed with a navicular fracture. She subsequently sought treatment on her own with a different orthopedic surgeon, Dr. O'Hara of Barrington Orthopedics Specialist. She commenced treatment with Dr. O'Hara on May 9, 2012. He performed a surgical procedure on Petitioner's left foot on May 23, 2012. Petitioner gradually improved post-surgery and eventually returned to work in September 2012. She last saw Dr. O'Hara in October 2012 and is not actively treating with any doctor since that time. Petitioner has continued working her normal job since September 2012 and earns the same rate of pay.

The Arbitrator finds Petitioner failed to prove she sustained accidental injuries which arose out of and in the course of her employment. The Arbitrator finds Petitioner failed to prove the accident occurred due to an increased risk of injury associated with Petitioner's employment or the employment premises. Petitioner's fall occurred on a stairway which is in a public area and not limited to use by Respondent employees. Petitioner did not present credible evidence that this fall occurred as a result of any defect in the premises. The Arbitrator does not find Petitioner's testimony credible or persuasive that the fall occurred from her shoe catching on stripping on the stairs. Petitioner did not report to her supervisor that the fall occurred for this reason. Further, contrary to Petitioner's testimony, the records of Northwest Community Hospital immediately following the incident do not reflect that the fall occurred as a result of her shoe catching on metal stripping. The records of the hospital simply state that Petitioner fell down stairs and twisted her left ankle. Similarly, Petitioner testified that she specifically told Dr. Kuesis later in the day January 9, 2012 that the fall occurred when her shoe caught on metal stripping. This statement is simply not true. Dr. Kuesis' records simply show that Petitioner reported a fall down stairs.

The Courts have found that the act of utilizing stairs does not in and of itself expose an employee to a risk greater than that faced by the general public. The Petitioner must show credible evidence to support an inference that a fall down stairs stems from a risk related to the employment. An injury resulting from a neutral risk to which the general public is equally exposed does not arise out of the employment. See *Baldwin v. Illinois Workers' Compensation Commission*, 949 N.E. 2d 1151, 409 Ill. App. 3d 472 (2011). In the present case, Petitioner has failed to present credible and persuasive evidence that the fall occurred as a result of any defect in the premises. The pictures of the stairs that are in evidence depict the stairs to be in good condition and there is no dispute these stairs are in a common area utilized by the public. The claim for compensation is hereby denied. All other issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Olsen,
Petitioner,
vs. NO: 11WC 26387
15IWCC0118
WFLD/Fox TV, Inc.,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 22, 2014, is hereby affirmed and adopted.

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

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

Bond for 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: FEB 9 - 2015
o020515
DLG/jrc
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OLSEN, LAURA
Employee/Petitioner

Case# **11WC026387**

15IWCC0118

FOX NEWS
Employer/Respondent

On 7/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JIGAR DESAI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS	)	☐ Injured Workers' Benefit Fund (§4(d))
	)SS.	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Second Injury Fund (§(e)18)
		☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LAURA OLSEN
Employee/Petitioner

Case # 11 WC 26387

FOX NEWS
Employer/Respondent

15IWCC0118

An *Application for Adjustment 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 Lammie, Arbitrator of the Commission, in the city of Chicago, on September 12 and October 13, 2011. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ **What temporary benefits are in dispute?**

☐ TPD ☐ Maintenance ☒ **TTD**

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

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

N. ☐ Is Respondent due any credit?

O. ☒ Other: **Is Petitioner entitled to any prospective medical care?**

FINDINGS

On May 26, 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.

In the year preceding the injury, Petitioner earned $80,000.00; the average weekly wage was $1,538.46.

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

Petitioner has received all reasonable, necessary and causally related medical services.

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

ORDER:

This case proceeded pursuant to Sections 8(a), 16, 19(b), 19(k), and 19(l) of the Act. The parties agree that no claims for PPD are being made at this time, as the Petitioner has not reached maximum medical improvement and proceeded with this case pursuant to Sections 8(a), 16, 19(b), 19(k), and 19(l) of the Act.

For the reasons set forth in the attachment to this Arbitration Decision, the Arbitrator finds that the Petitioner has failed to meet her burden of proving that she suffered an accident that arose out of and in the course of her employment.

Based on this finding, all other issues are moot. Compensation is hereby denied.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest 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.

Signature of arbitrator

07-21-14
Date

ICArbDec p. 2

JUL 2 2 2014

FINDINGS OF FACT

Trial Proceedings of September 12, 2011

Petitioner testified that she worked for the Respondent, Fox News, as a Master Control Technician. (T. 53). Petitioner testified that she worked for both Fox News and for Gould Academy in Elgin. (T. 53).

She testified that her job duties as a Master Control Technician were diverse. None of the duties she described were physical in nature. (T. 54-55).

Petitioner testified that she experienced an accident at work on May 26, 2011. (T. 55). She testified that an alarm went off on a transmitter. She testified that she turned her chair to where her computer was, approximately 3-4 feet from her main center console, and that she then stretched out her legs to "scootch" her chair toward the computer. (T. 55). She testified that her chair became stuck in between 2 plastic floor mats. (T. 56). She testified she dug her heels in, "went to pull," and "felt the back of [her] knee pull and a brief sharp pop." (T. 56). Petitioner later testified on cross-examination that she told Mr. Raphael Meza of the Respondent that she "felt like bad elastic release in the back of my knee and a light pop." (T. 132).

Following this incident she testified that she did not "feel any extreme pain," so she thought "she would be ok." (T. 57). She confirmed again that she was sitting, and that her "duties don't require [her] to get up and at the moment run around the station at any point." (T. 57). She testified that she pushed herself back to her main console and continued working for the rest of her shift. (T. 57).

She testified her shift was over at 8:00 PM on May 26, 2011, (T. 57), which is consistent with the time records submitted as Respondent's Exhibit 5. (Rx. 5). She testified that she did not actually leave work until 10:00 PM that evening. (T. 58).

Petitioner testified that she did not go to a doctor on May 26, 2011. (T. 58). She also testified that she did not visit an emergency room because "it was not an emergency situation." She testified an emergency situation would involve "bleeding to death." (T. 58-59). On cross-examination, she reiterated this testimony, but acknowledged that in September 2010 she went to the emergency room due to a headache. (T. 97). She confirmed she was not bleeding when she went to the emergency room in September 2010. (T. 97).

Petitioner testified that upon arriving at home on May 26, 2011, she had difficulty getting out of her car. She believed her knee was stiff. She thought she would be okay in a couple of days. (T. 59).

Petitioner testified that she also worked on Friday, May 27, 2011. She alleged that when she woke up on May 27, 2011 she had a "massive migraine." (T. 60). She testified she went to see her acupuncturist, Dr. George Stretch, on May 27. (T. 60). She testified that she then went to work after seeing Dr. Stretch. (T. 61).

Respondent's Exhibit 5 documents that Petitioner worked on May 27, 2011, the day following her alleged accident, from 1:30 PM until 10 PM. (Rx. 5). Petitioner testified that she had difficulty walking at work on May 27. (T. 61).

She also confirmed that she worked on Saturday, May 28, 2011. She testified that she worked a full day. (T. 61). Respondent's Exhibit 5 documents that Petitioner worked that day from 2:00 PM until 11:45 PM. (Rx. 5). Petitioner testified that her knee "felt stiffer" on May 28. (T. 61). She confirmed she was able to perform the essential duties of her job on May 27 and 28. (T. 121).

Petitioner testified that her coworkers were helping her sit with her leg up on May 27 and/or May 28, (T. 62), but Petitioner did not produce a single co-worker at trial to confirm this testimony. Petitioner testified that when she was working on May 27 or 28 she told a co-worker named Rich Bykowski about her knee. (T. 118-119).

She testified she saw Mr. Bykowski on Friday, May 27, or Saturday, May 28, 2011. (T. 118-119). However, based on Respondent's Exhibits 5 and 6, Petitioner could not have possibly reported any knee complaints to Mr. Bykowski on May 26, 27, or 28, 2011. (Rx. 5, 6).

On May 26, the alleged date of accident, Mr. Bykowski worked from 1:00 AM to 9:00 AM, (Rx. 6), whereas Petitioner worked from 1:30 PM to 11:00 PM. (Rx. 5). On May 27, Mr. Bykowski worked from 1:00 AM to 9:00 AM, (Rx. 6), whereas Petitioner worked from 1:30 PM to 10:00 PM. (Rx. 5). Finally, Mr. Bykowski did not work on May 28. (Rx. 6).

Petitioner testified that she did not visit a doctor on Saturday, May 28, because it was Memorial Day Weekend. (T. 62). She confirmed that the next day she was scheduled to work was Tuesday, May 31, 2011, the day after Memorial Day. (T. 62). The Arbitrator notes that by May 31, 4 full days had passed since the alleged date of accident, including 2 full days worked by the Petitioner, and 2 full days off.

Petitioner testified that on May 31, 2011, after 2 full days off from work, she "could not put any weight on [her] knee without it giving out and collapsing." (T. 62). She testified that she saw Dr. Stretch as a result. (T. 63). She testified that Dr. Stretch "verbally" took her off work, but that she worked anyway on May 31, 2011. (T. 63).

Petitioner alleged that when she went in to work she "ran, saw immediately my big boss, engineer John Baich, and he saw the knee brace on [her] leg." (T. 63). She testified that this was the first time she reported to the Respondent that she had an injury on May 26, 2011. (T. 63). Petitioner testified that she then reported her claim to Mr. Raphael Meza. (T. 64).

Petitioner's time sheet from May 31, 2011 document that she worked from 2:00 PM until 10:00 PM. (Rx. 5). Petitioner did not return back to work for the Respondent after this date. Petitioner acknowledged that she had an e-mail address at work, and that she did not e-mail any of her supervisors at work as her knee condition allegedly worsened over the weekend from May 26 to May 31, 2011. (T. 145-146).

Petitioner testified that Dr. Stretch gave her work restrictions on June 1, 2011, and that she provided those restrictions to Mr. Meza. (T. 65-66). She testified she was contacted by Mr. Meza and told her restrictions could not be accommodated. (T. 66).

With respect to her secondary employment, Petitioner testified that she taught dance and edited music for Gould Academy. (T. 75). She testified that she worked for Gould Academy for 12 years. (T. 76). She testified that she last taught a dance class on May 23, 2011. (T. 76). The Arbitrator notes this testimony was inaccurate as the records from Gould Academy, submitted as Respondent's Exhibit 8, confirm that Petitioner worked at Gould Academy on June 6 and June 13, 2011. (Rx. 8).

She testified that she did not actually perform any dance moves as part of her instruction because, "I don't believe I move as well as the younger girls, and it is their turn to move and dance and learn." (T. 78). She did not testify that she had any physical limitations that prevented her from performing dance moves.

Petitioner confirmed that some of her conditions that she treated with Dr. Stretch for would be aggravated by teaching dance. (T. 80). She alleged she has foot conditions that would be aggravated by teaching dance. (T. 81). She testified she stands and walks for pretty much her entire class and would try to "catch up to a student that when she comes towards me, hold her pose." (T. 81).

Petitioner reiterated on cross-examination that she did not perform any dance moves either in performance or during instruction for over 5 years prior to the start of trial. (T. 86). However, she acknowledged that she would see Dr. Stretch after teaching a dance class with complaints related to teaching dance. (T. 86). She acknowledged that Dr. Stretch's records reveal that she was "sore and tender from dancing and choreography." (T. 86). She confirmed that she reported to Dr. Stretch on June 15, 2010 that she was "sore all over" from moving props for a dance recital. (T. 87). She also confirmed that she treated with Dr. Stretch on June 21, 2010, and reported to him that "her entire body was sore after a 2-day dance recital and that [her] neck and upper back were hurting from bumping heads with a student dancer." (T. 88). Finally, she acknowledged that on October 22, 2010 she was seen by Dr. Stretch and told him that she struck a dance pole and turned her left foot while teaching dance on October 18, 2010. (T. 98).

Petitioner admitted that was she was informed that she was going to be laid off from Fox News. (T. 102-103). She admitted that her layoff was scheduled to take place "no earlier than May 27, 2011," (T. 103, Rx. 3), which was only 1 day after her alleged accident date. She acknowledged that she was hand-delivered Respondent's Exhibit 3, the May 12, 2011 notice advising Petitioner of her impending layoff, by Mr. Raphael Meza. (T. 104-105).

Petitioner testified that prior to retaining counsel she spoke with the insurance adjuster, Linda Talarico, numerous times regarding her claim. (T. 74). Petitioner also admitted that she spoke with the insurance adjuster, Linda Talarico, in June 2011. She confirmed she provided a recorded statement. Petitioner admitted that she denied any secondary employment to Ms. Talarico, (T. 113), intentionally withholding information that she worked as a Dance Instructor. She testified that she told the adjuster that she was a ballet

dancer when she was young, 10 to 20 years ago, and she denied that she participated in any other outside activities, hobbies or sports. (T. 114).

When asked whether she was "trying to mislead" the adjuster, Petitioner replied, "[c]onsidering she diagnosed me on June 1st as only having a sprained knee, yes." She later denied trying to mislead the adjuster. (T. 114). Petitioner also later admitted during re-direct by her attorney that she herself thought she had a "worse-than-average sprain" as of May 31, 2011. (T. 149). Finally, Petitioner acknowledged that she did not mention Mr. Bykowski's name during her recorded conversation with Ms. Talarico, (T. 118), thereby again depriving the Respondent of information relevant to a proper investigation of her claim.

Testimony of Donna Gould Jessen

Petitioner called one witness to testify on her behalf, Ms. Donna Gould Jessen. (T. 34-52). Ms. Jessen confirmed that she owned a dance studio. (T. 34). She confirmed that Petitioner was a teacher at the dance studio for the last 12 years. (T. 35). She confirmed that Petitioner taught ballet for 1.75 hours per week. (T. 35).

Ms. Jessen testified that Petitioner did not actually dance when she taught. (T. 35). She testified that Petitioner had "demonstrators" who would "demonstrate movements" for the Petitioner. (T. 36). She testified that Petitioner had not actually danced as part of her teaching duties for the last 6 years. (T. 36).

On cross-examination, Ms. Gould contradicted her earlier testimony by stating that Petitioner had not performed any dance moves for the last 5 years. (T. 37). She testified Petitioner last performed 5 years prior to the September 12, 2011 trial. (T. 37).

Ms. Gould testified that Petitioner never performed dance moves for instructive purposes. (T. 38). However, she testified that Petitioner would perform arm movements as part of her instruction. (T. 38). She testified that Petitioner had not performed arm movements as part of her instruction in over a year. (T. 38).

Ms. Gould testified that her dance studio has a website, and she provided the foundation for Respondent's Exhibit 2, which was a printout of the Gould Academy website as of September 1, 2011. (T. 43-44). She testified that she changed the information on the website recently. She acknowledged that the website was changed within 11 days prior to the start of trial. (T. 43-44). She testified that the website as of September 1, 2011 indicated that Petitioner continued to "study at Ruth Page Foundation to upgrade her technique and teaching methods." (T. 44). She acknowledged that the website indicated that Petitioner "performs in the annual production of the Nutcracker in Chicago." (T. 44). However, she testified that the website was inaccurate and that was why she changed the information on the website within the 11 days between September 1, 2011 and September 12, 2011, the start date of trial. (T. 48).

Ms. Gould testified that Petitioner did not perform any type of dance moves in June of 2010 or October 2010. (T. 40). This conflicts with Petitioner's prior medical records and as such the Arbitrator notes this did effect the credibility of Ms. Gould's testimony.

Ms. Gould testified that dance recitals are performed annually, and that Petitioner would instruct students in preparation for recitals. (T. 40). Ms. Gould testified that she observed all of Petitioner's dance classes leading up to the dance recital in June 2010. (T. 42). In fact, she testified that she observed almost every single minute of Petitioner's instruction and never once witnessed her performing any dance moves over the last 5 years. (T. 50-51). She testified that she never saw Petitioner performing any kind of dance moves during her instruction leading to the recital in June 2010. (T 42).

Petitioner testified that she has known Ms. Jessen for 16 or 17 years. (T. 121). She admitted that Ms. Jessen changed the website of Gould Academy after the date of accident. (T. 122). Petitioner confirmed that she asked Ms. Jessen to change the website. (T. 121).

Testimony of Raphael Meza

Testimony was also provided by Mr. Raphael Meza, Human Resources Director, of the Respondent. (T. 151-162). He confirmed Petitioner reported an accident on May 31, 2011. (T. 152). He testified Petitioner told him that "she hurt her knee," and that it occurred "throughout the course of her shift on the 26th." (T. 152). He testified that Petitioner gave him the impression that her knee was injured "throughout the course of the night when she was on the chair moving back and forth." (T. 153). He testified that Petitioner told him she did not have any restrictions as of May 31, 2011. (T. 154).

Mr. Meza testified that Petitioner never provided him with any documentation indicating she had work restrictions, other than a note taking Petitioner off work until further notice, which he received on June 2, 2011. (T. 155). This directly contradicted Petitioner's testimony that she provided light duty restrictions to Mr. Meza and that Mr. Meza told her that the Respondent could not accommodate her alleged light duty restrictions. (T. 66). Mr. Meza was not aware of any employee of the Respondent telling Petitioner her alleged restrictions could not be accommodated. (T. 157). Mr. Meza testified that Petitioner's job duties as a Master Control Technician involved "sitting mostly," and that she would not be required to stand for two and a half hours in that position. (T. 159).

Trial Proceedings of October 13, 2011

Mr. Rich Bykowski was called by Respondent as a witness on October 13, 2011. He testified he could not recall Petitioner mentioning anything to him about her knee at any point. Proofs were closed and exhibits were submitted, with the Arbitrator denying Respondent an opportunity to submit the IME report of Dr. Nikhil Verma or make objections on the record. Respondent was able to make an Offer of Proof with respect to Dr. Verma's report.

Medical Records

A. RELEVANT MEDICAL RECORDS PRIOR TO MAY 26, 2011

The records of Dr. Brandon, Petitioner's primary care physician, were submitted as Petitioner's Exhibit 1. The records begin on July 2, 2008. Petitioner was seen for

problems related to plantar fascitis of the left foot and low back pain. Petitioner reported good exercise habits including regular walking, elliptical, weight training, and swimming. (Px. 1).

On September 24, 2008, Petitioner confirmed to Dr. Brandon that she "started to teach dance class again." As a result, Petitioner reported that over the last two weeks she noted increased discomfort in her right SI joint. Through April 14, 2010, Petitioner continued to follow up with Dr. Brandon primarily, with respect to complaints related to her headaches. (Px. 1).

Petitioner also received a substantial amount of treatment prior to her date of accident from Dr. George Stretch, a naprapath. Petitioner confirmed that she treated with Dr. Stretch since April 30, 2010. (T. 85). Dr. Stretch is a Naprapath and Acupuncturist. (T. 68). Petitioner testified that she treated with Dr. Stretch for migraines, ovarian cyst pain, and occasional back pain. (T. 65). She later testified that she treated with Dr. Stretch for her upper back, headaches, and foot problems. (T. 85). She later acknowledged that she also treated with Dr. Stretch numerous times during the course of her treatment for lower abdominal pain, right-sided neck pain, bilateral upper, middle and lower back pain, and right-sided hip stiffness. (T. 89-90). She testified she never treated with him for knee pain prior to the accident date. (T. 65). She later acknowledged, however, that Dr. Stretch did previously perform acupuncture on her left and right knees. (T. 92-93).

The records of Dr. Stretch begin with her initial visit of April 30, 2010. Petitioner alleged complaints of a headache and abdominal cramps. A few days later, on May 3, 2010, Petitioner alleged pain in her lower, middle, and upper back. She also alleged pain in her hip. Petitioner also complained of headaches. (Px. 3).

Petitioner was seen for regular follow ups with Dr. Stretch through April 19, 2011. In fact, over the course of her treatment with Dr. Stretch, she was seen over 100 times for naprapathic and acupuncture treatment. (Px. 3).

Of significance, on June 8, 2010, Petitioner reported that her left heel was sore and tender from "dancing" and choreography. Petitioner confirmed that she was teaching dance the prior night for at least "three and a half hours." (Px. 3).

On June 15, 2010, Petitioner reported that she was "sore all over in general from moving prompts for dance recital coming up." She alleged pain in her right low back and left foot pain. On June 21, 2010, Petitioner reported that her entire body was sore after a "two day dance recital." She alleged that her neck and upper back were sore from "bumping heads with a student dancer." On June 28, 2010, Petitioner reported to Dr. Stretch that she felt that "everything in her body needs to be popped." (Px. 3).

On July 1, 2010, Petitioner complained of a headache, right-sided neck pain and stiffness, bilateral upper back pain and stiffness, bilateral middle back pain and stiffness, and bilateral lower back pain and stiffness. She also complained of right-sided hip pain and stiffness. Petitioner alleged that her symptoms were experienced "constantly." She described her pain as a dull ache. (Px. 3).

Petitioner continued to follow up through July 2010. On August 3, 2010, she alleged right-sided neck pain and stiffness. She also reported an episode of vertigo. Petitioner reported that she also strained the right side of her neck by pulling down her garage door. She alleged radiating pain down the right arm to the right shoulder area. She also complained of pain in the right upper thoracic region. (Px. 3).

On August 19, 2010, Petitioner had her usual complaints of back pain all over her back. She alleged that her back pain was due to stress as a result of work. She alleged that her back gave out on the prior night at work. She alleged her back went into spasm. (Px. 3).

Petitioner was seen by Dr. Stretch on September 4, 2010. She reported a headache that was so severe that she eventually had to seek treatment at the Delnor Hospital Emergency Room on September 3, 2010. Petitioner reported that she received seven injections of medications stronger than morphine, which did not help. She indicated she was released at midnight with a prescription for OxyContin. Petitioner also alleged that she had lower quadrant pain while in the hospital, which she related to a right ovarian cyst. (Px. 3).

Another notable record was from a follow up with Dr. Stretch on October 22, 2010. Petitioner complained of left ankle pain, stiffness, and weakness. There was no noted acute incident that caused her left ankle pain. Petitioner also complained of left foot pain due to a strained foot. Petitioner reported that on Monday, October 18, 2010, she struck a dance pole and turned her left foot while teaching dance class. (Px. 3).

In 2011, Petitioner continued following up with Dr. Stretch. She was seen on January 13, 2011. She continued to complain of lower back pain. She was now also complaining of left-sided hip pain and stiffness. Petitioner was seen again on January 17, 2011 with complaints of left-sided back pain and hip pain. On January 18, 2011, Petitioner reported that she was sore and tired and she alleged that she could "feel every joint in her body" with joint pain and soreness. (Px. 3).

On January 24, 2011, Petitioner was back to complaining about headaches, bilateral lower back pain, and bilateral hip pain. On January 31, 2011, she complained of right-sided middle back pain and stiffness. She also complained of right-sided mid thoracic pain around the right shoulder blade. On March 2, 2011, she complained of bilateral upper back pain and bilateral mid back pain. She also complained of light headiness. (Px. 3).

Petitioner was then not seen again for over a month by Dr. Stretch. She was next seen on April 12, 2011. She complained of bilateral neck pain and stiffness. She also complained of bilateral upper and middle back pain and stiffness. Petitioner reported that she was battling pneumonia and bronchitis. (Px. 3).

On April 19, 2011, Petitioner was seen by Dr. Stretch. She alleged bilateral neck, upper, and middle back pain and stiffness. Petitioner was seen for a number of additional follow ups with Dr. Stretch after April 19, 2011. Through May 17, 2011, Petitioner was seen for an additional 6 visits with Dr. Stretch. Significantly, on May 17, 2011, Petitioner reported to Dr. Stretch that she was experiencing stress at work. She reported that she had recently been notified that she would be laid off from her current job. (Px. 3).

As of May 24, 2011, Dr. Brandon's records continue to note that Petitioner had good exercise habit. (Px. 1). She was also seen by Dr. Stretch on May 25, 2011. Petitioner alleged right-sided neck pain and stiffness and right-sided upper back pain and stiffness. Petitioner alleged that her middle back problems had worsened since her last visit. Petitioner alleged the aggravation occurred as the result of her turning her head while in the shower. She also complained of headaches. (Px. 3).

The Arbitrator notes the records of Dr. Stretch from prior to Petitioner's alleged date of accident indicate a clear history of Petitioner reporting relatively minor medical problems during her visits.

B. RECORDS AFTER THE MAY 26, 2011 DATE OF ACCIDENT

Petitioner was seen on the day after the alleged accident, May 27, 2011, by Dr. Stretch. Significantly, Petitioner did not have any complaints of right knee pain. She did not report a history of any kind of injury while at work on May 26, 2011. Petitioner only complained of a headache, and upper, middle, and lower back pain. Dr. Stretch specifically noted that Petitioner had "not experienced an exacerbation that would affect her recovery." He continued to release Petitioner to return to work at full duty. There were no noted complaints of any right knee pain. (Px. 3).

Petitioner testified that she would see Dr. Stretch before she went to work in the morning. (T. 132). Petitioner testified that she did not say anything about her knee to Dr. Stretch on May 27, 2011, one day after her alleged accident, because she "did not feel it was pertinent at time." (T. 107). She acknowledged that she only complained about migraines, and right-sided upper, lower, and middle back pain. (T. 107).

Petitioner was next seen by Dr. Stretch on May 31, 2011. She complained of knee pain, stiffness, and weakness. She described her pain as a dull ache and a sharp or jabbing sensation. Petitioner alleged an injury occurring at work on May 26, 2011. Petitioner alleged that alarms went off and as she was seated, she scooted across the floor to address an alarm. Petitioner alleged that she felt a "pull or release" in the back of her right knee. (Px. 3).

Petitioner testified that she told Dr. Stretch she felt a pull or release in the back of her knee on the alleged date of accident when she was seen by him on May 31, 2011. (T. 107). She testified that she "should have" told him she felt a pop, (T. 107), but the records of Dr. Stretch do not indicate any history of Petitioner reporting that she felt a pop in her knee at the time of her alleged accident. (Px. 3).

On examination, Petitioner had somewhat limited range of motion. She had a positive Homans sign on the right. She also had point tenderness on palpation just slightly inferior to the right popliteal fossa. Dr. Stretch diagnosed a strain, but he did not rule out the possibility of a clot. He referred Petitioner for a Doppler venous ultrasound and released her to return to work at full duty. (Px. 3). This record contradicts Petitioner's testimony that she was placed on restrictions by Dr. Stretch as of May 31, 2011.

Petitioner underwent that venous Doppler study at St. Joseph's Hospital on May 31, 2011. The study was negative.

Petitioner was next seen by Dr. Stretch on June 1, 2011. She complained of continued knee pain. Petitioner described the intensity of her knee discomfort as severe. Petitioner alleged that her knee symptoms were becoming worse. Petitioner alleged that her knee symptoms were worse due to driving approximately two hours. She also alleged that her knee symptoms were aggravated as a result of getting up and down out of her chair while working for the insured. (Px. 3).

Dr. Stretch continued to diagnose a right knee sprain/strain. He referred Petitioner for an MRI. Significantly, his records show that he continued to release Petitioner to return to work at full duty, (Px. 3), again directly contradicting the testimony of the Petitioner.

Petitioner was then seen by Dr. Brandon on June 2, 2011. Petitioner alleged an injury at work while she was pulling herself along in a rolling chair. Petitioner now alleged that she felt a "pop and pain" in her right knee. She alleged mild swelling in her knee. (Px. 1).

Dr. Brandon's records again specifically noted that Petitioner had good exercise habits. It was noted Petitioner performs regular walking, elliptical, weight training, and swimming. He noted Petitioner was a moderate exerciser approximately three times per week. It was noted that Petitioner worked for the insured. There was no indication that Petitioner was working as a dance teacher in these records. (Px. 1).

Petitioner testified that the records of Dr. Brandon were incorrect when they mentioned that she was a moderate exerciser. (T. 108). However, earlier in her testimony she acknowledged that she did not remember everything she has told her providers, (T. 100), and that she would have no reason to dispute her medical records if they indicated certain information. (T. 93).

On examination, Petitioner had limited range of motion. Other objective testing was negative with the exception of a positive medial McMurray sign for pain. Dr. Brandon diagnosed possible internal derangement of the anterior horn of the medial meniscus. He also recommended an MRI and provided Petitioner with a prescription for crutches and ice massage. (Px. 1).

Petitioner underwent her MRI on June 3, 2011. The MRI indicated that the appearance of Petitioner's ACL was suggestive of a ligament sprain or some degree of internal partial tear. Also seen was patellar tendinosis and prepatellar bursitis. (Px. 2).

Petitioner was also seen by Dr. Stretch on June 3, 2011. She complained of constant right knee pain. Petitioner rated her right knee pain at 10/10. Petitioner alleged pain on palpation. Dr. Stretch noted some evidence of mild edema on the upper pole and lateral aspect of the right knee. He placed Petitioner off work. (Px. 3).

Petitioner was seen for additional follow ups with Dr. Stretch on June 4, 6, 7, and 9, 2011. It was noted on June 4 that Petitioner was using crutches to ambulate. It was also noted that Petitioner took a 1,000 milligram of Vicodin, which was provided by Dr. Brandon, on June 3, 2011. On June 6, Petitioner reported that her treatment was decreasing her right knee pain. However, she continued to report some soreness and

tightness in the posterior aspect of her right knee. Petitioner was noted to still be wearing her right knee brace. The records of June 7 and June 9, 2011 do not indicate any change in Petitioner's condition. As of June 9, 2011, it was noted that Dr. Stretch would be referring Petitioner to Fox Valley Orthopedics for further treatment. Petitioner alleged pain of 10/10 as of June 9, 2011. (Px. 3).

On June 9, 2011, Petitioner was also seen by Dr. Brandon. Petitioner alleged that she was unable to bear weight without pain. Petitioner appeared on June 9 with menthol patches on her knee applied by Dr. Stretch. Dr. Brandon noted that Petitioner's MRI revealed an ACL strain, but no tear. He noted Petitioner was very sensitive to touch and movement and therefore very difficult to examine. He noted that Petitioner's last exam did not reveal any specific findings other than pain with palpation and movement. He noted Petitioner did not get any x-rays done as her previously requested but did have the MRI done. (Px. 1).

Examination was again unremarkable. Dr. Brandon diagnosed a sprained ACL with no tear. He again referred Petitioner for an x-ray of her knee and advised her to follow up in two weeks. He provided Petitioner with a brace and referred her for physical therapy. He discussed with Petitioner the fact that her pain seemed out of proportion to her injury. He did not feel a custom knee brace was needed given the lack of a significant tear. (Px. 1). Petitioner acknowledged that Dr. Brandon was concerned that she was difficult to examine on June 9, 2011. (T. 109, 112).

Petitioner was seen for additional follow ups by Dr. Stretch on June 13 and 14, 2011. She had continued complaints of knee pain at 10/10. Petitioner alleged that she needed crutches to ambulate. Otherwise, there was no change in the examinations performed by Dr. Stretch. (Px. 3). (Notably, during June 6 and 13, 2011, Petitioner was working as a dance instructor at Gould Academy.)

On June 17, 2011, Petitioner was seen at Fox Valley Orthopedic Institute by Dr. Jasper Petrucci. Petitioner reported a history of her chair coasters getting caught on a rugged plastic runner. Petitioner alleged that as she tried to pull herself harder, she felt a "pop and pain" in the posterior aspect of her right knee. Petitioner alleged that she was able to continue working but that after some time, when she tried to stand up, she had "extreme pain" with standing and was unable to completely extend "her leg." (Px. 2). Petitioner testified that she could not remember whether she told Dr. Petrucci that she had "extreme pain immediately following the accident" of May 26, 2011. (T. 110).

The records show that Petitioner told Dr. Jasper that she exercised weekly. She confirmed that she worked for Fox News. The records do not reveal that Petitioner also worked as a dance instructor. On examination, Petitioner was noted to be 5'9" weighing 250 pounds. She was using crutches to ambulate with a hinged knee brace for support. (Px. 2). The Arbitrator notes Petitioner was wearing the hinged knee brace against the orders of Dr. Brandon.

Dr. Jasper noted very mild prepatellar fusion. He noted Petitioner had a significant amount of guarding and that Petitioner had a good end point with varus and valgus stress testing. (Px. 2). Petitioner acknowledged Dr. Petrucci commented to her about "guarding" during her exam. (T. 112).

Petitioner had a negative Lachman's. Petitioner had a good end point to anterior drawer testing. Dr. Jasper noted essentially subjective complaints of pain on testing. He diagnosed Petitioner with a questionable ACL injury. He provided Petitioner with a short course of Ultram for pain relief He referred her to Dr. Vishal Mehta for further treatment. In addition, x-rays were performed on June 17, 2011. The x-rays showed mild lateral tilting of the patellar bilaterally, left worse than right. Otherwise, the x-ray was negative. (Px. 2).

Petitioner was next seen at Fox Valley on June 21, 2011 by Dr. Vishal Mehta. Petitioner alleged that she injured herself when her chair got caught on a plastic runner. The records indicate that Petitioner was now alleging a "twisting type injury to her right knee." Petitioner alleged pain and instability within the knee. (Px. 2).

Upon examination, it was noted Petitioner had diffuse tenderness about the knee. It was not particularly localized. Petitioner also had range of motion limited by pain. Dr. Mehta noted Petitioner "guards a lot" but appeared to be stable to varus and valgus stress testing. Petitioner did have a positive Lachman, but again, but Dr. Mehta noted Petitioner guarded quite a bit. He noted Petitioner had a negative posterior drawer. He noted Petitioner could not perform an accurate McMurray's test. He also noted that he could not properly perform an Apley's exam due to guarding. Finally, he noted that Petitioner had no edema or calf tenderness bilaterally. (Px. 2). Petitioner acknowledged that Dr. Mehta commented to her about "guarding" during her exam. (T. 112).

Dr. Mehta diagnosed a right knee injury. He noted that Petitioner likely had an ACL rupture. He noted Petitioner appeared to have laxity on examination but that she was not comfortable enough for him to perform a proper examination. He recommended Petitioner continue using her knee brace. He referred her to physical therapy and advised her to check in 2-3 weeks. He placed Petitioner off work pending physical therapy. (Px. 2).

Petitioner underwent her initial evaluation at CoSport on June 22, 2011 on the referral of Dr. Mehta. Prior to her evaluation, she filled out a questionnaire. (Px. 4, Rx. 4). Petitioner testified concerning her Co-Sport Physical Therapy treatment. She confirmed she filled out a health questionnaire. (T. 126). She testified that she indicated she worked as a Master Control Operator on the questionnaire, but did not mention anything about instructing dance. (T. 127). She also confirmed that under "hobbies," she mentioned sewing, and admitted that she crossed off another indicated hobby, and testified that she could not recall whether she wrote "dance" before crossing if off. (T. 128).

With respect to what type of exercise/activities Petitioner performed on a regular basis, Petitioner indicated "none really." With respect to her job as a master control operator, Petitioner alleged that her job involved working between consoles, sitting for long periods of time, and getting up and down and walking through the station. (Px. 4, Rx. 4).

Petitioner reported a history of pulling herself around the office area from one console to another and pushing herself backwards extending her leg. Petitioner reported that at one point a coaster of the chair got caught on the plastic runner underneath the chair.

Petitioner alleged that she felt a "pop" in her right knee. Petitioner alleged immediate pain in the right knee. (Px. 4).

Petitioner confirmed she had not worked since June 1, 2011. The record again notes that she reported her job involved sitting for long periods of time between consoles. Petitioner alleged that she needed to get up and down as needed to walk through her station. (Px. 4).

Petitioner was seen for a physical therapy reevaluation at CoSport on July 8, 2011. It was noted that Petitioner was very apprehensive in therapy. She was only able to perform table exercises and even that was "a stretch on some days." It was noted Petitioner constantly wore a knee brace and used crutches. Petitioner cancelled a scheduled physical therapy visit on July 12, 2011. (Px. 4).

On July 12, 2011, Petitioner was seen for a follow up with Dr. Mehta. Petitioner alleged instability within her knee. She complained of worsening knee pain with any activity. On examination, Petitioner had a positive Lachman, positive anterior drawer, negative posterior drawer, and stable varus and valgus testing. Dr. Mehta again noted Petitioner guarded too much to perform an accurate pivot shift. He noted Petitioner had a negative McMurray's and Apley's grind test. He noted Petitioner was neurovascularly intact. He continued to diagnose a right ACL rupture. He recommended surgery. Dr. Mehta continued to place Petitioner off work. (Px. 4).

On August 9, 2011, Petitioner was seen for a follow up with Dr. Mehta. Petitioner alleged continued pain in the right knee with instability. She noted her pain was improving. Dr. Mehta continued to recommend surgery. (Px. 2). Following her alleged accident Petitioner also visited with Dr. Stretch regularly. (Px. 3).

Finally, and significantly, Petitioner did not submit any evidence at trial from her treating physicians causally connecting the mechanism of injury she described – pulling forward in her chair – to her alleged injury – an ACL rupture.

CONCLUSIONS OF LAW

As to the following disputed issues, the Arbitrator makes the following conclusions of law based on the evidence presented:

C & F. Accident and Causal Connection

The Arbitrator finds Petitioner failed to prove that she suffered an accident that arose out of and in the course of her employment. The reasons for this finding are diverse.

First, the Arbitrator places great significance in the fact that Petitioner visited Dr. Stretch on May 27, 2011, only 1 day after her alleged accident, and did not report any complaints related to her knee despite later claiming to Dr. Brandon that she felt a "pop and pain" in her knee, and "extreme pain" immediately following her alleged accident to Dr. Petrucci

of Fox Valley Orthopedic. The Arbitrator finds that the records of Dr. Stretch reveal that Petitioner visited with him regularly prior to the accident and reported even minor complaints of pain. This makes it incredibly unlikely that Petitioner would not have reported feeling a "pop" and "extreme pain" to Dr. Stretch the morning after her alleged accident.

Second, the Arbitrator finds that Petitioner lacks credibility for multiple reasons. Petitioner admitted that she intentionally withheld information regarding her secondary employment from the insurance adjuster. The Arbitrator finds that Petitioner also failed to disclose information about her secondary employment to her numerous medical providers. The fact that this secondary employment involved a physical activity, dance, is significant.

Petitioner also repeatedly failed to disclose that she worked as a dance instructor even as a hobby or activity. The Arbitrator notes that it appears Petitioner originally wrote "dance" as a hobby on Respondent's Exhibit 4, the Co-Sport questionnaire, only to cross it out. This again reveals a pattern of intentionally withholding material information from the Respondent in an effort to bolster her workers' compensation claim. The fact that Petitioner also failed to allege any of her wages from the Dance Studio as concurrent earnings supports this finding.

Petitioner also lacked credibility with respect to her testimony concerning her ability to work. Her testimony was wholly inconsistent with the medical records and testimony of Respondent's representative. Petitioner testified that Dr. Stretch "verbally" took her off work on May 31, 2011. That testimony was directly contradicted by Dr. Stretch's records which indicated he released Petitioner to return to full duty work.

Petitioner then testified that she was placed on work restrictions by Dr. Stretch on June 1, 2011, and that she provided those work restrictions to Mr. Meza. The records of Dr. Stretch, contrary to her testimony, indicate that Dr. Stretch did not give her any work restrictions on June 1, 2011. He released her to full duty work. Mr. Meza also credibly testified that Petitioner never provided him with any documentation indicating she had work restrictions, other than an off work slip that he received on June 2, 2011.

Petitioner also testified that she told a co-worker, Mr. Bykowski, about her knee on May 27 or May 28, 2011. However, the undisputed evidence submitted at trial directly contradicted Petitioner's allegations. The time sheets submitted at trial conclusively establish that the Petitioner and Mr. Bykowski were not working together on May 26, 27, or 28, 2011. The Arbitrator notes that Mr. Bykowski's time sheets document that he also did not work from May 29, 2011 to June 2, 2011, and therefore Petitioner could not have made any complaints of knee pain to Mr. Bykowski at any point on or after May 26, 2011. In addition, the fact that Petitioner was not able to produce a single co-worker to corroborate her testimony lends support to the Arbitrator's finding that Petitioner did not experience an accident at work.

Petitioner also testified on September 12, 2011 that she last worked for Gould Academy as a dance instructor on May 23, 2011. Again, the actual evidence submitted at trial directly contradicted her testimony. Those records, submitted as Respondent's Exhibit 8, documented that Petitioner worked on June 6 and June 13, 2011 at Gould Academy.

Third, the Arbitrator places great significance in the fact that Petitioner waited a full 4 days prior to reporting her alleged accident. Petitioner alleged her accident occurred on May 26, 2011, but waited until she worked 2 more days, and was off for 2 days, to report any accident. Petitioner acknowledged that she had access to office e-mail. The Arbitrator finds that she did not provide an adequate explanation at trial for her failure to report her alleged accident on the 2 days she worked immediately following the alleged date of accident.

Fourth, the Arbitrator finds that Petitioner reported different histories of how her accident occurred. Petitioner testified that her accident occurred while pulling forward. She testified that she did not "feel any extreme pain."

Mr. Meza, Respondent's representative, contradicted Petitioner's testimony by credibly testifying that Petitioner told him her accident occurred "throughout the course of her shift." The records of Dr. Stretch reveal that she told him that she felt a "pull or release" on May 31. The records of Dr. Brandon then indicate that Petitioner told him on June 2 that she felt a "pop and pain" when her accident occurred.

Petitioner also testified that her pain was not that bad immediately after the accident, but the records of Dr. Petrucci reveal allegations of "extreme pain" immediately after the accident. Finally, while Petitioner testified that her accident occurred when she was pulling forward, the records of Co-Sport indicate Petitioner reported a history of pushing herself backwards and extending her knee, while the records of Dr. Mehta indicate a "twisting type injury."

Fifth, the Arbitrator also finds the testimony of Ms. Jessen seemed to lack some credibility. Ms. Jessen testified that she basically watched every single minute of Petitioner's instruction over the last 5 years and that Petitioner never performed dance moves. The Arbitrator finds that statement difficult to believe. It was also directly contradicted by the evidence submitted at trial.

Ms. Jessen testified that she observed Petitioner's instruction in June and October 2010, and that Petitioner did not perform any type of dance moves during those months. The records of Dr. Stretch conclusively establish that testimony is overstated. Specifically, Petitioner reported to Dr. Stretch that she struck a dance pole and turned her left foot while teaching dance class on October 18, 2010. On June 8, 2010, Petitioner reported to Dr. Stretch that her left heel was sore and tender from "dancing" and choreography. Petitioner confirmed that she was teaching dance the prior night for at least "three and a half hours." On June 15, 2010, Petitioner reported to Dr. Stretch that she was "sore all over in general from moving prompts for dance recital coming up." She alleged pain in her right low back and left foot pain. On June 21, 2010, Petitioner reported that her entire body was sore after a "two day dance recital." She alleged that her neck and upper back were sore from "bumping heads with a student dancer."

Sixth, the Arbitrator places significance in the fact that Petitioner was notified of an impending layoff that was to occur no earlier than May 27, 2011, approximately one day after her alleged injury.

While Respondent cannot point to a specific incident that caused Petitioner's alleged knee condition, the cumulative findings cited above support the Arbitrators conclusion that Petitioner did not experience any accident while working for the insured on May 26, 2011. Based on the foregoing, compensation is denied. The Arbitrator finds that Petitioner did not experience an accident that arose out of and in the scope of her employment.

J, K, O. Medical benefits, TTD benefits, and Prospective Medical Treatment

Based on the finding that Petitioner did not suffer a compensable accident, the Arbitrator finds that Respondent is not liable for any past or future medical or TTD benefits.

M. Penalties

Based on the foregoing and the finding that Petitioner did not suffer a compensable accident, the Arbitrator finds that Respondent's denial of TTD and medical benefits was not unreasonable or vexatious. Petitioner's petition for penalties is denied.

W:\DOCS\2885\26\01160657.DOC

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Rutherford,
Petitioner,

vs. NO: 11 WC 32266

15IWCC0119

State of Illinois
Pinckneyville Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19b 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 and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof..

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2014, is hereby affirmed and adopted.

DATED: FEB 9 - 2015

Daniel R. Donohoo

o-01/27/15
drd/wj
68

Ruth W. White

15IWCC0119

DISSENT

I respectfully dissent from the majority's decision to affirm and adopt the Arbitrator's findings. The Petitioner has proven that he had accidental injuries arising from the work he performed on or about August 1, 2011.

Dr. George Paletta testified on February 6, 2014, that based on the history given to him by the Petitioner and the increase in symptoms due to specific work activities, his job was an aggravating factor in his diagnosis of cubital tunnel syndrome.

I find that the Petitioner's testimony was credible.

Under the Act, Petitioner need only show that the work activities aggravated a pre-existing condition and made his symptoms worse. The Petitioner successfully did that in this case.

Charles J. DeVriendt

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

RUTHERFORD, DANIEL Case# **11WC032266**
Employee/Petitioner

PINCKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

15IWCC0119

On 6/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
FARRAH HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MGMT SERVICES RISK MGMT
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

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

JUN - 3 2014

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0119

Daniel Rutherford
Employee/Petitioner

v.

Pinckneyville Correctional Center
Employer/Respondent

Case # 11 WC 32266

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon, IL**, on **04/09/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

15IWCC0119

FINDINGS

On the date of accident, **August 1, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was not* given to Respondent.

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

In the year preceding the injury, the Petitioner's average weekly wage was $**1,105.67**.

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 1, 2011, that arose out of and in the course of his employment with Respondent. Claim 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.

Carl Lee
Signature of Arbitrator

6/2/14
Date

ICArbDec19(b)

JUN - 3 2014

The Arbitrator finds the following facts:

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. Petitioner alleges that he sustained injuries to his bilateral hands and arms as a result of repetitive duties while working for Pinckneyville Correctional Center. Petitioner has alleged the date of accident as August 1, 2011. This is a repetitive trauma claim where Respondent disputed accident, notice, causation, medical, and prospective medical.

Petitioner is a forty year old, right hand dominant correctional officer. He was employed at Pinckneyville Correctional Center since July 1, 1998 until May 2013 when he transferred to DuQuoin Impact Incarceration Program. Petitioner testified that he worked the second shift (3pm-11pm) for a period of 2 ½ years in general population from 2000-2003, but the remainder of his time at Pinckneyville Correctional Center he worked on the first shift (7 am-3pm). Petitioner testified that 96-97% of his career at Pinckneyville Correctional Center was spent as a wing officer in general population or segregation. Petitioner testified that he performed no bar rapping as a wing officer in general population.

Petitioner testified that he worked in R5 segregation, where there was no bar rapping. Petitioner testified that on the first shift (7am-3pm) in R5 segregation, there would be four wing officers, a property officer, a control pod officer, and two escort officers. Petitioner testified that showers in segregation were not performed on the first shift (7am-3pm), so he did not do showers. Petitioner testified that the R5 segregation unit is made up of two wings of segregation and two wings of general population. Petitioner testified that segregation is a lockdown unit. The A wing of R5 has 56 cells. The cells are capable of double occupancy. One feed occurs on each shift. For a feed, Petitioner would open the chuckhole and the inmate porter would pass the trays through the slot. The chuckholes are shut by closing them with your hand. The chuckholes do not need to keyed to be shut.

Petitioner testified that Pinckneyville Correctional Center was a state-of-the-art facility when it opened in 1998. The control pod officer uses a touchscreen to open cell doors for mass movements and individual cells in general population. Petitioner testified that this was the way movements occurred the majority of the time in general population. Petitioner testified that in general population he would have to cuff an inmate and use a Folger-Adams key two to three times per week.

As for shakedowns, Petitioner testified that he shakes down one cell per day. Petitioner confirmed that in segregation, Petitioner does not shake down property boxes. The only boxes inmates are allowed in segregation are correspondence boxes, which are the smaller of the two boxes. Petitioner testified that he would look through maybe two correspondence boxes per day. He estimated it would take approximately 15 minutes if they were doing a cell check.

Petitioner testified that he had symptoms and knew they were related to work in 2009 or 2010. However, he did not report the problem to his bilateral hands/arms to Pinckneyville Correctional Center until August 2011. Petitioner testified that the first person he saw for his condition was an attorney, who referred him to Dr. Paletta. Petitioner confirmed on cross-examination that lockdown does not change the workload in segregation; it stays the same regardless of lockdown status. Petitioner testified that even though he transferred to DuQuoin Impact Incarceration Program in May 2013, at the time of trial in April 2014, his symptoms had worsened. He did not have an explanation for same since he was no longer performing the duties that he testified caused or aggravated his bilateral cubital tunnel syndrome. Petitioner confirmed on cross-examination that he had continued to work out several days a week since leaving Pinckneyville Correctional Center.

On cross-examination, Petitioner was questioned about his exercise.

> Q. You talked about exercise. How often do you work out?
> A. I work out four, probably four days a week.
> Q. How many hours a day?
> A. About 45 minutes a day.
> Q. Do you curl?
> A. Have I curled, yes, Ma'am.
> Q. Is that something you do every day?
> A. No.
> Q. How often do you do that?
> A. Probably two days a week.
> Q. And approximately how many curls do you do?
> 66
> A. I do probably 10 to 12 --
> Q. How many --
> A. -- per set --
> Q. How many --
> A. -- two to three sets.
> Q. And how much weight?
> A. Thirty-five, 40 pounds.
> Q. Okay. And you bench press?
> A. I do bench press.
> Q. How much weight?
> A. On average probably 200 pounds.
> Q. And how many repetitions?
> A. I generally keep it 10 to 12 repetitions.
> Q. And how many sets?
> A. Three to four sets.
> Q. And would you agree that those activities involve repetitive flexion and extension of your elbows?
> A. Yes.
> Q. And they also involve bending and straightening of the elbows through a full cycle?
> A. Yes.

Q. And those activities include repetitive forceful forearm grip activities?
A. Yes.
Q. And do you do any triceps activity or exercises that would involve pushing?
A. Well, when you do bench press, you push, yes.

Lt. Jason Thompson performed a key study usage estimation entered into evidence as RX11. Per his estimates, on R5 A wing, Petitioner would key 90 large keys and 20small keys on the 7am-3pm shift Monday thru Friday and 120 large and 30 small keys on the 7am-3pm shift Saturday and Sunday. This is explained in further detail under the heading R5 Usage Factors.

Petitioner testified that he worked various assignments including tower officer, control pod office, escort officer, walk officer, relief officer, gatehouse officer, yard officer, gym officer, chapel officer, armory officer, dietary officer, school officer, healthcare unit officer, caustics toxics officer, and maintenance officer. Petitioner testified that he did not use a Folger-Adams key or bar rap in those assignments. Petitioner testified that he would only use a Folger-Adams key in general population when working the second shift to pass out mail or when Pinckneyville Correctional Center was on lockdown or when he had to restrain an inmate. Petitioner testified that he did not know how often Pinckneyville Correctional Center was on lockdown. The Job Site Analysis from Corvel Visit #2, showed that Pinckneyville Correctional Center was on lockdown for the year 2010 as follows: 01/01/2010-01/03/2010: Level 1 lockdown status; 01/04/2010-01/12/2010: Level 4 lockdown status; 02/19/2010-02/21/2010: Level 1 lockdown status.

On August 1, 2011, Petitioner presented to Dr. George A. Paletta, Jr. at The Orthopedic Center of St. Louis. Petitioner completed a "Patient Health Questionnaire for Dr. Paletta's Office" in which he reported that his problem began approximately 2 years ago. He described the problem as his hands get numb. He reported that he had not seen a doctor for this problem and had not undergone any tests for this problem. However, he reported that he had tried braces/orthotics as a treatment method. Petitioner reported that he was a correctional officer. He reported that he exercised 5 days a week doing weights and cardio. Petitioner reported that he was being seen for a work-related injury and there was a lawsuit related to his injury. Petitioner reported that he worked as a correctional officer at Pinckneyville Correctional Center. He presented for evaluation of a chief complaints of numbness and tingling involving the fourth and fifth fingers of both hands. Petitioner reported his symptoms had been present for about two years. He noted the onset of symptoms gradually without any precipitating trauma or injury. Petitioner reported that he thought it was just poor circulation. He continued to have symptoms and they increased particularly at night. He stated that he woke up at night or in the morning his arm often asleep and his hand dead sensation. He had to drag his hand out of bed. The numbness and tingling were confined to the fourth and fifth fingers in the ulnar nerve distribution. Petitioner reported that he used a cock-up splint that his wife had for some other issue. However, this did not help his symptoms at all. Other than that, he had no treatment to date. He had to work a lot at the doors and slots and had to do some opening and closing as well. This seemed to aggravate his symptoms. He had EMG and nerve conduction studies completed. Physical examination revealed examination of both elbows was essentially identical. There was no tissue swelling or effusion. Petitioner exhibited full elbow range of motion, 0 to 140 degrees. He had full forearm pronation and supination. He had mild

tenderness at the cubital tunnel. Mildly positive ulnar nerve compression test. Negative Tinel sign. Negative elbow flexion test. No ligamentous findings. Valgus stress test was negative. Normal wrist flexion and forearm pronation strength. Distal neurovascular exam was intact including ulnar nerve motor and sensory function. EMG and nerve conduction studies were completed by Dr. Daniel Phillips at the Neurological and Electrodiagnostic Institute on August 1, 2011. The findings were consistent with mild ulnar neuropathy at the right elbow. The findings on the left were mild to moderate at worst. There was no evidence of severe irreversible ulnar nerve changes. Petitioner was assessed with bilateral cubital tunnel syndrome with electrophysiologic evidence of ulnar nerve compromise. Given that the findings were mild, Dr. Paletta gave Petitioner options of a conservative nature. Dr. Paletta opined that Petitioner's work activities were an aggravating factor in his bilateral cubital tunnel syndrome. This was based on Dr. Paletta's understanding of Petitioner's job requirements and the hand-intensive nature of some aspects of his work. Petitioner was returned to work full duty.

On August 1, 2011, Petitioner completed a CMS Workers' Compensation Employee's Notice of Injury. He reported that he sought medical treatment with Dr. Paletta. He reported an injury on 08/01/2011 from keying chuckholes and doors, applying and removing restraints, repetitive trauma. Petitioner reported that place where the injury occurred was R5 segregation. Petitioner described the injury as numbness and tingling in both hands.

Petitioner's supervisor at the time of reporting the repetitive trauma claim was Major Pickering. On August 3, 2011, Major Pickering completed a document entitled "CMS Demands of the Job" which indicated that Petitioner used his hands for gross manipulation(grasping, twisting, handling) 0-2 hours per day, and use of hands for fine manipulation (typing, good finger dexterity) 0-2 hours per day.

On August 3, 2011, Petitioner completed a Department of Corrections Incident Report. Petitioner reported that he went to the Orthopedic Center of St. Louis to discover why his hands have at times numbness and tingling sensations. Petitioner reported he had a nerve conduction test ran and Dr. Paletta gave Petitioner the results. Dr. Paletta stated that Petitioner had damage in both elbows causing the numbness in his hands. Petitioner reported that Dr. Paletta stated that the damage was from repetitive trauma, turning keys, applying restraints, and removing restraints.

On September 12, 2011, Petitioner returned to Dr. Paletta for continued follow-up of his bilateral cubital tunnel syndrome. Petitioner reported that the right and left were about equal in terms of involvement and in terms of symptoms. He treated nonsurgically with the night splints and nonsteroidal anti-inflammatories. He stated that he had really noted no significant improvement, but at the same time, things had no gotten significantly worse. Physical examination of both elbows was essentially unchanged. Dr. Paletta assessed Petitioner with chronically symptomatic bilateral cubital tunnel syndrome.

The Staff Assignment History for Petitioner at Pinckneyville Correctional Center for 4/11/2009-3/23/2011 was entered into evidence as Respondent's Exhibit #7. On this document, it was noted that Petitioner had the following job assignments during that time period: Res 5A Wing; R5 Yard 1; Res 5B

Wing; Res 5 Control; LV Relief 15; Res 3 A Wing; and Res 2 B Wing. It was confirmed that Petitioner worked the 7am-3pm shift during the time frame of 4/11/2009-3/23/2011.

Dr. James Williams reviewed Petitioner's medical records, the Corvel Job Analysis reports and DVDs, key estimation study by Lt. Jason Thompson, job descriptions, and toured Pinckneyville Correctional Center. Based upon the information, his knowledge and expertise, Dr. Williams opined to a reasonable degree of medical certainty that Petitioner's job duties as a correctional officer at Pinckneyville Correctional Center did not cause or aggravate carpal tunnel syndrome. Dr. Williams explained that he had opened chuckholes in R5 segregation. He did not believe that activity would cause or aggravate cubital tunnel syndrome because there was sufficient rest in between, that it wasn't highly repetitive, and not something that would be aggravating in nature due to the amount at which it was done.

On October 11, 2012, the deposition of Dr. Williams was taken by Respondent. While Dr. Williams agreed with the diagnoses of bilateral cubital tunnel syndrome, Dr. Williams did not believe Petitioner's job activities at Pinckneyville Correctional Center caused or aggravated his bilateral cubital tunnel syndrome. Dr. Williams testified that the activity of opening chuckholes or food slots and key turning even if in R5 segregation would not cause or aggravate bilateral cubital tunnel syndrome because he did not feel that it was something which required a great deal of force and it was something that was done with significant rest in between the opening. Dr. Williams testified that he based his opinions on his tour of Pinckneyville Correctional Center where he performed the act of key turning and opening of a chuckhole and the key estimation study performed by Lt. Jason Thompson.

On February 6, 2014, the deposition of Dr. Paletta was taken by Petitioner's counsel. Dr. Paletta testified that Petitioner has bilateral cubital tunnel syndrome and opined that based upon the history that he was given he believed his job duties caused or aggravated the bilateral cubital tunnel syndrome. Dr. Paletta testified when asked about risk factors associated with the development of cubital tunnel syndrome testified to the following:

> Typically activities that involve repetitive flexion extension of the elbow or bending and straightening of the elbow through almost a full cycle. So, for example, we will see this condition not infrequently in baseball players because of the repetitive flexion extension that they do when they throw. You can also see it in patients that have to do repetitive forceful forearm grip activities or have to do a lot of triceps activities such as pushing. Because the nerve runs right along the medial border of the triceps, and that can sometimes cause compression of the nerve as well.

Dr. Paletta noted that Petitioner reported to him that his work involved a lot of keying of cells, he works in the segregation unit, and he has to work a lot at the doors and slots. He has to do some opening and closing as well. Those are the things that he reported to Dr. Paletta as aggravating his symptoms. Dr. Paletta opined that "[b]ased on the history he provided to me and the correlation of an increase in symptoms to those specific work activities, it was my opinion that his job activities were an aggravating factor in his cubital tunnel syndrome." Dr. Paletta testified that if he would have been given a history by Petitioner that sitting, lying down and sleeping aggravated his symptoms, he would have had a

different opinion with regard to causation. Dr. Paletta confirmed that the questionnaire completed by Petitioner for Dr. Phillips for the nerve conduction study which was performed prior to Petitioner seeing Dr. Paletta in which Petitioner did not report repetitive activities as aggravating his symptoms as being different from the history that Petitioner gave him.

Dr. Paletta confirmed on cross-examination that he did not review a specific job description for Petitioner. Dr. Paletta testified that Petitioner presented himself as a CO (correctional officer). Dr. Paletta did not know how long Petitioner had worked in the segregation unit. Dr. Paletta did not know which shift Petitioner worked and did not think it was relevant because he thought they do the same thing on either shift. Dr. Paletta did not know the types of keys that Petitioner used to open cell doors; did not know the number of keys that Petitioner would use per day as a correctional officer; did not recall the number of keys Petitioner would turn based upon his review of the key estimation study performed by Lt. Thompson. Dr. Paletta confirmed that Petitioner did not report to him that he did bar rapping or that activity correlated with the onset or worsening of symptoms. Dr. Paletta testified that Petitioner did not report any cuffing or uncuffing inmates to him. Dr. Paletta opined on cross-examination that if Petitioner did curl activities, bench press, the arms going through a full flexion/extension cycle that type of activity would cause cubital tunnel syndrome. Dr. Paletta confirmed on cross-examination that repetitive forceful grip when lifting weights would be a risk factor for the development of cubital tunnel syndrome. He testified that the more weight one is lifting, the more forceful the grip to hold the weight.

Therefore, the Arbitrator concludes:

1. Petitioner has failed to prove that his current condition of ill-being to his bilateral arms/elbows in the form of cubital tunnel syndrome were a result of his work-related duties as a correctional officer for Pinckneyville Correctional Center. The job description given to Dr. Paletta was not an accurate representation of Petitioner's jobs or duties. Dr. Williams' knowledge of the job duties of a correctional officer at Pinckneyville Correctional Center is more extensive than Dr. Paletta's and is given more weight. Not only had Dr. Williams reviewed Petitioner's medical records and job assignment history, but he also reviewed the Job Analysis reports and DVDs and key estimation usage study before rendering his opinion. In addition, Dr. Williams has toured Pinckneyville Correctional Center and has performed the job duties which Petitioner was alleging caused his conditions. 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. Paletta clearly shows that any causal opinion was based on incomplete information. Dr. Paletta did not know the number of times a key was turned.

2. Notice was not properly given within 45 days under the Act. Petitioner testified that his symptoms began in 2009 or 2010 and he knew then that they were related to his work at

15IWCC0119

Pinckneyville Correctional Center. However, Petitioner did not report his problem to his bilateral arms to Pinckneyville Correctional Center until August 2011.

3. Claim is denied.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF CHAMPAIGN	)	☐ 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

Jacqueline Dunlap,
Petitioner,

vs. NO: 08 WC 34412
08 WC 34413

University of Illinois,
Operations Maintenance.
Respondent.

15IWCC0120

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, temporary total disability 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 April 22, 2014, is hereby affirmed and adopted.

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

DATED: FEB 9 - 2015

Daniel R. Donohoo

o-01/27/15
drd/wj
68

Ruth W. White

DISSENT

I must respectfully dissent from the majority's decision to affirm and adopt the Arbitrator's findings.

The Petitioner testified that she did repetitive work using various tools and wrenches. Regardless of whether or not a doctor gave a causal connection opinion, her testimony was enough for the Commission to draw reasonable inferences from both the direct and circumstantial evidence. This also applies to an aggravation of a pre-existing condition. The medical records in this case, as well as Petitioner's credible testimony regarding her job duties, allows the Commission to draw a reasonable inference that there is a causal connection between Petitioner's current condition of ill-being and the work that she performed.

The Commission should have drawn those inferences and found that the Petitioner successfully proved that her current condition of ill-being was in fact causally connected to her work activities.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUNLAP, JACQUELINE
Employee/Petitioner

Case# **08WC034412**

08WC034413

UNIVERSITY OF ILLINOIS OPERATIONS MAINTENANCE
Employer/Respondent

15IWCC0120

On 4/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK & KOHEN LTD
HAYLEY K GRAHAM
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

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

0522 THOMAS MAMER & HAUGHEY LLP
KENNETH D REIFSTECK
PO BOX 560
CHAMPAIGN, IL 61824

1073 UNIVERSITY OF ILLINOIS
OFFICE OF CLAIMS MANAGEMENT
100 TRADE CENTER DR
SUITE 103
CHAMPAIGN, IL 61820

0904 STATE UNIVERSITY RETIREMENT SYS
PO BOX 2710 STATION A*
CHAMPAIGN, IL 61825

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

APR 22 2014

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

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JACQUELINE DUNLAP
Employee/Petitioner
v.
UNIVERSITY OF ILLINOIS, OPERATIONS MAINTENANCE
Employer/Respondent

Case # 08 WC 34412

Consolidated cases: 08 WC 34413

15IWCC0120

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly Dearing, Arbitrator of the Commission, in the city of Urbana, on February 26, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 19, 2007** and **June 25, 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 these dates, 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 **$34,715.18 (April 19, 2007), $35,612.34 (June 25, 2008)**; the average weekly wage was **$667.60 (April 19, 2007), $684.85 (June 25, 2008)**.

On the date of accident, Petitioner was **51** years of age, **single** with **0** children under 18.

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

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

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

Respondent is entitled to a credit of **all medical bills** paid under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that she sustained an accident on April 19, 2007 or June 25, 2008 that arose out of and in the course of employment. Petitioner failed to prove that her current condition of ill-being is casually related to the alleged accidents of April 19, 2007 or June 25, 2008. 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

April 17, 2014
Date

APR 2 2 2014

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JACQUELINE DUNLAP
Employee/Petitioner

15IWCC0120

v.

Case Nos. 08 WC 34412 and
08 WC 34413

UNIVERSITY OF ILLINOIS, OPERATIONS MAINTENANCE
Employer/Respondent.

MEMORANDUM OF DECISION OF ARBITRATOR

These matters were consolidated and tried jointly. Given that the same facts and issues apply to both claims, the Arbitrator issues a single decision encompassing both cases.

FINDINGS OF FACT

Petitioner began working for Respondent in 1990, and at the time of her alleged accidents, she was employed an automotive mechanic assistant in Respondent's garage. Petitioner testified that she worked in that position five days a week, and seven and a half hours per day. Her duties included changing tires on vehicles, performing oil changes, cleaning, and general maintenance. Petitioner's job duties required her to use tools, including impact wrenches, breaker bars, wrenches, and power washers.

Petitioner utilized impact wrenches to remove tires and their bolts. She described the impact wrenches as measuring approximately twelve inches long and seven to eight inches around, and weighing five pounds. The impact wrench was vibratory, and required Petitioner to use significant force with both hands. She testified that she would hold the impact wrench on the top with her left hand, and grip it with her right. Petitioner testified that she gripped the impact wrench with all of her force. Petitioner would remove eleven to twenty two bolts per tire, and in a typical shift, she would service all four tires on three vehicles. If she had to rotate or balance the tires, she may remove more. While she used an impact wrench, Petitioner's hands would tingle, which worsened after using it for long periods of time. Petitioner also used wrenches to loosen bolts and lug nuts during oil changes and transmission work. She used one hand to hold the tool, and the other to break the bolt. Her right hand would grip the wrench and apply force.

Petitioner testified that she used a pressure washer approximately three times a day for up to two and a half hours, depending upon the size of the automobiles. She used the pressure washer for an hour on farm trucks and backhoes, or half an hour for small cars. Petitioner gripped the pressure washer with all of her strength with both hands, which would cause her fingers to go numb.

Petitioner would also use breaker bars as part of her job duties to open tires. The breaker bar was about Petitioner's height, but just a few inches around. She utilized the bars approximately

twice a week for fifteen to thirty minutes for tires that did not have a machine to break open the tire. Petitioner used the breaker bar by pushing down with her right hand into the seal of the rim to break it. The breaker bars would vibrate during use, and she felt aches and pains in her hands while using it.

Petitioner testified that on April 19, 2007, she began to notice numbness and tingling in her dominant right hand. She testified that her symptoms began that day, and she denied feeling similar symptoms prior to that date. Petitioner completed an accident report with the assistance of a friend, and advised her supervisor, Craig Wilson, of her condition.

Petitioner presented to Dr. Clifford Johnson at Carle Clinic on April 19, 2007 for a second evaluation for her right hand upon referral by Dr. Alcaraz. She had also previously been evaluated and treated by Dr. Sobeski, who had recommended operative treatment by way of a carpal tunnel release. Petitioner reported having problems with her right hand "now for some time", and wanted a second opinion regarding her condition. She indicated suffering with numbness and tingling in her right thumb, index and middle fingers. Petitioner denied any such previous similar problem, but Dr. Johnson noted that Petitioner had a prior visit with "Hand Surgery" in October 2005. A physical examination revealed a negative Durkan's test, positive Tinel's, and positive Phalen's maneuver at the right wrist, but negative Tinel's of both elbows. Dr. Johnson diagnosed Petitioner with right carpal tunnel syndrome, and recommended she undergo electrodiagnostic testing. He indicated that, although Petitioner made no reference or discussion regarding her work as it relates to her right hand problem during his evaluation, she mentioned to his staff that this is to be filed as a worker's compensation claim. PX 1.

On April 23, 2007, Petitioner presented to Dr. Thomas Sutter at Carle Clinic Department of Occupational Medicine for evaluation of complaints of numbness and tingling in the right second and third fingers. PX 1. Petitioner testified that she gave Dr. Sutter a history of how she injured her right hand. Petitioner reported to Dr. Sutter that "[s]he thinks it is from doing things such as twisting her hands in the work that she does each day as she functions. She denied falling on this hand. She did state she had some symptoms about a year ago." Petitioner had a negative examination for any Tinel's, Finkelstein's, and Phalen's signs, and she was scheduled to undergo electrodiagnostic studies the next day. Dr. Sutter ordered her to return in three weeks, and allowed her to continue to work full duty at that time. PX 1.

The EMG of April 24, 2007, as interpreted by Dr. Kenneth Aronson, revealed a normal examination of the right upper extremity. PX 1.

Petitioner returned to Dr. Johnson on May 3, 2007 with unchanged right hand symptoms. Dr. Johnson noted that Petitioner had had a previous carpal tunnel release, a normal electrodiagnostic study, but continued complaints of numbness with no change upon examination to explain her subjective complaints. Dr. Johnson was hesitant to perform surgery in the absence of documented electrodiagnostic changes, as he did not expect it would yield positive results for her. Dr. Johnson stated, "I do not, further believe that surgical intervention in the form of a repeat carpal tunnel release would be of benefit to her." Petitioner requested a radiograph of her right hand, which Dr. Johnson ordered. He offered a diagnostic injection of the carpal tunnel, which he noted to be an excellent predictor of surgical outcome in a carpal tunnel release; however, Petitioner refused the injection at that time. Dr. Johnson also offered a fourth consultation with another

physician, which Petitioner declined. He released her to return on an as needed basis in a full duty work capacity. PX 1.

On May 22, 2007, Petitioner returned to Dr. Sutter with continued complaints of numbness at the base of her hand, a sleepy feeling in her hand, and some pain in her forearm. Petitioner indicated that a brace she was wearing at bedtime was helping. She also reported "doing some plugging at work where she takes a plug out of a tire." A physical examination revealed full range of motion at her right elbow, wrist and fingers, and a negative Tinel's, Finkelstein's, and Phalen's signs. Dr. Sutter diagnosed her with paresthesias of the right hand, and ordered a workstation evaluation. PX 1.

On October 18, 2007, Petitioner presented to Dr. Johnson upon referral from Dr. Alcaraz for complaints of right wrist pain, numbness and shooting pains up to her elbow. She related that splints had been unsuccessful in alleviating her symptoms, and her primary care physician, Dr. Sutter, had referred her back to Dr. Johnson for treatment. Dr. Johnson noted a small click with forced ulnar deviations, negative Durkan's, negative Tinel's, and negative Phalen's maneuvers over the median nerve at the right wrist. Petitioner was diagnosed with right wrist pain, and Dr. Johnson "would not entertain the thought of any intervention regarding her carpal tunnel", as her symptoms are at the ulnar border of the forearm and he "did not have any anatomic explanation for this." He recommended "at most" a trial corticosteroid injection, but after Petitioner indicated she was allergic to cortisone shots, he stated that he had nothing more to offer her, other than a referral to another hand surgeon. PX 1.

Petitioner presented to Dr. Kala at Carle Clinic on January 24, 2008 with complaints of pain, numbness and tingling in the right arm extending from the fourth and fifth finger up to her elbow. "The patient states that prior to the symptoms, she did fall at work, falling off of a machine landing on her buttocks, catching herself with both hands. She states she only had mild soreness for a couple of days in the palm of her right hand. These symptoms have persisted and worsened since that time." Dr. Kala recounted Petitioner's history of treatment with Dr. Sobeski, Physician's Assistant Jim Berkes, and Dr. Johnson. Petitioner requested a referral to a chiropractor in Champaign, who she saw previously and who advised her that she had scar tissue in her arm. Dr. Kala forwarded his notes to Petitioner's group health insurer for approval for treatment with a chiropractor. PX 1.

On May 15, 2008, Petitioner saw Physician's Assistant James Wallace, at which time Petitioner was four months status post release of the left first extensor compartment for De Quervain's tenosynovitis. Petitioner's left wrist was doing well, but she reported persistent pain and paresthesia in the right hand extending into the small and ring fingers. Petitioner indicated her work history as an automotive maintenance assistant at the garage at the University of Illinois, and recounted some of her job duties. After discussions with Dr. Johnson, Mr. Wallace ordered an MRI of the right wrist, which revealed small wrist join effusion, fluid within the distal radial ulnar joint, and a tiny area of high signal within the central triangular fibrocartilage complex possibly due to a small TFCC tear. Following the MRI, Petitioner returned to Mr. Wallace, at which time he noted a positive Tinel's sign at the ulnar nerve of the right elbow. He diagnosed her with probable cubital tunnel syndrome in spite of previous negative electrodiagnostic studies, and ordered conservative treatment by way of Heelbo pads, and anti-inflammatory medication. PX 1. On June 12, 2008, Mr. Wallace noted that he believed Petitioner's work as a "mechanic at the University of Illinois may be

aggravating her symptoms. She is hopeful that she can continue her work for another three and one-half years, at which time she plans to retire." PX 1.

Petitioner's symptoms persisted despite conservative treatment through June 25, 2008, at which time Dr. Sutter referred Petitioner to Dr. Sobeski for a second opinion and ordered a workstation evaluation. PX 1.

Petitioner testified that as of June 25, 2008, her right hand and arm had worsened, and therapy was not helping. She was still working for Respondent, and Petitioner testified that her job duties became more difficult to accomplish on June 25, 2008 due to the worsening right wrist pain. On that date, Petitioner notified her supervisor, Craig Wilson, that her condition was worsening, and she completed another accident report. Petitioner acknowledged that she did not suffer a separate injury on June 25, 2008. She thereafter sought a second opinion with Dr. Sobeski.

Petitioner presented to Dr. Sobeski on July 7, 2008, who noted Petitioner's history to be "a little bit sketchy." He believed that, based upon her symptoms, she may benefit from a cubital tunnel release and a Guyon's canal release, which she underwent on July 29, 2008. Dr. Sobeski diagnosed her with right Guyon's canal compression and right cubital tunnel syndrome. Post-operatively, Petitioner underwent extensive physical therapy at Carle Hospital (PX 3), but despite improvement in her numbness and tingling sensations, she continued to have pain and weakness in her right hand. PX 1.

Petitioner testified that while she was undergoing physical therapy, Respondent accommodated her restrictions and she returned to work. Eventually, Dr. Sobeski recommended Petitioner have a functional capacity examination, and he released Petitioner from his care on August 12, 2009 with a ten pound weight lifting restriction. PX 1.

On October 15, 2009, Petitioner underwent a functional assessment, which indicated that Petitioner displayed functional capabilities at a medium physical demand level, or forty one to fifty one pounds of occasional lifting, which meant that her physical capabilities fell below the heavy demand level of an automotive mechanic assistant. The Assessment Specialist, Chad Koch, recommended work hardening and work conditioning to attempt to return Petitioner to work. PX 4.

Petitioner began work conditioning on February 4, 2010, and continued same through March 5, 2010. PX 3. Thereafter, Petitioner continued to experience sensations as if bugs were crawling on her and pins sticking in her arm. On March 17, 2010, Dr. Sobeski ordered restrictions pursuant to the functional capacity examination (PX 1), which Petitioner testified were permanent.

At Arbitration, Petitioner acknowledged that her physicians ruled out carpal tunnel syndrome as a diagnosis for her. She testified that despite treatment for her right upper extremity, she currently experiences difficulties doing dishes, fixing her hair, and lifting things with her right hand. She utilizes her left hand to lift milk, as her right hand drops things often without her knowing it. Petitioner continues to work her right hand and arm, and exercises them. She experiences sensations of pins and "bugs", because she feels as if something is crawling on.

Petitioner last worked for Respondent on October 7, 2008. Petitioner received disability for a condition unrelated to her alleged work accidents from October 7, 2008 until December 31, 2011.

Petitioner testified that she did not search for light duty work during that time because she was on disability leave, and she acknowledged that she did not explore light duty work within the University of Illinois or request Respondent to place her elsewhere within the University within her restrictions. Petitioner voluntarily retired from her employment on January 1, 2012.

CONCLUSIONS OF LAW

In regards to disputed issues (C) and (F), given the common facts relative to these issues, the Arbitrator addresses them jointly.

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

The Arbitrator finds no credible causation opinion in the record relating Petitioner's right upper extremity condition to her work duties for Respondent. Although Dr. Johnson's assistant, James Wallace, opined that Petitioner's "work as a mechanic at the University of Illinois may be aggravating her symptoms", the Arbitrator is not able to place any weight on Mr. Wallace's opinion, given that he fails to enumerate any basis for same and because the job duties Petitioner related to him were not corroborated at trial. Without indicating a basis for his opinion, the Arbitrator is unable to ascertain upon what information his opinion is formulated, and consequently, whether his opinion is credible. While Mr. Wallace took a history of Petitioner's job duties on May 15, 2008 wherein Petitioner reported using the heel of her hand to push hubcaps onto the wheels of automobiles and utilizing tools that press up against the hypothenar eminence of her hand while using them, Mr. Wallace provides no indication at anytime as to whether it was those job duties in which he believed gave rise to Petitioner's symptoms. Yet, even if the Arbitrator were to infer that Mr. Wallace's causation opinion was based upon the job duties Petitioner recited to him during the visit of May 15, 2008, the opinion nonetheless remains unreliable, as Petitioner never testified at Arbitration to performing any such job duties. While Petitioner testified to gripping vibratory tools as part of her job duties, she failed to mention using the palm of her right hand to push hubcaps onto wheels, or utilizing tools that pressed upon the palm of her right hand.

While Petitioner seeks the Arbitrator to find that her daily use of pneumatic tools and manual force aggravated or exacerbated the severity of her right upper extremity condition, without more than a conclusory causation opinion and a job duty narrative to Mr. Wallace that was uncorroborated at trial, the Arbitrator declines to speculate as to any relationship between her job duties as described at Arbitration and the condition for which she was treated. Although Petitioner's unrebutted testimony indicates that her job duties included gripping and use of vibratory tools, given the totality of the evidence, discussed further below, the Arbitrator is not inclined to make the medical inference that her job duties caused or aggravated Petitioner's right upper extremity condition in the absence of a medical opinion indicating such.

Dr. Sutter noted on April 23, 2007that "[s]he thinks it is from doing things such as twisting her hands in the work that she does each day as she functions", but he failed to comment on any relationship between her job duties and her condition. Instead, Dr. Sutter's verbiage only indicates that Petitioner subjectively determined a causal relationship exists between the two, as he noted that "[s]he is stating that she was injured at work and wants to put it under compensation." PX 1. Similarly, while Dr. Sutter noted on May 22, 2007 that Petitioner was "doing some plugging at work where she takes a plug out of a tire", he did not relate that task to her condition. PX 1.

The Arbitrator further declines to find causation because Petitioner's testimony regarding the onset of her right upper extremity symptoms at work on April 19, 2007 is undermined by another mechanism of injury contained in her medical records. While presenting to Dr. Kala on January 24, 2008, Petitioner reported that prior to experiencing her symptoms of pain, numbness and tingling in her right arm extending from her fourth and fifth fingers, she fell at work in which she caught herself with both hands and had persistent and progressive symptoms thereafter. PX 1. Petitioner did not attempt at Arbitration to explain or refute the history indicated in Dr. Kala's record. The Arbitrator finds this history to be significant, given that Petitioner indicated the fall was prior to her onset of symptoms, and resulted in persistent and worsening symptoms thereafter. The history given to Dr. Kala calls into question any relationship between her alleged accidents and her right upper extremity condition.

The Arbitrator notes that while Petitioner denied experiencing symptoms prior to April 19, 2007, and told Dr. Johnson that she had experienced no similar symptoms in her upper extremities, her medical records indicate otherwise. Petitioner reported to Dr. Sutter having symptoms about a year prior to presenting to him and she had a visit with "Hand Surgery" in October 2005. Prior to April 19, 2007, Petitioner had treated with Dr. Alcaraz and Dr. Sobeski for right hand complaints such that Dr. Sobeski had previously recommended surgical treatment in the form of a carpal tunnel release. PX 1. The evidence of symptomatology prior to April 19, 2007, when Petitioner specifically denied any symptoms prior to that date, undermines the credibility of her testimony.

Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove that she sustained an accident on April 19, 2007 or June 25, 2008 that arose out of and in the course of her employment with Respondent, and that her current condition of ill-being is causally related to her alleged work accidents of April 19, 2007 or June 25, 2008.

The Arbitrator notes that, although Petitioner filed a second Application for Adjustment of Claim alleging a June 25, 2008 accident (Arb. X 4), Petitioner's testimony, coupled with her June 15, 2008 injury report (RX 2), establishes that her condition at that time was merely a continuation of her previous condition for which she was receiving treatment. Therefore, the Arbitrator finds no new accident or manifestation of symptoms on June 25, 2008.

In regard to disputed issue (J), and based upon the Arbitrator's conclusions as to disputed issues (C) and (F), all medical benefits are denied.

In regard to disputed issue (K), and based upon the Arbitrator's conclusions as to disputed issues (C) and (F), all temporary benefits are denied.

In regard to disputed issue (L), and based upon the Arbitrator's conclusions as to disputed issues (C) and (F), all permanent partial disability benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Barbara J. Dukich,
Petitioner,

vs. No: 12 WC 13758

Fenton Community H.S.—Dist. 100,
Respondent.

15IWCC0121

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, future medical expenses, temporary total disability, and nature and extent of the permanent disability, and being advised of the facts and law, reverses the November 15, 2013 Decision of the Arbitrator, which is attached hereto and made a part hereof.

Arbitrator Carolyn Doherty found that Petitioner proved that she sustained an accident that arose out of and in the course of her employment on February 23, 2012 and also proved that her current condition of ill-being was causally related to that accident. The Arbitrator awarded Petitioner 3-4/7 weeks of temporary total disability, medical expenses, and permanent partial disability for 10% loss of the person as a whole for injuries to her face, right shoulder and right hip.

After considering the entire record, and for the reasons set forth below, the Commission reverses the November 15, 2013 decision of the Arbitrator.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner filed an Application for Adjustment of Claim on April 4, 2012, claiming injury on February 23, 2012 to her body as a whole. Petitioner described the accident as occurring when she slipped on wet pavement on her way to lunch as she walked down the sidewalk from the school building to her assigned parking spot.

2. Petitioner offered a surveillance video of the incident as Petitioner's Exhibit 8. The video depicts Petitioner walking out of the school building onto obviously wet cement paving between the building and parking lot. Petitioner is seen stumbling, tripping and falling face first onto the pavement.

3. Petitioner was holding her umbrella and purse when she slipped on water and fell forward onto the pavement.

4. Petitioner testified that she was taken to the school nurse's office in a wheelchair after the accident. The school nurse's notes indicate that Petitioner complained of a headache and she noticed some bleeding in Petitioner's mouth.

5. An ambulance transported Petitioner to Elmhurst Memorial Hospital's Emergency Room, where Petitioner was diagnosed with a contusion/hematoma on her head and was referred for a CT scan of her brain and facial bones. The brain CT scan was normal, but the maxillofacial CT scan revealed a nasal bone fracture. Petitioner was taken off work and instructed to follow up with her primary care physician, Dr. Dorothy Prusek.

6. On February 27, 2012, Petitioner followed up with Dr. Prusek, complaining of headaches and cervical spasms with episodic vertigo. Dr. Prusek diagnosed Petitioner with a nasal bone fracture, severe headaches, and post-concussive syndrome. She prescribed Tramadol for pain and Antivert for vertigo and ordered Petitioner off work. On March 5, 2012, Dr. Prusek noted that Petitioner's post-concussive syndrome was improved, but continued her off work status until March 19, 2012.

7. Dr. Prusek referred Petitioner to Dr. Jolanta Milet for physical therapy. On February 28, 2012, Petitioner complained of stiffness in her upper neck and back with severe headaches and pain in her right elbow, right shoulder, face, and low back. Petitioner continued to receive therapy from Dr. Milet through May 9, 2012.

8. On August 6, 2012, Petitioner was evalulated by Dr. Howard Freedburg, an orthopedic specialist. Dr. Freedburg noted that three years earlier Petitioner had suffered a right shoulder injury, which resolved after eight weeks of physical therapy. Dr. Freedburg suspected that Petitioner had now suffered a rotator curr tear and ordered an MRI of Petitioner's right shoulder. The September 6, 2012 MRI showed probable posterior labral tearing and interstitial tearing of the supraspinatus and infraspinatus tendons, as well as moderate acromioclavicular degenerative change. On September 25, 2012, Dr. Freedburg diagnosed Petitioner with right rotator cuff tear with AC joint degenerative joint disease, and he administered an injection to Petitioner's right shoulder.

9. Petitioner reported 50-60% improvement following the first injection on November 8, 2012 and told Dr. Freedburg that she did not have time for additional physical therapy, as she was currently working two jobs. On December 27, 2012, Petitioner reported to Dr. Freedburg that her shoulder was still bothering her. Dr. Freedburg noted that additional therapy, injections or even surgery might be warranted if her complaints continued, but

Petitioner did not return to Dr. Freedburg or any other physician for treatment of her right shoulder after December 27, 2012.

10. At the time of hearing, Petitioner continued to work for Respondent in her same position. She testified that she noticed some pain in her right shoulder at the end of the work day and either took Advil or iced it for pain relief.

11. Respondent offered the testimony of two of the groundskeepers at Fenton High School. Both testified that there was no ice or snow in the area where Petitioner fell, but it was wet from the rain that day. Officer Matthew Nelson testified that he served as school resource officer on the date of the accident and had helped Petitioner to the nurse's office after her fall.

12. All witnesses, including Petitioner, testified that there were no defects in the pavement that would have contributed to her fall.

13. Arbitrator Doherty found that the parties agreed that the accident occurred within the course of Petitioner's employment. However, Respondent disputed that the accident arose out of the employment. The Arbitrator noted the following:

> Petitioner must present evidence which supports a *reasonable inference* that the fall stemmed from a risk associated with the employment. Employment related risks are those to which the general public is not exposed, such as "the risk of tripping on a defect at the employer's premises, falling on uneven or *slippery ground* at the work site. . ." *First Cash Financial Services,* 367 Ill. App. 3d 102, 853 N.E.2d 799 (2006). In the instant matter, the record as a whole supports a finding that the accident sustained by Petitioner arose [out] of her employment. Petitioner provided direct evidence in the form of her credible testimony, as buttressed by the video, that she slipped on the wet concrete walkway located on Respondent's premises resulting in her fall. The Arbitrator further notes that Petitioner was in fact exposed to an increased risk as the wet concrete area where she slipped and fell is a Respondent-controlled designated pathway specifically for Petitioner to reach her employee designated parking spot.

Arbitrator's Decision, p. 4.

Having found accident and causal connection, the Arbitrator awarded Petitioner 3-4/7 weeks of temporary total disability, reasonable and necessary medical expenses, and permanent partial disability of 10% loss of the person as a whole.

Respondent timely appealed the Arbitrator's award of benefits to the Commission. After considering the entire record, the Commission reverses the Arbitrator's findings with respect to accident.

Employment-related Risk. On appeal, Respondent argues that Petitioner failed to prove that her accident arose out of her employment. It points to Petitioner's admissions that there was no defect in the sidewalk and that she did not slip on ice, snow, or a rain puddle, but that the rain

made the employer-controlled sidewalk slippery, as evidence that Petitioner was not exposed to an employment related risk and also was not exposed to a neutral risk to a greater extent that the general public.

The Appellate Court recently reviewed the law with regard to accident risks in *Don Young v. Illinois Workers' Comm'n*, 2013 IL App. (4th) 130392WC, 13 N.E.3d 1252, 383 Ill. Dec. 131. In that case, the Arbitrator, Commission, and Circuit Court had all found that Petitioner failed to prove that he suffered an accident that arose out of his employment. After reviewing the evidence and the relevant caselaw, the Appellate Court reversed that finding and remanded the matter to the Commission for further findings and awards.

In *Young*, as in the instant case, the parties agreed that the accident occurred in the course of Petitioner's employment. The issue in both cases was whether the accident arose out of the Petitioner's employment. The Court cited the Illinois Supreme Court in *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 192, 204, 797 N.E.2d 665, 672, 278 Ill. Dec. 70 (2003) (quoting *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill. 2d 52, 58, 541 N.E.2d 665, 667, 133 Ill. Dec. 454 (1989)):

> 'an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. [Citations.] A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties.'

In *Young*, the Appellate Court found that the mechanism of injury alleged by Petitioner, reaching into a box for items to be inspected, was employment-related. In reaching that conclusion, the Court considered that there are three categories of risks to which an employee may be exposed: (1) risks distinctly associated with her employment; (2) personal risks; and (3) neutral risks which had no particular employment or personal characteristics. Employment risks are compensable under the Act, as they arise out of the employment. Personal risks are non-compensable. Neutral risks are non-compensable unless the employee is exposed to a greater degree than the general public by reason of his employment. In *Young*, the Court concluded that reaching into the box was an employment-related risk, as defined in *Sisbro* and *Caterpillar*. Petitioner was injured while performing his job duties, inspecting parts contained in a box. The Court found that the evidence "unequivocally shows claimant was performing acts that the employer might reasonably have expected him to perform so that he could fulfill his assigned duties on the day in question."

Arbitrator Doherty relied upon language in *First Cash Financial Services v. Industrial Comm'n,* 367 Ill. App. 3d 102, 853 N.E.2d 799, 304 Ill. Dec. 722 (1st Dist. 2006), to conclude that Petitioner's slip and fall on wet cement was employment-related. In *First Cash*, the claimant was a bank teller, who was injured when she slipped and fell on the floor of the employees' bathroom, which was not accessible to the public. Despite the fact that no direct evidence was presented establishing the cause of the teller's fall, the Arbitrator found that the risk was employment-related and awarded Petitioner benefits; the Commission affirmed the award; and

the Circuit Court confirmed. The Appellate Court reversed, finding that the claimant failed to prove that the risk of falling was work-related.

> Employment related risks are those to which the general public is not exposed such as the risk of tripping on a defect at the employer's premises, falling on uneven or slippery ground at the work site, or performing some work related task which contributes to the risk of falling. [Citations omitted.]

First Cash, 367 Ill. App. 3d at 186. Arbitrator Doherty applied the "slippery ground" language to determine that Petitioner's fall on the wet cement resulted from an employment-related risk. However, the Arbitrator failed to take into account the remaining language which restricted the location of the "slippery ground" to "at the work site." The results here might be different if Petitioner had fallen on an uneven or slippery floor inside the school building. Here Petitioner had left her office and the building. She alleged no defect in the cement's surface or accumulation of ice or snow, and she was performing no work-related task that contributed to her risk of falling. Therefore, Petitioner's risk in this case does not meet the *First Cash* definition of employment risk.

Neutral Risk. Arbitrator Doherty also found that Petitioner was exposed to an increased risk "as the wet concrete area where she slipped and fell is a Respondent-controlled designated pathway specifically for Petitioner to reach her employee designated parking spot." Arbitrator's Decision, p. 4. Illinois has rejected the positional risk theory of recovery (*Brady v. Louis Ruffolo & Sons Constr. Co.*, 143 Ill. 2d 542, 578 N.E.2d 921, 161 Ill. Dec. 275 (1991)), so the mere fact that Petitioner was injured while on her employer's property does not suffice to establish that the injury arose out of the employment.

However, Arbitrator Doherty also found that Petitioner suffered an increased risk as a result of her employment. Petitioner's increased risk would be relevant if the risk she encountered in walking on wet cement were deemed to be neutral. In *Young*, the Appellate Court acknowledged the general rule that neutral risks do not arise out of the employment and are compensable only where the employee was exposed to the risk to a greater degree than the general public by reason of his employment, citing *Springfield Urban League v. IWCC*, 2013 IL App (4th) 120219WC, ¶27, 990 N.E.2d 284 and *Orsini v. Industrial Comm'n*, 117 Ill. 2d 38, 45, 509 N.E.2d 1005, 109 Ill. Dec. 166 (1987). Therefore, if Petitioner in this case were exposed to a greater risk of falling on wet cement than the general public due to her employment with Respondent, then the neutral risk could be compensable under the Act.

At the time of her accident, Petitioner was not carrying anything other than her own purse and umbrella. She was not hurrying to complete an assigned task. The walkway where Petitioner fell was not defective. There was no accumulation of ice or snow that caused her to fall, and the walkway was open to the public. The Commission finds that Petitioner was not at an increased risk for injury over that faced by any member of the general public in transversing wet pavement. Because Petitioner faced no increased risk due to her employment, the neutral risk of walking on wet pavement while it was raining remains non-compensable.

After considering all of the evidence, the parties' briefs, and the relevant case law, and after hearing oral arguments by both parties, the Commission finds that Petitioner's injury did not result from an employment-related risk or from a neutral risk to which Petitioner was at increased exposure as a result of her employment with Respondent. Petitioner's risk of injury, given the evidence in this case, was personal. Therefore, Petitioner's accident is not compensable under the Act, and the Arbitrator's Decision finding that the accident arose out of her employment with Respondent and awarding benefits is hereby reversed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the November 15, 2013 Decision of the Arbitrator is reversed. The Commission finds Petitioner failed to prove by a preponderance of the evidence that her accident on February 23, 2012 arose out of and in the course of her employment. All benefits are therefore 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: FEB 9 - 2015

Daniel R. Donohoo

Ruth W. White

o-12/17/14
drd/dak
68

DISSENT

I vehemently dissent from the findings of my colleagues. The Arbitrator correctly found that Petitioner's undisputed fall arose out of and in the course of her employment.

Respondent agrees that Petitioner's fall on the asphalt entrance to Respondent's school was in the course of employment. However, it argues that the Petitioner failed to show that the water in the entranceway caused her to fall, or in the alternative, arise out of her employment since the general public could have been equally exposed to such a condition.

The Petitioner had an employee designated parking space and had to walk past the area of the entranceway to get to and from the school building on a regular basis.

The Petitioner gave a consistent history to the emergency room that she "slipped on a wet surface." (Petitioner Exhibit 2 Pg. 2) She also gave a consistent history, which appeared in the ambulance report that she "slipped on the wet asphalt." (Petitioner Exhibit 2 Pg. 25) Matthew Nelson, the school policeman, acknowledged that following the incident he helped the Petitioner "get back in the building because it was wet that day, it was raining." (Transcript Pg. 48) The school nurse's notes indicate that the Petitioner was placed in a wheel chair "due to rain/safety concerns." (Petitioner Exhibit 1) Clearly, Petitioner sustained the burden of proof that she had slipped on the wet pavement.

Petitioner was exposed to a greater risk than the general public because she regularly passes the entranceway where she fell to access her vehicle in her designated parking spot. In Mores-Harvey v. Industrial Commission, 345 Ill. App. 3d 1034, 1093 (2004), the Court noted that "by restricting where claimant could park her vehicle, the employer exercised control over its employees actions. In this way, the employee faced risks to a greater extent than the general public." The court held the same in University of Illinois v. Industrial Commission, 355 Ill. App. 3d 906, 912, when they held that the Petitioner was placed at an increased risk since she regularly passes the entrance way in which she sustained her injury.

The Petitioner sustained accidental injuries in the course of her employment with Respondent. It is also clear that the fall was a result of wet pavement which was a hazardous condition. Petitioner had to use that hazardous parking lot to access her car which was placed in an employee assigned spot. This clearly put her at a greater risk than that of the general public.

The Arbitrator should be affirmed and adopted.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DUKICH, BARBARA J Case# **12WC013758**
Employee/Petitioner

FENTON COMMUNITY HS-DISTRICT 100 15IWCC0121
Employer/Respondent

On 11/15/2013, 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 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN HASKINS NICHOLSON ET AL
JOSE M RIVERO
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

1120 BRADY CONNOLLY & MASUDA PC
KELLY MOORE
ONE N LASALLE ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Barbara J. Dukich
Employee/Petitioner

Case # **12WC013758**

v.

Consolidated cases: **none**

Fenton Community H.S. - District 100
Employer/Respondent

15IWCC0121

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Wheaton**, on **10/15/2013**. 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. [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. [x] Should penalties or fees be imposed upon Respondent?
N. Is Respondent due any credit?
O. [ ] Other ____

15IWCC0121

FINDINGS

On **02/23/2012**, 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 $31.532.80; the average weekly wage was $606.40.

On the date of accident, Petitioner was 62 years of age, *single* with 0 dependent children.

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

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

Respondent shall be given a credit of $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 $4.277.82 under Section 8(j) of the Act. ARB EX 1.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $404.27/week for 3-4/7 weeks, commencing February24, 2012 through March 19, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred by Petitioner in the care and treatment of her causally related injuries pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $363.84/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Carolyn Doherty
Signature of Arbitrator

11/14/13
Date

NOV 15 2013

FINDINGS OF FACT

Petitioner, Barbara Dukich, works as an attendance clerk for Respondent Fenton High School. (P. 6 – 7). She has worked for the Respondent since 1996. (T. 7). She drives to work on a daily basis and was provided a designated parking spot # 48 in the school parking lot located adjacent to the school. (T. 7).

On February 23, 2012, Petitioner was leaving the school to have lunch at home. As she was leaving the premises and stepped out of the building, she noticed that it was raining hard. (T. 7 – 8). Petitioner testified that she was holding an umbrella and her purse when she slipped on the water that was on the school premises causing her to fall forward onto the pavement. (T. (T. 8-9).

Petitioner offered into evidence a surveillance video of the incident as Petitioner's Exhibit 8. Petitioner viewed the video at hearing and identified herself as the individual falling in the video (T. 9). Petitioner testified that she slipped forward and she believed that her head hit the pavement first. (T. 10). The Arbitrator viewed the video at trial and again after the trial. Petitioner is seen on the video walking out of school on the cement pavement between the school building and the parking lot. Petitioner is seen stumbling, tripping and falling face first onto the pavement. The video depicts raining conditions and obviously wet pavement. Petitioner recalled that following the incident she was taken to the school nurse's office in a wheelchair. (T. 11). According to the school nurse's notes, "due to rain/safety concerns patient assisted in with wheelchair and escorted to health office." (PX. 1). The note further indicates that Petitioner was complaining of headache and noticed some bleeding in the mouth.

Petitioner testified that an ambulance arrived from Bensenville Fire Protection and transported her to Elmhurst Memorial Hospital emergency room. (T. 12). The ambulance records of Bensenville Fire Protection state: "patient stated that she was walking to her car when she slipped on the wet asphalt of the parking lot and hit her head." (PX. 2, pg. 25).

Petitioner testified that upon arrival at Elmhurst Memorial Hospital, she noticed pain in her head, right shoulder and right hip. (T. 14 – 15). At Elmhurst Memorial Hospital, history was taken of "patient presents here via ambulance after she slipped on a wet surface, fell face forward injuring her face and forehead." (PX. 2, pg. 28). She was diagnosed with a contusion/hematoma and referred to a CT of the brain and facial bones. (PX. 2, pg. 30). The CT of the head was performed that day and interpreted as negative. (PX. 2, pg. 36 – 37). The CT of the maxillofacial region was also performed and demonstrated a nasal bone fracture. (PX. 2, pg. 39). Petitioner was told to stay off work until 2/27/12 and to follow up with her primary care doctor in 3 to 5 days. PX 2, p. 31.

Following the hospital visit, Petitioner followed up with her primary care physician, Dr. Dorothy Prusek of the York Medical Center on February 27, 2012. (T. 12, PX. 3). On that day, Dr. Prusek noted that "patient here for follow up after ER evaluation following a fall while walking out of work falling into a rain. Fell onto nose and…" (PX. 3, pg. 4). Dr. Prusek noted Petitioner

was complaining of headache, cervical spasms with episodic vertigo. She diagnosed her with a nasal bone fracture, severe headaches, and post concussive syndrome and placed her off of work through March 5, 2012. (PX. 3, pg. 4). She was provided with Tramadol and Antivert for vertigo. (PX. 3 pg. 4). On 3/5/12, Dr. Prusek diagnosed post concussive syndrome partially improved and kept Petitioner off work through 3/19/12. RX 2.

Petitioner testified that Dr. Prusek referred her for physical therapy with Dr. Jolanta Milet of Chicagoland Health, Inc. (PX. 4). On February 28, 2012 Dr. Milet noted that Petitioner was complaining of stiffness in her upper neck bilaterally and upper back bilaterally with severe headaches. (PX. 4). In addition, she was complaining of pain in her right elbow, right shoulder, face and low back. Dr. Milet noticed bruising and swelling around both eyes. (PX. 4). In the description of accident it was noted that Petitioner fell on her face, right shoulder, right elbow and right knee. (PX. 4). Dr. Milet noted Petitioner reported, "I fell down on my face stepping off the sidewalk onto the street on the way from the building of the school I work at." PX 4.

Petitioner underwent physical therapy with Dr. Milet from February 28th through May 9, 2012. Throughout this period she was receiving care from Dr. Milet, to her right hip, upper back and neck and right shoulder. By May 9, 2012, Dr. Milet noted that Petitioner stated that she was slowly "getting back to her old self." (PX. 4). Petitioner testified that she was off of work from February 24th until March 19, 2012. (T. 13).

Following her course of physical therapy with Dr. Milet, Petitioner was referred to Dr. Howard Freedburg, an orthopedic specialist with Suburban Orthopedics. Petitioner first saw Dr. Freedburg on August 6, 2012 wherein a history was taken of 63 year old female who complains of right shoulder and right hip injury from work related injury on February 23, 2012 when she was "...exiting the school when she fell on the concrete and injured her right shoulder and right hip. States when this occurred it was freezing rain." (PX. 5, pg 31). Dr. Freedburg noted that Petitioner had a pre-existing condition with respect to her right arm three years prior for which she received 8 weeks of physical therapy and then reported being "100% resolved". Dr. Freedburg suspected a right shoulder rotator cuff tear upon physical examination and recommended that Petitioner undergo an MRI of the right shoulder. He ordered Petitioner to perform home exercises and discussed injections and surgery as possible future options. PX 5.

An MRI of the right shoulder was performed on September 6, 2012 at Suburban MRI which revealed a "probable posterior labral tearing..., linear interstitial insertional tearing of the supraspinatus and infraspinatus tendons..., moderate acromioclavicular degenerative change." (PX. 5, pg. 27). On follow up on September 25, 2012, Dr. Freedburg reviewed the MRI report and diagnosed right shoulder rotator cuff tear with AC joint degenerative joint disease. PX 5. He performed an injection to Petitioner's right shoulder. (PX. 5, pg. 24 and 27).

Petitioner followed up with Dr. Freedburg on November 8, 2012 where Petitioner reported that she was feeling a 50-60% improvement since the injection performed in September and that she was living with the shoulder pain. (PX. 5, pg. 18). Petitioner reported "all in all she is 100% on the hip." PX 5. Dr. Freedburg recommended a home exercise program and discussed the possibility of a future injection and surgery. (PX. 5, pg. 21). Physical therapy was discussed as

an option but it was noted that Petitioner "elects to wait she is working 2 jobs and has no time for PT." PX 5, p. 21.

Petitioner saw Dr. Freedburg on December 27, 2012 and noted that Petitioner's shoulder was still bothering her. (PX. 5, pg. 14). Dr. Freedburg's records and recommendations therein appear unchanged from the prior visit. Petitioner did not return to Dr. Freedburg or to any doctor for any additional care of her injuries after 12/27/12. She testified that she has not had any surgery for her injuries.

Currently, Petitioner continues to work for the Respondent in the same position. Petitioner testified that she still notices pain in her right shoulder particularly at the end of the work day. (T. 16). She testified that to alleviate her pain she will either ice it or take Advil. (T. 16). When it is particularly bad, she will lie down. (T. 16). On cross-examination, Petitioner admitted to having suffered a work injury to her right shoulder three years prior. (T. 20). She clarified that she did not file a workers' compensation claim or receive a settlement for that case. (t. 20). She underwent eight weeks of physical therapy and could not recall he medical providers she treated with in 2008. Petitioner testified that she did not pursue anything further in that matter as her arm completely resolved. (T. 19 – 20).

Respondent offered the testimony of Walter Glomp, a former groundskeeper at Fenton High School for 34 years. Mr. Glomp testified that he recalled the incident involving the Petitioner of February 23, 2012. He testified that he immediately inspected the area where Petitioner claimed to have fallen. (T. 28). He did note that it was raining and wet but that there was no snow or ice that he had to remove from the area that day. (T. 28 – 29). RX 8. He did not detect any seams. (T. 33). On cross-examination, Mr. Glomp clarified that by the time the Petitioner had fallen, whatever snow had been accumulated prior to that time had been melted. He testified that the area was damp from rain. (T. 37 – 38).

Respondent also offered the testimony of Ruben Angel Perez, also a groundskeeper with Fenton High School. Mr. Perez also testified that he inspected the area that Petitioner claimed to have fallen and testified that there was no snow or ice in the location, but that it was wet from having rained that day. (T. 42). RX 7.

The Respondent offered the testimony of Officer Matthew Nelson, a police officer with the City of Wood Dale. Office Nelson testified that his particular assignment is that of school resource officer to Fenton High School. Officer Nelson recalled the incident of February 23, 2012 and testified that he responded to the incident nearly thirty seconds following the fall. (T. 46, 53). Officer Nelson testified that Petitioner did not tell him that she slipped on ice or snow or that she tripped on a crack or defect. Officer Nelson admitted that the area in which Petitioner fell was wet as it was raining. (T. 53).

CONCLUSIONS OF LAW

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

Petitioner credibly testified that upon exiting the school for lunch, she slipped on rainwater causing her to fall forward and sustain injuries to her face, right shoulder, and right hip. Petitioner's account is supported by the histories in the ambulance report from Bensenville Fire Protection, the medical records of Elmhurst Memorial Hospital, Dr. Prusek, Dr. Milet as well as Suburban Orthopedics. Furthermore, the Arbitrator has reviewed the surveillance video of the incident which clearly shows that the conditions outside were wet and rainy. The Arbitrator notes that the video clearly depicts Petitioner slipping on the water as described in her testimony.

The Respondent does not dispute that Petitioner was "in the course of her employment" as the area in which the Petitioner slipped was in the control of the Respondent. Respondent's groundskeeper indicated it was an area that he would otherwise clean or inspect. Respondent does not dispute that the accident occurred in a wet area. All of the Respondent's witnesses support the Petitioner's account that the area was wet.

The Arbitrator notes that for an injury to have "arisen out of the employment," Petitioner must present evidence which supports a *reasonable inference* that the fall stemmed from a risk associated with the employment. Employment related risks are those to which the general public is not exposed, such as "the risk of tripping on a defect at the employer's premises, falling on uneven or *slippery ground* at the work site..." *First Cash Financial Services*, 367 Ill. App. 3d 102, 853 N.E.2d 799, (2006). In the instant matter, the record as a whole supports a finding that the accident sustained by Petitioner arose of her employment. Petitioner provided direct evidence in the form of her credible testimony, as buttressed by the video, that she slipped on the wet concrete walkway located on Respondent's premises resulting in her fall. The Arbitrator further notes that Petitioner was in fact exposed to an increased risk as the wet concrete area where she slipped and fell is a Respondent-controlled designated pathway specifically for Petitioner to reach her employee designated parking spot.

With respect to issue (F), whether Petitioner's condition of ill-being is causally related to the accident, the Arbitrator finds as follows:

Given the chain of events, the Arbitrator finds that Petitioner's condition of ill-being is causally related to the accident of February 23, 2012. Petitioner testified that prior to her work accident of February 23, 2012, she did have a prior medical issue involving her right arm in 2008. She testified that she received eight weeks of physical therapy and that her condition fully resolved. Immediately following her accident of February 23, 2012, Petitioner sought treatment with Elmhurst Memorial Hospital Emergency Department. The doctors at the emergency room primarily treated Petitioner's nasal fracture and headaches. The following day she followed up with her primary care doctor and complained of upper back/neck pain, in addition to her headaches and vertigo. Four day later, she sought treatment with Dr. Milet who noted right shoulder pain and right hip pain in addition to the neck and head pain. Petitioner's headaches and hip pain resolved with the treatment provided to her by Dr. Milet. Since her shoulder pain persisted, she sought treatment with Dr. Freeburg, an orthopedist who, after reviewing an MRI of Petitioner's right shoulder, diagnosed Petitioner with a rotator cuff tear. Respondent offered no medical opinion regarding causation to the contrary.

With respect to issues (J), whether the medical services rendered to Petitioner were reasonable and necessary, (K), whether Petitioner is entitled to temporary total disability benefits, the Arbitrator finds as follows:

Based on the Arbitrator's findings on the issues of accident and causation, the Arbitrator further finds that the Respondent shall pay Petitioner for medical expenses incurred by Petitioner in the care and treatment of her casually related injuries pursuant to Sections 8 and 8.2 of the Act. ARB EX 1. Respondent's objection was based on liability. Respondent shall receive credit for amounts paid and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent receives credit pursuant to Section 8(j) of the Act. ARB EX 1.

The Arbitrator further finds that Petitioner is entitled to temporary total disability benefits from February 24, 2012 through March 19, 2012, that being the period in which Petitioner was off work per her treating doctors, a period of 3-4/7 weeks pursuant to Section 8(b) of the Act. Respondent shall receive credit for amounts paid, if any.

With respect to issue (M), whether Petitioner is entitled to penalties, the Arbitrator finds as follows:

The Arbitrator notes Respondent's reliance on its witnesses, the video and its investigation in denying the claim. The Arbitrator finds that the Respondent's conduct was not so unreasonable or vexatious so as to justify the imposition of penalties and fees in this matter under Sections 19(k) or 16 of the Act.

With respect to issue (L), the nature and extent of Petitioner's condition, the Arbitrator finds as follows:

In considering permanent disability in this matter, the Arbitrator shall base the determination on the following factors pursuant to Section 8.1b(b) of the Act: (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 are explained below. The Arbitrator initially notes that no reported level of impairment pursuant to Section 8.1b(a) was provided. The remaining enumerated factors were considered as follows.

The 62 year old Petitioner suffered a nasal fracture, right hip contusion, and right rotator cuff tear as a result of this accident as reflected in her treating medical records. She received conservative treatment and returned to work in her full duty capacity with the Respondent. The record does not support any finding that Petitioner sustained any impairment to her future earning capacity.

Currently, Petitioner notices pain in her right arm, especially at the end of the workday. She uses either ice or Advil to alleviate the pain. In some circumstance she will lie down to address the pain. Accordingly, the Arbitrator finds that Petitioner sustained an injury equal to 10% loss of use of person as a whole pursuant to Section 8(d)(2) of the Act.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas A. Anderson ,

Petitioner,

vs.

NO: 12WC 17855

Oak Lawn Toyota,

15IWCC0122

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 19, 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.

15IWCC0122

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,100.00 . 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: FEB 1 0 2015
MJB/bm
o-2/2/2015
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ANDERSEN, THOMAS A
Employee/Petitioner

Case# **12WC017855**

15IWCC0122

OAK LAWN TOYOTA
Employer/Respondent

On 5/19/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN & CLARK LAW OFFICES
CAMERON B CLARK
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

4200 NILES AND ASSOCIATES
MARTHA NILES
906 W GUNNISON ST SUITE 2
CHICAGO, IL 60640

15IWCC0122

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

Thomas A. Andersen
Employee/Petitioner

v.

Oak Lawn Toyota
Employer/Respondent

Case # **12** WC **17855**

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 **Svetlana Kelmanson**, Arbitrator of the Commission, in the city of **Chicago**, on **April 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. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **12/16/2010**, 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 $**17,736.54**; the average weekly wage was $**344.09**.

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

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

Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services. The parties stipulate Respondent paid $**133,478.00** for medical expenses.

Petitioner is entitled to temporary total disability benefits from **December 17, 2010**, through **February 16, 2011**, and temporary partial disability benefits from **February 17, 2011**, through **March 31, 2011**.

Respondent shall be given a credit of $**2,031.73** for TTD and $**318.55** for TPD, for a total credit of $**2,350.28**.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**220.00**/week for **200** weeks, because the injuries sustained caused the **40%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

5/16/2014
Date

MAY 1 9 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner testified that he worked for Respondent car dealer from August of 2007 through May of 2013. From August of 2007 until June of 2010, he worked part-time, 26 to 32 hours a week, as a car porter. In June of 2010, he was promoted to lube rack technician, a full time (40 hours a week), union position. His hourly wage as a lube rack technician was $9.75 on weekdays and $10.75 on Saturdays. Petitioner's job duties as a lube rack technician included a great deal of lifting and some climbing when he did light maintenance of the garage. Petitioner explained that he was required to lift over 50 pounds. He lifted or helped lift batteries, engines, transmissions and tires, and pushed vehicles from the lot.

On December 16, 2010, Petitioner sustained severe injuries to his lower legs when he was guiding a snow plow, driven by a coworker, inside the garage. Petitioner testified the snow plow struck him and pinned him against a tool rack.

An ambulance transported Petitioner to Christ Hospital and Medical Center (Christ Hospital). The medical records in evidence show Petitioner underwent emergency open reduction of bilateral comminuted mid shaft tibial-fibular fractures. The following day, Petitioner underwent intramedullary nailing of the tibial shaft fractures and closure of complex wounds. On December 27, 2010, Petitioner was discharged from Christ Hospital and admitted to the Rehabilitation Institute of Chicago for inpatient rehabilitation. On January 7, 2011, Petitioner was discharged home.

Thereafter, Petitioner regularly followed up with his orthopedic surgeon, Dr. DeFrino, and underwent physical therapy. Dr. DeFrino released Petitioner to return to work on sedentary duty on February 17, 2011. On February 21, 2011, Dr. DeFrino limited Petitioner's work hours to four a day, five days a week. On March 10, 2011, Dr. DeFrino increased the work hours to 30 a week, and on March 31, 2011, he increased the work hours to 40 a week, with limited walking, standing and climbing. Petitioner testified that Respondent accommodated the restrictions.

Petitioner last saw Dr. DeFrino on September 29, 2011, complaining of some bilateral anterior knee pain, but reporting doing well otherwise. He ambulated with a normal gait and had a normal sensation in the feet. Dr. DeFrino declared Petitioner at maximum medical improvement and imposed permanent restrictions of no prolonged standing or walking, and no heavy lifting, pushing or pulling.

Petitioner testified that Respondent accommodated his permanent restrictions by placing him in the position of service dispatcher/customer service representative. In May of 2013, Petitioner left Respondent's employ to continue his education.

On March 6, 2013, Dr. Kodros, an orthopedic surgeon, examined Petitioner at Respondent's request. Petitioner mainly complained of knee pain radiating to the lower legs and stated he was unable to squat or kneel because of the pain. He rated the pain a 6/10. On physical examination, Dr. Kodros noted traumatic and surgical scars, a palpable bony defect along the anterior crest of the right tibia at mid shaft, and mild bilateral tenderness with deep palpation at mid shaft level. Petitioner was unable to do a deep knee squat. The remainder of the

examination was grossly normal. X-rays showed bony union in anatomic alignment, with intact hardware. Dr. Kodros opined Petitioner's symptoms were causally related to the work accident. He recommended permanent restrictions of no kneeling or deep knee squatting.

On July 9, 2013, Dr. Coe, an occupational medicine specialist, examined Petitioner at the request of his attorney. Petitioner complained of pain in the knees, lower legs and ankles, which was worse with prolonged standing. He also complained of lower leg weakness and difficulty kneeling and squatting due to knee and ankle stiffness. He walked with a normal gait. On physical examination, Dr. Coe noted obvious anterior lower leg scarring and deformity and surgical scars on the knees as a result of hardware placement. There was tenderness in the areas of the scars. A bone defect was palpable through the scar of the right lower leg. The range of motion in the knees and ankles was normal, with the exception of reduced flexion in the right knee. The heel walking ability was limited, but toe walking was intact. Dr. Coe opined Petitioner was permanently limited to no kneeling, squatting or safety-sensitive climbing, and lifting no more than at the medium physical demand level.

Regarding his current condition, Petitioner testified that he has constant aching pain in his lower legs, knees and ankles, especially with prolonged standing or walking up the stairs. The pain is worse with weather changes. The knees feel weaker than before the accident. Petitioner takes over-the-counter Ibuprofen two to three times a week, more often when the weather changes. Petitioner further testified that the hardware in his legs remains. He introduced into evidence X-rays showing the hardware extends from the knee to the ankle bilaterally.

In support of the Arbitrator's decision regarding (G), what were Petitioner's earnings, the Arbitrator finds as follows:

The parties introduced into evidence Petitioner's wage records for the year preceding the accident, showing earnings of $17,736.54, without any overtime pay. Petitioner's average weekly wage calculated pursuant to section 10 of the Workers' Compensation Act (the Act) (820 ILCS 305/10 (West 2010)) is $341.09 ($17,736.54 / 52). See, *e.g.*, Illinois-Iowa Blacktop, Inc. v. Industrial Comm'n, 180 Ill. App. 3d 885, 892 (1989). In the request for hearing form Respondent claimed an average weekly wage of $344.09. Respondent is bound by that stipulation. See Walker v. Industrial Comm'n, 345 Ill. App. 3d 1084, 1088 (2004).

In support of the Arbitrator's decision regarding (L), what is the nature and extent of the injury, the Arbitrator finds as follows:

Petitioner was 21 years old when he sustained severe injuries to the lower legs, which necessitated two surgeries and prolonged rehabilitation. Petitioner credibly testified regarding his residual symptoms. Dr. DeFrino, Dr. Kodros and Dr. Coe agreed that as a result of the injuries Petitioner is permanently restricted from performing certain activities involving the legs. Respondent accommodated Petitioner's permanent restrictions by placing him in the position of service dispatcher/customer service representative, whereas before the accident Petitioner worked as a lube rack technician after being promoted from car porter. Petitioner does not claim an impairment of earning capacity. In May of 2013, Petitioner left Respondent's employ to continue his education.

Having carefully considered the entire record, the Arbitrator finds the injuries sustained caused permanent disability to the extent of 40 percent of the person as a whole. See Lusietto v. Industrial Comm'n, 174 Ill. App. 3d 121, 129 (1988) ("Schedule allowances were originally exclusive. A strong trend, however, now views schedule allowances as nonexclusive. (See General Electric Co. v. Industrial Comm'n (1982), 89 Ill. 2d 432; see generally 2 A. Larson, Workmen's Compensation §58.23, at 10–344.86 (1987); 37 Ill. L. & Prac. *Workers' Compensation* §125, at 383 (1987).) Instead of simple losses compensated strictly on the schedule value of the listed members, the loss or impairment could be compensated on the percentage disability of the body as a whole, or of a general disability. (See 2 A. Larson, Workmen's Compensation §58.23, at 10–344.86 (1987).)"). In the instant case, an award under section 8(d)2 of the Act is appropriate, as Petitioner, who has a work life expectancy of over 40 years, can no longer perform physically demanding job duties. See, *e.g.*, Will County Forest Preserve District v. Workers' Compensation Comm'n, 2012 IL App (3d) 110077WC.

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

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SARAH LOUISE CARR,

15IWCC0123

Petitioner,

vs. NO: 10 WC 8748

DAYSTAR CARE CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, notice, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 16, 2014, 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.

15IWCC0123

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: FEB 1 1 2015
o1/27/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0123

CARR, SARAH LOUISE Case# **10WC008748**
Employee/Petitioner

DAYSTAR CARE CENTER
Employer/Respondent

On 6/16/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

2500 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

2965 KEEFE CAMPBELL BIERY & ASSOC LLC
MICHAEL SHANAHAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

15IWCC0123

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
19(b)

SARAH LOUISE CARR
Employee/Petitioner

v.

DAYSTAR CARE CENTER,
Employer/Respondent

Case # **10** WC **008748**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **NANCY LINDSAY**, Arbitrator of the Commission, in the city of **BELLEVILLE**, on **April 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **10-03-2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**18,591.00**; the average weekly wage was $**357.52**.

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

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

Respondent shall be given a credit of **$31,949.10** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of **$31,949.10**.

Respondent is entitled to a credit of $**0.00** for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $245.33/week for 94 weeks, commencing June 26, 2012 through April 15, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 11 subject to the Medical Fee Schedule, as provided in Section 8(a) and 8.2 of the Act. Respondent shall receive credit for any bills previously paid by it.

Petitioner's request for prospective medical care is denied.

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

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

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

Nancy Lindsay
Signature of Arbitrator

June 11, 2014
Date

JUN 16 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the commencement of the hearing, Petitioner moved to add the Illinois Guarantee Fund and State Treasurer as party respondents. There was no objection and the motion was allowed. Petitioner sustained an undisputed accident on October 3, 2009. The issues in dispute are causal connection, medical expenses, TTD, and prospective medical care.

The Arbitrator finds:

According to the medical records Petitioner has been a patient at Community Health and Emergency Services since early 1998. Prior to her undisputed work accident on October 3, 2009 she had been diagnosed and treated for diabetes, anxiety, obesity, fatigue, a hernia, and an over active bladder. (PX 1) At the time of Petitioner's undisputed accident on October 3, 2009 Petitioner was a 47 year old Certified Nursing Assistant (CNA) for Respondent. On that date Petitioner was working in a resident's room when she slipped on water, fell, and landed on her back, buttocks, and right side. Petitioner also hit her left elbow/arm on a television stand while falling.

On October 3, 2009, Petitioner presented to Dr. Kirk Wong at Community Health and Emergency Services Inc., (CHESI) reporting that she had fallen in a wet spot, landed on her back and hit the back of her head. (PX 1) Petitioner complained of pain in her left elbow/arm, right ribs, back, neck, and the back of her head. Petitioner was noted to be very tender in her right rib area and she was diagnosed with neck, right side, and left arm pain. A pain shot was given to Petitioner. X-rays of her neck, head, right rib area, left arm, and low back were ordered.

Petitioner was advised to go to Southeast Missouri Hospital (SEMO) emergency room for further evaluation. (PX 1) Petitioner arrived at SEMO by ambulance where she reported right-sided rib pain, left forearm pain, and headache stemming from a fall of 3 - 5 feet onto a hard surface. A detailed physical examination was conducted (PX 5, p. 3-4/11) Diagnostic tests of Petitioner's head and left arm revealed no acute abnormalities or fractures. (PX 5) Diagnostic images of Petitioner's mid-thoracic spine showed dextroscoliosis and spondylosis. (PX 5) Petitioner was noted to be up and walking while in the emergency room. Upon discharge, Petitioner was prescribed Ibuprofen and instructed to return if her symptoms worsened or to see Dr. Wong on Monday for a re-check. (PX 5)

On October 6, 2009, Petitioner returned to see Dr. Wong at CHESI complaining of pain on the right side of her head and right side of her rib cage. Dr. Wong noted all studies performed at the hospital were normal. Petitioner was kept off work and given medications. (PX 1)

Petitioner returned to CHESI on October 21, and October 24, 2009 regarding an upper respiratory condition. (PX 1)

On January 11, 2010, Petitioner returned to CHESI for an annual well-woman exam. (PX 1) Petitioner gave a history of having fallen at work in October and being initially seen by Dr. Wong and then sent to the emergency room. Petitioner reported she "still hurt" and her right leg was giving out. (PX 1) Petitioner's diagnoses were listed as diabetes, anxiety, an over active bladder, and lower back pain. For the latter condition, Petitioner was advised to follow-up with Dr. Wong "since it was a workers' compensation issue." (PX 1)

On January 26, 2010, Petitioner presented to Dr. Wong at CHESI complaining of low back pain radiating down her legs. Petitioner reported her pain had persisted since her work accident and worsened over the preceding two weeks. She was continuing to work full-time for Respondent as a CNA. Petitioner's weight was listed as 289 lbs. On examination Petitioner's low back was tender but she had full range of motion and a negative straight leg test. Treatment recommendations included physical therapy, an MRI of the lumbar spine, and Ibuprofen. (PX 1, 4) Additionally, Petitioner was taken off work from January 26, 2010 to January 31, 2010. (PX 1)

On February 11, 2010, Petitioner presented to Cape Imaging for an MRI of her lumbar spine. (PX 1) The MRI revealed Petitioner had mild lumbar hyperlordosis, mild disc protrusions, hypertrophy bilateral facet disease and congenital central canal stenosis resulting in foraminal narrowing as well as a disc protrusion at L3-4 and L4-5. (PX 1)

As Dr. Wong had ordered physical therapy Petitioner underwent an evaluation at Memorial Hospital of Carbondale on February 16, 2010. Petitioner provided a history of her work accident and advised the therapist she had been off work since January 26, 2010. Petitioner also reported that Dr. Wong had recommended she be seen by a neurosurgeon. (PX 1) According to the March 5, 2010 physical therapy note, therapy wasn't helping. It was noted that Petitioner was scheduled to be seen by a neurologist on March 9, 2010 and, therefore, further therapy was put on hold pending that examination. (PX 4)

On March 9, 2010, Petitioner presented to Dr. Fakhre Alam complaining of low back pain and lower extremity pain. (PX 2) According to the doctor's note, Petitioner had fallen and landed on her buttock. Petitioner reported having had some headaches soon after her fall. She

denied any significant improvement from physical therapy. Petitioner's weight was recorded at 280 lbs. Dr. Alam reviewed Petitioner's MRI and diagnosed "evidence of degenerative disease of the lumbar spine. Some of these findings are pre-existing and not related to her injury." She had a negative sitting root compression test and negative straight leg raising test. Dr. Alam felt Petitioner's symptoms were musculoskeletal in nature but he recommended an EMG and nerve conduction study. He also prescribed medication. (PX 2)

Petitioner was again seen at CHESI on March 17, 2010. Her weight was at 287 lbs.

Petitioner was seen at CHESI in April of 2010 for bladder issues and requested medication to assist with fluid retention. Petitioner's weight was recorded at 296 lbs. and 300 lbs. Petitioner was initially prescribed 20 mg. of Lasix which was then doubled when Petitioner wasn't seeing any improvement. Petitioner was also noted to be experiencing chronic back pain. (PX 1)

In May of 2010 Petitioner returned to CHESI due to problems with increased swelling, weight gain, and left foot swelling. Petitioner was noted to have redness on top of her foot and complaints of weakness and feeling faint. Dr. Wong referred Petitioner for a cardiology work-up due to chest pain, shortness of breath and obesity. (PX 1) A cardiac treadmill test scheduled for May 17, 2010 was cancelled due to Petitioner's inability to ambulate on the treadmill. (PX 2)

Dr. Sonjay Fonn examined Petitioner on June 2, 2010, regarding Petitioner's complaints of severe back pain which radiated into her legs bilaterally. Petitioner also reported paresthesia in her legs secondary to pain. Petitioner's complaints included chest pain, ankle swelling, forgetfulness, headaches, loss of sleep, nervousness, sinus problems, rapid weight gain, bloating,

constipation, numbness and swelling in her legs, and tingling in her extremities. Petitioner reported having undergone physical therapy but no epidural injections. Dr. Fonn reviewed Petitioner's February 11, 2010 MRI noting it also revealed a traumatic tear to the annular fibers at L3/4 and disc herniations at L3/4 and L4/5 "which would be consistent with [her] mechanical injury and since her current symptomatology began after her fall, within a reasonable degree of medical certainty, I believe that [her] fall of 10/03/09 is the causative factor of her current pathology and symptomatology." He recommended a CT myelogram of Petitioner's lumbar spine. (PX 1, 3)

Petitioner returned to CHESI on June 9, 2010 for a follow-up visit. According to the progress note, Lasix wasn't helping as Petitioner was still experiencing swelling in her arms, legs, and feet. Petitioner returned about a week later for lab work. (PX 1)

Petitioner's CT myelogram confirmed the pathology at L 3/4 and L4/5 and Dr. Fonn recommended epidural injections bilaterally. (PX 3)

Petitioner called into CHESI on July 16, 2010 to report she was undergoing the cortisone injections and experiencing elevated blood sugars. Petitioner was advised to keep a record of her blood sugars. (PX 1)

The injections were of no benefit and Petitioner returned to see Dr. Fonn on August 4, 2010 at which time they discussed proceeding with fusions at L4/5 and L5/S1 which Dr. Fonn noted were, according to the MRI, the most severe areas. (PX 1, 3) A discogram was performed on August 31, 2010 but, due to Petitioner's size, it was of limited benefit. (PX 3)

Petitioner called CHESI on September 1, 2010 regarding a urinary tract infection for which medication was prescribed. (PX 1)

Petitioner ultimately underwent lumbar fusion surgery on September 20, 2010 which was performed by Dr. Fonn. (PX 3) Post-operatively, she followed up with the doctor on September 23, 2010 at which time he addressed some drainage coming from the dressings and arrangements were made with Home Health to monitor her dressings. (PX 9) As of October 3, 2010 Petitioner was progressing "very well." Dr. Fonn noted significant resolution of Petitioner's pre-operative signs and symptoms. Petitioner was advanced to driving and a 20 pound weight limit with no excessive bending or stooping at the surgical site. She was instructed to continue using the bone stimulator and her brace. Medications were refilled. (PX 3)

Petitioner next presented to CHESI on October 13, 2010 reporting she had undergone back surgery on September 20, 2010 and was experiencing elevated blood pressure, increased swelling, and pitting edema in her feet and ankles. While the doctor's notes are difficult to fully read it appears he noted, "complains of swelling to legs for a long time but getting worse after injury of back." (PX 1) Petitioner complained of back pain rated "7-8/10." Dr. Wong's assessment was edema of the legs of uncertain etiology; however, he noted recent back surgery. Petitioner's Lasix was increased to 60 mg. (PX 1)

On November 3, 2010 Petitioner presented to Dr. Donald Gentle for difficulties with urination. According to the doctor's note, Petitioner had been seen two years earlier for a renal lesion at which time it was recommended that she undergo a repeat CT scan several months later; however, Petitioner had not done so. Dr. Gentle also noted he had given her some anticholinergics which she had never tried. Petitioner's current medications included Lasix for

lower extremity edema. She was noted to be ambulating with a walker but with some difficulty. Petitioner was given medication and the doctor recommended a renal ultrasound after which she was to follow-up. Petitioner asked about intravenous diuretics and was told to speak to her primary care physician regarding that. (PX 6)

Petitioner underwent a renal scan on November 22, 2010. The right kidney cyst noted in 2008 appeared to be gone. Petitioner was also noted to have incomplete emptying of her bladder. Dr. Gentle's nurse telephoned Petitioner on December 7, 2010 to update her on the scan. Petitioner was told that her kidneys were okay and she was to return in February. Petitioner reported she was having a great deal of trouble with her bladder and had been told by her neurologist that she might have a neurogenic bladder. Petitioner was reportedly unable to drive and was worried about making her next appointment. (PX 6)

Petitioner then presented to CHESI on November 30, 2010 due to ongoing complaints of weakness and lethargy. Petitioner's weight was noted to be 338 lbs. Her primary diagnosis was listed as chronic back pain. She was referred for a sleep apnea study[1]. (PX 1)

At her next visit with Dr. Fonn on December 29, 2010 Dr. Fonn noted Petitioner was doing "very well" with continued resolution of her pre-operative symptoms. Her CT showed good fusion and placement of the instruments although he noted a spacer at L5/S1 might not be as deep as it could be. Petitioner was sent for more physical therapy and bracing was to be stopped. Petitioner was advised that healing could continue to take place for up to a year and, according to the office note, she appeared pleased with her progress to date. (PX 3)

---

[1] There are no further records from CHESI after this date.

As instructed, Petitioner underwent physical therapy from January 14, 2011 through March 1, 2011. At her last visit Petitioner reported she was better than before she began therapy but still having a "lot of pain" and problems with balance and endurance. (PX 4)

Petitioner didn't show up for her February 2, 2011 appointment with Dr. Collyer (Dr. Gentle's office) but did present on February 18, 2011. According to his office note, Petitioner presented for "a history of hypotonic neurogenic bladder and recurrent urinary retention related to degenerative disc disease in her back as well as back surgeries performed by Dr. Fonn." Dr. Collyer's assessment was complex cystic lesion in the lower pole of the right kidney and a hypotonic neurogenic bladder with significant irritative symptoms with urgency and frequency and intermittent dysuria. While the CT scan had not shown the cystic lesion, Dr. Collyer believed that was due to Petitioner's obese body habitus and not because it wasn't there. Dr. Collyer recommended she take Bethanechol and undergo a CT of the abdomen and pelvis as well as a cystoscopy to rule out intravesical pathology. Petitioner subsequently reported she couldn't afford the Bethanechol and her pharmacist had recommended Oxybutynin; however, Dr. Collyer believed that would make her symptoms worse. Petitioner phoned again on March 11, 2011, and they reviewed the CT of her abdomen which had, indeed, shown a complex cyst. She wanted to discuss it with Dr. Collyer and, upon inquiry, she was advised she could restart her diabetes medications. (PX 6)

When Petitioner returned to see Dr. Fonn on March 2, 2011, Dr. Fonn noted Petitioner's history and exam were unchanged from her previous visit. Petitioner had finished physical therapy with a "reasonable outcome." He did not feel she needed any more therapy and ordered a functional capacity evaluation (FCE) to determine her return to work status. When Petitioner

returned to Dr. Fonn's office on April 6, 2011 she reported the FCE had been cancelled due to her cardiac issues. Petitioner reported she continued to be in pain in her low back but still better than before her surgery. Petitioner was unable to walk without a walker. Dr. Fonn recommended a spinal cord stimulator to assist with that. Petitioner's physical examination was "essentially normal, but difficult to assess due to pain." As of April 20, 2011 Petitioner was still waiting for approval on both the FCE and the spinal cord stimulator. Dr. Fonn noted a new EMG had been performed on March 24, 2011 and revealed bilateral carpal tunnel syndrome but no evidence of cervical radiculopathy. Dr. Fonn recommended first addressing Petitioner's low back symptoms before turning to the wrists. (PX 3)

On May 12, 2011, Petitioner underwent the FCE. The FCE report indicated Petitioner was capable of working in a sedentary physical demand level but was unable to tolerate an eight-hour workday due to severe limitations in functional tolerances. The FCE noted Petitioner was not able to complete some tests due to poor aerobic and endurance capacity based on medical history, dependency on cardiac medication, dyspnea, and high blood pressure. (PX 7)

Upon referral of Dr. Fonn, Petitioner presented to Amy Churchill, PA-C, Southern Illinois Pain Management, on July 18, 2011. In her questionnaire, Petitioner was noted to be unable to work but still employed by Respondent. Her chief complaints included pain in her left leg, back, left buttock, right buttock, left hip, right hip, left foot, right thigh, right leg, and left thigh. Petitioner denied any improvement in her pain after her back surgery and described her current complaints as constant aching, stabbing, and sticking pain along with spasms and jerking. She also reported numbness and tingling in her left foot post surgery. Petitioner was described as 5'4" tall and 320 lbs. Her gait was "waddling" and assisted with a wheeled walker. A spinal cord

stimulator trial was discussed and information was given to her. Worker's compensation approval was to be requested. (PX 8)

At the request of Respondent, Dr. James J. Coyle examined Petitioner on November 22, 2011 and a written report issued thereafter. Petitioner described her occupation as "disabled/retired" having not worked for two years. Her care and treatment with Dr. Wong and Dr. Fonn was reviewed with the doctor. At the time of her exam Petitioner's pain diagram revealed bilateral lower extremity pain, diffuse low back pain in a band-like pattern through her low back, mid and upper back pain, shoulder pain, and neck pain. Petitioner described pins and needles radiating down both legs and a numb left foot. According to Petitioner, standing, walking, sitting, or lying for too long increases her pain. Petitioner's medical history was noted to include a neurogenic bladder, diabetes, myocardial infarction, and a history of arthritis. Petitioner's weight was 312 pounds. On examination, Petitioner displayed bilateral buttock pain, pain radiating down the sides of both thighs and calves, numbness in the outer three toes of the left foot and bilateral numbness on the bottom of both feet. She could walk approximately 100 feet with a walker, needed help with personal hygiene, and had no reflexes at the knee or ankle. Pedal edema was present bilaterally. Petitioner could not heel walk and had difficulty going up on her toes. Dr. Coyle was of the opinion Petitioner's symptoms were "secondary to her work [accident]." He described her as "substantially worse" after her surgery than beforehand as she now had a neurogenic bladder, was requiring large amounts of continuous narcotics and was unable to walk any significant distance without a walker. He did not feel she should have undergone the type of surgery she did and needed to undergo an EMG to determine her level of nerve damage. He did not think she was properly fused and needed to undergo a CT scan. He did not think she could work in any reasonable capacity at the present time and would need to lose

approximately 100 lbs. before considering any surgery that might help improve her condition. (PX 12)

Dr. Coyle re-examined Petitioner on June 20, 2012 at which time her complaints and weight remained unchanged from the previous visit. Petitioner reported having checked into bariatric surgery but was concerned about it as she would be required to go on insulin. He recommended a supervised structured weight loss program before any surgery could be considered. Pending weight loss efforts he also recommended a kinetic physical therapy program and a physiatry consultation for pain management. He did not feel she was at maximum medical improvement pending weight reduction and imaging studies. She remained "essentially incapacitated and unable to work." (PX 12)

The record contains no further evidence of any medical care or treatment to Petitioner since her visit with Dr. Coyle in June of 2012.

At the arbitration hearing, Petitioner testified that she had more complaints and problems after her surgery than before and that the left side of her foot never "woke up" after surgery. According to Petitioner she continues to experience a "weird feeling" in her foot and when she walks it feels like she's walking on a bunch of rubber. Petitioner also testified that her leg gives way, she is frequently "off balance," wobbles, and experiences ongoing pain. She testified that she has used a walker since 2010. Petitioner continues to notice pain and numbness in her back, leg, and feet and she "shifts" around a lot. According to Petitioner she has tried a bone growth stimulator and physical therapy but they did not help. She further testified that Dr. Fonn ultimately ordered a functional capacity evaluation which determined certain limitations for her.

Petitioner also testified that she began experiencing bladder problems after her surgery and was ultimately advised she had a neurogenic bladder and bowel due to her surgery and that nothing more could be done. While Petitioner acknowledged some urinary tract infections and treatment for bladder problems before her accident she felt none of those problems were like what she currently experiences. Petitioner explained that she frequently has to go to the doctor and be catheterized to get a fully empty bladder. She retains a great deal of fluid and swells up as a result. While she was on Lasix in 2008 for her bladder symptoms the dose was doubled in early 2010 and she is currently taking the maximum amount allowable.

Petitioner testified that she received temporary total disability benefits from Respondent's workers' compensation carrier until sometime in June of 2012 when they were stopped and the carrier filed bankruptcy. Petitioner acknowledged that she had been pursuing weight loss options when her benefits were terminated and had experienced some success (a sixty pound weight loss) with nutritional weight loss programs. Nevertheless, weight loss has not alleviated her symptoms and problems. According to Petitioner, bariatric surgery is not an option due to her many medical conditions. Petitioner also went through a period of time when she was unable to receive any treatment due to the bankruptcy proceedings.

On cross-examination Petitioner acknowledged she is diabetic, has high cholesterol, and also has cardiac issues. Petitioner testified that she reported back pain when she fell. When asked about the lack of documentation of back pain in early treatment records (October 2009) Petitioner testified that the doctors she was seeing during that time all worked together and they knew she was having back pain because she always told them she was hurting. Petitioner further explained that in January of 2011 she underwent her annual female exam and mentioned her

back pain to her doctor who advised her she needed to see Dr. Wong. Petitioner then tried to contact her case manager for assistance but it took several weeks to get any response. She further testified that in February of 2011 Dr. Wong recommended that she go see a neurosurgeon; however, the workers' compensation carrier wouldn't approve that. Instead, the carrier referred her to a neurologist who just gave her medicine. When that didn't help, she was able to get in and see Dr. Fonn.

Petitioner was asked many questions about her back and the findings shown on her first MRI. Petitioner testified she was unaware of her congenital dextroscoliosis condition and that she had no back problems until she went to work for Respondent. She further testified that with regard to MRI findings, Dr. Fonn did not really discuss them with her -- indeed, she testified he did not tell her a great deal about her back at all but anything she did learn about her back was told to her after her work injury. She also acknowledged some prior treatment with Dr. Wood for a trigger thumb but denied any treatment with him for back problems.

Petitioner testified that the therapy she undertook in early 2010 was of no avail.

Petitioner candidly acknowledged that, even before her accident, she has always been told to lose weight. She weighed approximately 300 lbs. at the time of her surgery with Dr. Fonn and she gained weight immediately after the surgery due to the injury to her bladder and her inability to walk. While Dr. Fonn indicated in his October 13, 2010 note that Petitioner's symptoms had significantly improved, Petitioner denied same testifying that her symptoms never improved.

Petitioner acknowledged seeing Dr. Coyle in November of 2011 and that he is the doctor who told her the fusion had not taken. Petitioner testified that Dr. Coyle was very upset with Dr. Fonn and the location and manner in which he performed the surgery. Dr. Coyle has recommended that Petitioner lose a hundred pounds before she undergoes any further invasive procedures. Petitioner testified that the workers' compensation carrier was supposed to provide her with a diet program but it never did. Petitioner further acknowledged that she listed her occupation at the time of her initial visit as "disabled/retired." She explained that she used the word "retired" because it sounded a little bit better at her age; however, she is disabled.

Petitioner also acknowledged that she underwent an FCE. When asked if it determined that she could return to work in a sedentary position, Petitioner asked for clarification as to what "sedentary" meant. As counsel attempted to explain the specific limitations/restrictions given at the time of the FCE, Petitioner interrupted him indicating that the restrictions were "on occasion" and further stated that if one reads the report, she was even taken off the treadmill portion of the test because she could not do it. She acknowledged having a heart attack after her back injury.

Petitioner has not returned to work in any capacity since 2010. She denied that Dr. Fonn ever returned her to work.

Petitioner testified that she was pursuing a career in nursing when she fell and was taking an anatomy class in August of 2009.

Respondent tendered no exhibits.

The Arbitrator concludes:

1. Petitioner's credibility. Petitioner was a credible witness. She appeared honest and forthright. She acknowledged prior medical problems but credibly explained how the symptoms and care before and after her accident differed.

2. Causal Connection (Issue F). Petitioner's current condition of ill-being is causally connected to her October 3, 2009 accident. This conclusion is based upon Petitioner's credibility, a chain of events, and the opinions of Dr. Wong, Dr. Fonn, and Dr. Coyle. Despite pre-existing conditions, Petitioner credibly testified that she never had any back problems or treatment before her work accident and she was working full unrestricted duty at the time of her accident. While there was a gap in treatment between October of 2009 and January of 201 Petitioner was working full duty as a CNA during that time and her testimony regarding the persistent nature of her complaints during same was corroborated by the medical records. Petitioner's testimony was unrebutted.

3. Medical Expenses (Issue J). Petitioner is awarded the medical expenses contained in Petitioner's Exhibit 11 subject to the Medical Fee Schedule and with credit to be given to Respondent for any amounts previously paid.

4. Temporary Total Disability (Issue L). Petitioner is awarded temporary total disability benefits from June 26, 2012 through April 15, 2014, a period of 94 weeks. This is based upon the opinion of Dr. Coyle, Respondent's Section 12 examining physician.

5. Prospective Medical Care (Issue K). It is clear from Dr. Coyle's reports that Petitioner is not at maximum medical improvement and needs to lose a substantial amount of weight before any further treatment recommendations can be seriously considered. Dr. Coyle has recommended a supervised structured weight loss program with a kinetic physical therapy program and a physiatry consultation. However, Petitioner did not ask for any of this to be awarded and to simply award a generic "weight loss program" seems speculative and, perhaps, counter-productive given Petitioner's many medical conditions that need to be factored in along with her previous attempts to lose weight through a variety of different methods. Accordingly, the Arbitrator does not award any prospective medical care at this time.

****

15IWCC0124

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ANTHONY L. SCHOEDEL,

Petitioner,

vs. NO: 13 WC 4013

CITY OF PEKIN,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent disability, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2014, is hereby affirmed and adopted.

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

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

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

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

DATED: FEB 1 1 2015
o1/28/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0124

SCHOEDEL, ANTHONY Case# **13WC004013**

Employee/Petitioner

CITY OF PEKIN

Employer/Respondent

On 7/1/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1004 BACH LAW
ROBERT W BACH
110 S W JEFFERSON SUITE 410
PEORIA, IL 61602

2461 NYHAN BAMBRICK KINZIE & LOWRY PC
DAVID VICTOR
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)

Anthony Schoedel
Employee/Petitioner

Case # **13** WC **4013**

v.

City of Pekin
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 **Peoria, IL**, on **May 20, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other

FINDINGS

On the date of accident, **October 9, 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 **$72,265.96**; the average weekly wage was **$1,389.73**.

On the date of accident, Petitioner was **34** years of age, *married* with **1** dependent child.

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

Respondent shall be given a credit of **$36,133.11** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$36,133.11**.

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

ORDER

Respondent shall authorize and pay for reasonable and necessary medical expenses associated with the right knee surgery prescribed for the Petitioner by Dr. Cole, pursuant to the medical fee schedule s provided in section 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$926.49**/week for **82 1/7** weeks, commencing **October 9, 2012** through **May 20, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **October 9, 2012** through **May 20, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of **$36,133.11** for temporary total disability benefits that have been paid.

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

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

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

Arbitrator Anthony C. Erbacci

June 27, 2014
Date

13 WC 4013
ICArbDec19(b)

JUL 1 - 2014

15IWCC0124

FACTS:

On October 9, 2012, the Petitioner was employed by the Respondent as a firefighter, having been so employed for 13 years. On that date, the Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent when, while fighting a fire, the scaffolding on which the Petitioner was standing broke and the Petitioner's right leg fell through the planking on the scaffold. The Petitioner testified that when he eventually climbed down from the scaffolding, his right knee was swollen, red, and unstable, mostly on the inside of the knee.

The Petitioner was initially seen for his injury by Dr. Dru Hauter on October 15, 2012. Dr. Hauter's assessment was that the Petitioner "likely has completely torn his ACL again" and he prescribed an MRI. On October 18, 2012, Dr. Hauter noted that the MRI showed a complete tear of the ACL as well as a medial meniscus tear and he referred the Petitioner to Dr. Steven Orlevitch at Great Plains Orthopaedics.

On October 23, 2012 the Petitioner saw Dr. Orlevitch who noted that he had performed a partial medial meniscectomy and ACL reconstruction on the Petitioner's knee in 2010 and the Petitioner had returned to work as a firefighter and "was doing fine" until his injury on October 9, 2012. Dr. Orlevitch noted that the recent MRI demonstrated a tear of the ACL graft, bone bruising, degenerative changes and deficiency of the posterior horn of the medial meniscus. Dr. Orlevitch opined that the Petitioner might be a candidate for a meniscal transplant, and he referred the Petitioner to Dr. Brian Cole at Midwest Orthopaedics at Rush.

Dr. Cole saw the Petitioner on November 29, 2012 and Dr. Cole noted that the Petitioner had no medial sided pain or instability prior to his October 9, 2012 injury and had "rehabilitated perfectly well from and was asymptomatic after July 2010 ACL reconstruction with allograft by Dr. Stephen Orlevitch." Dr. Cole's impression was "ACL retear right knee of prior allograft and meniscal derangement with no evidence of post meniscectomy syndrome in the medial compartment of the right knee." Dr. Cole indicated that he would recommend an ACL revision surgery without a meniscal allograft as a "less rather than more" treatment mentality. Dr. Cole indicated that the Petitioner had a very guarded prognosis that he would get back to full-duty firefighting with a medial meniscus allograft in place.

On February 5, 2013, the Petitioner underwent a right knee arthroscopy which included anterior cruciate ligament revision, bone-tendon-bone autograft, and right knee medial meniscus debridement. Dr. Cole's postoperative diagnoses were right knee anterior cruciate ligament tear, right knee medial meniscus tear, and focal defect, medial femoral condyle. There is no dispute as to the reasonableness, necessity, or causal relationship of this surgery.

Postoperatively, the Petitioner followed up with Dr. Cole and commenced a course of physical therapy. On May 9, 2013, Dr. Cole noted that the Petitioner reported continued discomfort along the medial aspect of his right knee and Dr. Cole injected the knee with lidocaine and Depo-Medrol. On May 21, 2013, Dr. Cole noted that the Petitioner continued to have pain in the medial aspect of his right knee along with a feeling of instability. Dr. Cole

15IWCC0124

indicated that he was concerned that the Petitioner's medial femoral condyle defect and relatively absent medial meniscus was becoming "more of a relevant problem" and he might need a fresh osteochondral allograft in his medial femoral condyle and a medial meniscus allograft as well. Dr. Cole requested authorization for the procedure from the Respondent's insurance carrier.

On June 3, 2013, Dr. Cole noted that the Petitioner continued to have persistent pain as well as intermittent complaints of instability. Dr. Cole again indicated that the Petitioner was a candidate for medial femoral condyle osteochondral allograft along with medial meniscal allograft transplantation and requested authorization for the procedure.

On July 10, 2013, the Petitioner was seen and examined by Dr. Lawrence Lieber at the request of the Respondent. Dr. Lieber's diagnosis was "status post ACL reconstruction, meniscal surgery, along with degenerative osteoarthritis of the knee." Dr. Lieber opined that the diagnosis of status post ACL injury and medial meniscus tear was the direct result of the Petitioner's October 9, 2012 injury but the pre-existing degenerative arthritic changes in the Petitioner's knee were not related to the injury. Dr. Lieber opined that the Petitioner's complaints appeared to be related to the pre-existing degenerative abnormality within the Petitioner's knee, which was neither aggravated, caused, nor accelerated by the injury. Dr. Lieber opined that the Petitioner's treatment to date was reasonable and necessary but any further treatment and/or surgical intervention, as recommended by Dr. Cole, would not be.

Dr. Cole's testimony was taken on February 21, 2014 and admitted into the record as Petitioner's Exhibit 4. Dr. Cole testified as to his treatment of the Petitioner including the surgery of February 5, 2013 and the Petitioner's post-surgical course. Dr. Cole opined that the Petitioner's October 9, 2012 injury aggravated the pre-existing meniscus deficiency and the cartilage defect in the Petitioner's knee and that the surgery that he has prescribed for the Petitioner is reasonable, necessary, and causally related to the Petitioner's October 9, 2012 injury.

Dr. Lieber's testimony was taken on April 3, 2014 and admitted into the record as Respondent's Exhibit 1. Dr. Lieber testified as to his examination of the Petitioner and his review of the Petitioner's medical records. Dr. Lieber opined that the Petitioner sustained an isolated ACL injury on October 9, 2012 and that there was no evidence of any significant osteochondral injury that could be related to the October 9, 2012 event. Dr. Lieber opined that the initial surgery performed by Dr. Cole was reasonable and necessary but the allograft surgery and meniscal transplant surgery being proposed by Dr. Cole was related to the pre-existing degenerative problems in the Petitioner's knee and not the the injury of October 9, 2012.

The Petitioner testified that, in the months prior to October 9, 2012, he had no pain, symptoms or problems in his right knee and he was able to pass his annual fitness for duty exam and perform all of the duties of his job as a firefighter without difficulty or problems. The Petitioner testified that he was active and participated in cross-fit training on a regular basis. The Petitioner testified that he had just completed a cross-fit training course at the request of

15IWCC0124

the Respondent so that he could instruct the Respondent's other firefighters in cross-fit training techniques.

The Petitioner testified that he currently continues to experience constant pain in his right knee as well as instability and grinding. The Petitioner testified that he wants to undergo the surgery prescribed for him by Dr. Cole.

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 Petitioner sustained undisputed accidental injuries arising out of and in the course of his employment with the Respondent when, while fighting a fire, the scaffolding on which the Petitioner was standing broke and the Petitioner's right leg fell through the planking on the scaffold. The Petitioner was diagnosed as having a tear of previously repaired anterior cruciate ligament, bone bruising, degenerative changes and deficiency of the posterior horn of the medial meniscus. Dr. Orlevitch opined that the Petitioner might be a candidate for a meniscal transplant, and he referred the Petitioner to Dr. Brian Cole. The Petitioner then underwent a right knee arthroscopy which included anterior cruciate ligament revision, bone-tendon-bone autograft, and right knee medial meniscus debridement. Following surgery, the Petitioner began a course of physical therapy and began to complain of medial knee pain and a feeling of instability. The Petitioner continued to have persistent pain as well as intermittent complaints of instability, and Dr. Cole prescribed a medial femoral condyle osteochondral allograft and medial meniscal allograft transplantation for the Petitioner's right knee.

Prior to his injury, the Petitioner had no pain, symptoms or problems in his right knee and he was able to pass his annual fitness for duty exam and perform all of the duties of his job as a firefighter without difficulty or problems. Since the date of the accident, Petitioner has been restricted from duty as a fire fighter by each of his three treating physicians. In addition, Dr. Cole testified that the Petitioner's current knee problem is the result of the October 2012 accident which aggravated the preexisting meniscus deficiency and cartilage defect in his knee. While Dr. Lieber, the Respondent's examining physician, opined that the Petitioner's knee was not aggravated in the accident, he assumed that the Petitioner had symptoms in his knee prior to the accident. There is no evidence to substantiate that assumption.

The Arbitrator finds that Petitioner has established by substantial circumstantial evidence that his current condition of ill being is causally related to the accidental injury of October 9, 2012. The Petitioner's unrefuted testimony is that he had no symptoms of any condition of ill being in his right knee prior to the accident in question. He underwent and passed a fitness for duty exam and yearly physical. He was working full time full duty prior to the accident in a physically demanding job. All of the medical records support the conclusion that he was not experiencing any problems from his prior ACL injury in 2010 at the time of the accident. Since the Petitioner has shown a clear and substantial difference in his activity level

15IWCC0124

before as compared to after the accident which is supported by medical opinion that his knee problems are causally related to the accident, the Arbitrator finds that the Petitioner has established a causal connection between the accident and his current condition of ill-being.

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 work accident of October 9, 2012.

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:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Arbitrator finds that the Petitioner has sustained his burden to prove that he sustained an injury to his right knee in the accident in question which continues to cause symptoms and which disables him from his occupation as a fire fighter. The Petitioner's treating physician, Dr. Cole, has recommended surgery consisting of a meniscal transplant and osteochondral allograft. Both Dr. Orlevitch, the Petitioner's prior treating physician, and Dr. Cole, expressed the opinion that the Petitioner's injury required a medical meniscus transplant. This was the reason for the referral by Orlevitch to Dr. Cole at the outset of his treatment.

The Arbitrator finds that Dr. Cole's explanation of his clinical decision to attempt to avoid the meniscal transplant in the initial surgery is credible. Further, given Dr. Cole's qualifications, his opinion that the Petitioner requires a further surgery is accepted as the clinical judgment of a well-qualified treating physician. As such, the surgery as proposed by Dr. Cole is found to be reasonable and necessary to treat the injury sustained by Petitioner in October 2012 and Respondent is ordered to approve and pay the cost thereof subject to the limitations of the Medical Fee Schedule provided for in 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 Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The records of the Petitioner's treating physicians, Dr. Hauter, Dr. Orlevitch, and Dr. Cole, substantiate the Petitioner's continuing inability to perform his job duties from the date of the accident to the present. In addition, the Petitioner testified that he continues to suffer from medial sided knee pain and instability of the knee joint even when walking on level surfaces. The Arbitrator finds that the greater weight of the medical evidence substantiates that the Petitioner is and has been temporarily totally disabled from the date of the accident to

15IWCC0124

the date of the hearing on May 20, 2014.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner is entitled to Temporary Total Disability benefits from October 9, 2012 through May 20, 2014, a period of 82 1/7 weeks.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jorge Serrano,

Petitioner,

15IWCC0125

vs. NO: 08 WC 10103

Ogden Lincoln Mercury,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical treatment, temporary total disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of an additional amount of temporary total compensation or of compensation for permanent disability, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

Petitioner, a 54-year-old porter, was employed by Respondent for three months prior to sustaining slip and fall injuries on February 7, 2008. Petitioner testified that he fell on ice while performing his job duties retrieving cars from Respondent's lot. He continued working on the date of accident did not seek medical treatment until February 11, 2008. Respondent did not dispute that Petitioner sustained accidental injuries to his low back in the course of and arising out of his employment on February 7, 2008, but denied that Petitioner injured his neck or right knee. Respondent argued that Petitioner reached maximum medical improvement and denied authorization for additional treatment.

Dr. Malek performed an L4-5 fusion on January 12, 2010. Prior to surgery, Dr. Ghanayem examined Petitioner at the request of Respondent and opined that Dr. Malek's recommendation for a lumbar fusion was reasonable and related to the February 7, 2008 accident. Following the lumbar fusion, Petitioner began to complain of worsening neck pain and right knee pain. Petitioner underwent a two-level cervical fusion by Dr. Malek on July 5, 2011. Respondent denied liability for Petitioner's cervical condition on the basis of Dr. Ghanayem's opinions. Dr. Ghanayem opined that Petitioner's cervical condition was degenerative and did not require surgery. The medical records show that Petitioner did have some pre-existing neck and back problems; x-rays from July of 2007 showed degenerative changes at L4-5 and C5-6 and C6-7, however we agree with the Arbitrator that that the accident aggravated Petitioner's cervical condition.

Respondent contends that Petitioner's low back injury reached maximum medical improvement on September 16, 2010, per the records of Dr. Malek, and that his current condition of ill-being in the low back is not related to the injuries sustained on February 7, 2008. The records of Dr. Malek show that Petitioner's condition improved after the January 12, 2010 lumbar fusion and Petitioner had little to no complaints with respect to his low back for nine months. On September 16, 2010 Dr. Malek stated that he anticipated no further treatment for Petitioner's low back, although Petitioner continued to treat for his neck and his right knee. On May 13, 2011, Petitioner participated in a functional capacity evaluation. Several days later Petitioner reported to Dr. Malek that he was pushed beyond his tolerance during testing and suffered a severe aggravation of low back pain. Dr. Malek concluded that the functional capacity evaluation was invalid. Due to the intractability of Petitioner's back pain, Dr. Malek recommended an extension of the prior fusion to the adjacent lumbar disc level. Respondent denied authorization for surgery on the basis that it is not medically necessary or related to the accident. Dr. Ghaneyem believed that the additional surgery was not necessary and would provide no long-term benefit. The Arbitrator relied on the opinions of Dr. Malek and found that Petitioner is entitled to prospective medical treatment for the lumbar spine. We agree and we affirm the findings of the Arbitrator on this issue.

Petitioner's claim of injury with respect to the accident of February 7, 2008 also includes the right knee. Respondent denied liability for Petitioner's right knee condition based on the absence of any report of injury to the right knee. In fact, Petitioner initially reported *left* knee complaints. Respondent argues that Petitioner's right knee condition is not related to the accident, and that Petitioner's claim that he injured his right knee on February 7, 2008 is contradicted by the evidence and is not credible. After considering all of the evidence, we reverse the decision of the Arbitrator on the issue of causal connection with respect to the right knee.

We find that Petitioner failed to prove that his right knee condition is related to the accident. The initial medical records show that Petitioner did not have complaints of right knee pain when he was first examined on February 11, 2008. He did not report striking his knee or

twisting it on February 7, 2008. Petitioner subsequently remained in the hospital for several days and the records show no right knee complaints; the acute reason for the hospitalization was diverticulitis. Petitioner then saw his primary care physician, Dr. Love, one week after the accident. He reported that he fell and hit his *left* knee and his right elbow and that he was experiencing neck and back pain. At a February 27, 2008 physical therapy evaluation for his back, Petitioner again reported *left* knee pain and gave no history of having struck or twisted his right knee. Approximately one month after the accident, on March 5, 2008, Petitioner reported to Dr. Castellanos that he had *left* knee pain. Therefore, Petitioner's current claim that he injured his right knee at the time of accident is entirely contradicted by the initial medical records and is not credible.

Petitioner was first examined by Dr. Malek on May 7, 2008, three months after the accident. Petitioner did not report to Dr. Malek that he struck or twisted his right knee. Instead, he complained of radiating pain down the lower extremities, worse on the right side, with some localized pain in the right knee. Dr. Malek ordered a right knee MRI and the study was negative for any significant abnormalities. Dr. Malek subsequently focused treatment on Petitioner's most severe complaint, lumbar pain. After the January 2010 fusion, Dr. Malek referred Petitioner to Dr. Silver for an evaluation of Petitioner's right knee complaints. On May 6, 2010, Petitioner reported to Dr. Silver that he fell on ice at work and struck and twisted his right knee and he denied any pre-existing right knee problems. Dr. Silver noted that Petitioner's right knee x-ray was normal, but he stated that potentially Petitioner had sustained articular cartilage damage.

Petitioner was examined by Dr. Stover for an independent medical examination with respect to the right knee on June 2, 2010. Petitioner reported to Dr. Stover that he injured his right knee at the time of the accident and that performing activities in physical therapy made the knee worse. Dr. Stover believed there was a temporal connection between Petitioner's knee pain and the accident, based on Petitioner's claim that his pain started with the accident. He noted, however, that Petitioner's knee was stable on examination and had good range of motion and Petitioner had only mild tenderness at the medial joint line. Dr. Stover recommended a steroid injection and another MRI study.

Dr. Silver injected Petitioner's right knee on June 24, 2010 but Petitioner reported only minor relief from the injection. Petitioner had another right knee MRI on July 30, 2010 that showed a borderline, partially discoid lateral meniscus without a definite discrete meniscal tear, and also mild grade II chondromalacia along the inferior pole of the patella without any full thickness cartilage defect. Dr. Silver interpreted these findings as evidence of damage to the articular cartilage; he stated that Petitioner's right knee required surgery.

On August 31, 2010 Dr. Stover issued an addendum report after he reviewed the MRI study. Dr. Stover did not believe that Petitioner had a significant amount of arthrosis and he did not observe any loose bodies within the knee. He noted that Petitioner reported only very slight benefit from the steroid injection and no benefit from the use of pain medications or anti-inflammatory medications. Therefore, Dr. Stover believed that Petitioner reached maximum

medical improvement with respect to the right knee and he recommended a functional capacity evaluation and return to work. Dr. Stover examined Petitioner again on February 9, 2011 and he again opined that Petitioner was at maximum medical improvement and surgery was not reasonable or necessary. He still believed that based on Petitioner's timeline of complaints, Petitioner's right knee pain was causally related to the original accident, however he did not believe that the accident caused any acceleration of Petitioner's minor right knee arthrosis.

As a third opinion, Petitioner was examined by Dr. Nam on October 8, 2011. Petitioner denied any prior right knee pain and reported to Dr. Nam that he had experienced knee pain ever since the accident and had no relief with subsequent conservative treatment. Dr. Nam requested a new MRI and the October 11, 2011 study indicated a diffuse tear in the anterior horn of the lateral meniscus and grade I chondromalacia of the medial facet of the patella. Dr. Nam did not agree that a definite tear was apparent and he found the cartilage to be grossly intact. He performed another injection, but on Petitioner's insistence that he could not live with his right knee pain Dr. Nam offered an exploratory arthroscopy. The records show on December 3, 2011 Dr. Nam advised Petitioner that he saw no definitive pathology in the right knee.

Furthermore, Petitioner's denial of pre-existing right knee problems is contradicted by the prior medical records from Petitioner's primary care physician, Dr. Love. Petitioner sustained a motor vehicle accident in 1997 where, as a pedestrian, he was reportedly struck by a car at both shins. Petitioner's credibility with respect to his right knee claim is therefore further negatively affected by his failure to fully disclose his history to his examining and treating physicians

In conclusion, although we reverse the Arbitrator's findings with respect to the right knee, we find the Arbitrator's temporary total disability award is supported by the medical records. As a result of the compensable injuries he sustained to his neck and low back on February 7, 2008, Petitioner was either medically restricted from working or under restrictions that could not be accommodated from February 12, 2008 through the date of hearing. We modify the Arbitrator's award of medical expenses to exclude any bills for treatment to the right knee, based on our findings set forth above, and we strike the Arbitrator's award of prospective right knee surgery.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $303.53 per week for a period of 260 and 2/7 weeks, commencing February 12, 2008 through February 6, 2013, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $27,074.17 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for treatment related to the low back and neck injuries sustained on February 7, 2008 pursuant to §8(a) and §8.2 of the Act, and that Respondent shall authorize and pay for the lumbar surgery prescribed by Dr. Malek.

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

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

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

Bond for 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: FEB 1 1 2015
RWW/plv
o-12/17/14
46

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0125

SERRANO, JORGE Case# **08WC010103**

Employee/Petitioner

OGDEN LINCOLN MERCURY

Employer/Respondent

On 2/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

1869 PRESBREY & ASSOCIATES
KURT NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

0481 MACIOROWSKI SACKMANN & ULRICH LLC
ROBERT B ULRICH
10 S RIVERSIDE PLZ SUITE 2290
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0125

JORGE SERRANO
Employee/Petitioner

v.

OGDEN LINCOLN MERCURY
Employer/Respondent

Case # **08** WC **10103**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Geneva IL**, on **February 6, 2013 and November 12, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?

G. [ ] What were Petitioner's earnings?

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

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

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

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **2/7/08**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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 $**23,675.60**; the average weekly wage was $**455.30**.

On the date of accident, Petitioner was **54** 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 total disability benefits of $303.53/week for 260-2/7 weeks, commencing February 12, 2008 through February 6, 2013, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 2/7/08 through 2/6/13, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $27,074.17 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of $ 19,911.00 to Dr. Gerald Reed (PX3), $ 127,364.00 to Michel Malek MD (PX4), $ 1,086.24 to Illinois Bone & Joint (Ronald Silver MD)(PX6), $ 98,340.03 to Provena Saint Josephs Medical Center, $ 898.00 to Chicago Orthopaedic & Sports Medicine (Dr. Nam), $ 582.48 to ATI (PX8), $ 609.00 to Midwest Hospitalists LLC (Dr. Venkataraman) (PX11), and $1,125.00 to Instant Care Medical Group (PX11), as provided in Sections 8(a) and 8.2 of the Act. Respondent shall hold Petitioner harmless from demands for reimbursement by the group carriers.

Respondent shall also provide the right knee surgery and related rehabilitation prescribed by Dr. Nam.

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 — 2/13/14 Date

ICArbDec19(b)

FEB 14 2014

15IWCC0125

FINDINGS OF FACT:

Petitioner testified that on February 7, 2008 he fell on ice twice, once in the morning and once in the afternoon. Petitioner provided that he hit the back of his head, twisted his right knee and low back in the second fall. Petitioner stated that he experienced swelling in the knee and low back pain. He completed his shift, went home and took "pain killer."

On February 12, 2008, Petitioner sought treatment at Provena Mercy Center where he was admitted through February 14, 2008. The history in the "Patient Short Form w/Lab Result" show Petitioner complained of "low back pain since Thursday, fell on that day, took Tylenol this weekend and pain has been better but after working today pain worse again." The handwritten "BACK PAIN" chart show Petitioner complained of " low back pain [for] 3 days; history of fall 5 days ago; (+) head injury…also complained of right flank pain." The "History and Physical" report provides a history of back pain for three days, following his fall at work on ice. Petitioner reported that he had gotten up after the fall and gone back to work. Over the next several days, he noticed that his back pain had worsened. Petitioner's low back pain at the time of presentation was reported as 11 on a 0-10 scale, sharp in nature and worse with any movement. Petitioner denied previous episodes of such back pain. The examination revealed tenderness in the lumbar region, primarily on the right side, with point tenderness localized to the right side. Range of motion testing elicited lumbar pain with resistance to right leg raise, right hip flexion and eversion. No findings were reported for the neck. X-rays and a MRI were performed. The MRI demonstrated: 1.) central disc protrusion at L4-L5 which effaced the ventral thecal sac and mildly impressed upon the traversing right greater than left L5 nerve roots; 2.) mild diffuse annular bulging at L5-S1 and L3-L4; 3.) mild hypertrophic degenerative changes of the zygapophyseal joints on the right at L5-S1 and bilaterally at L4-L5; 4.) mild degenerative disc disease at L4-L5 greater than L3-l4 and T11 –T12. Amongst other non-related diagnosis, Petitioner was assessed with back pain. Upon discharge, physical therapy, occupational therapy, bed rest and pain management was recommended. Petitioner was also advised to see his primary care physician Dr. Love. (PX 3)

Petitioner followed up with Dr. Love on February 19, 2008 with a history that he had fallen on ice on February 7th, when he hit his left knee, right elbow and he had neck pain. The history further noted that Petitioner completed his shift but developed increasing back pain by February 11th. At that point he went to Provena Mercy Center and was admitted for two days, with attending physicians indicating a desire to operate on their diagnosis of diverticulitis. Dr. Love examined Petitioner and found no numbness, tingling or weakness into his lower extremities. An examination of the low back demonstrated good range of motion. Motor exam shows 5/5 strength in his lower extremities. Reflexes were 2+ and equal bilaterally. He was able to straight leg raise to 90 degrees. Dr. Love assessed low back pain secondary to a fall. Dr. Love noted that he would get the Provena records to see what was really going on at the time of his admission to Provena. (RX 1)

On February 27, 2008, Petitioner began treatment with Dr. Gerald Reed, a chiropractor. (PX3) At the initial visit, Dr. Reed recorded, "…Examinee states that he injured himself on 2/7/08 when he slipped and fell at work and landed on his back. He reports sharp pain in his L/S which is localized with occasional pain in his right leg." Petitioner reported non-radiating low back pain at 8 out of 10 and bilateral cervical spine pain at 6 to 7 out of 10. Dr. Reed's February 27, 2008 office record also contains a pain drawing, which appear to document complaints of pain in the cervical, low back and at the proximal part of the right leg, near the buttocks. Dr. Reed's upper extremity examination noted posterior tenderness in Petitioner's paravertebral muscles, and the right trapezius and levator muscles. (PX 3)

Petitioner testified that pursuant to Dr. Reed's referral he next saw Dr. Jose Castellanos from Diversey Medical Center. Petitioner presented on March 5, 2008 with complaints of low back pain that radiate into the

right thigh. He also reported right epicondyle tenderness which he indicated had been present since the fall. Dr. Castellanos reviewed the recent MRI and performed an examination. The examination revealed a full range of motion of the cervical spine, with tenderness throughout the cervical spine on palpation. Multiple findings were made with respect to the lumbar spine. His right elbow had tenderness of the epicondyle on the right side. He was able to squat, but he had difficulty getting up. Petitioner was also able to walk without any assistance, and he was able to stand from a sitting position. Dr. Castellanos assessed lumbosacral pain with radiculopathy. The doctor referred Petitioner to pain management and recommended an EMG/NCV. He also continue Petitioner's chiropractic treatment and his medication. (PX 2)

Petitioner underwent the EMG/NCV on April 1, 2008. The presenting complaints noted on the report were, 1.) low back, bilateral buttock pain; 2.) numbness and tingling in left anterior and posterior-lateral thigh extending left; and, 3.) pain in right knee. The impression was left L5-S1 radiculopathy. (PX 2)

On April 15, 2008, Dr. Reed noted that Petitioner's condition had improved approximately 20%. Petitioner had made gains with the timing and severity of his cervical pain. He still had moderate to severe lumbar pain with flexion and extension. Dr Reed prescribed a lumbar MRI which when completed on April 25, 2008 was read to show mild degenerative changes in the lumbosacral spine. There was a minimal posterior annular tear at L4-5 with minimal posterior bulging. (PX 2)

Petitioner also underwent a cervical MRI which when performed on May 2, 2008 showed reversal of cervical lordosis in the upper cervical spine and an osteophyte complex at C5-6 and C6-7 resulting in stenosis. (PX 4)

On May 6, 2008, Dr. Reed recommended Petitioner see an orthopedic surgeon. (PX 2)

On May 7, 2008, Petitioner reported to Dr. Michel Malek, an orthopedic surgeon. Dr. Malek recorded a history of neck pain radiating down right upper extremity associated with numbness after the accident. Petitioner also reported low back pain with pain down both lower extremities as well as knee pain. Dr. Malek noted that Petitioner reported that the axial symptoms are worse than the appendicular symptoms. Petitioner indicated that although he had symptoms in both the low back and neck, the low back was the worse. Dr. Malek diagnosed cervical radiculopathy, lumbar radiculopathy and knee pain. Dr. Malek recommended an orthopedic evaluation for the right knee and an epidural steroid injection for the back, but not unless Petitioner could first stop taking Plavix. (PX 4)

On May 8, 2008, Petitioner underwent a left knee MRI revealing a lateral tibial contusion. (PX 6)

On May 8, 2008, Dr. Reed reported Petitioner had reached maximum medical improvement with conservative care and need more aggressive pain management. By May 13, 2008, Dr. Reed reported that Petitioner had experienced significant improvement in his cervical pain and apparent resolution of the headaches. However, Petitioner continued to report difficulty with left lower extremity pain, numbness, tingling and moderate to severe low back pain with movement. Dr. Reed recommended that Petitioner obtain pain management treatment. (PX 2)

At Respondent's request Petitioner underwent a Section 12 examination with Dr. Kern Singh on June 4, 2008. Dr. Singh testified via deposition in this matter. Dr. Singh testified that he examined Petitioner on June 4, 2008. As part of that examination, Dr. Singh took a history, performed a physical examination and reviewed Petitioner's April 25, 2008 lumbar MRI scan and the May 2, 2008 cervical MRI scan. Dr. Singh diagnosed a cervical muscular strain, a lumbar muscular strain and degenerative disc disease at C5-C6 and C6-C7. Dr. Singh testified that the April 25, 2008 lumbar MRI scan showed only minimal evidence of an L4-L5 disc protrusion with no evidence of central canal foraminal stenosis. In regard to his review of the May 2, 2008

cervical MRI scan, he thought it showed a slight loss of cervical lordosis and cervical disc protrusions at C5-C6 and C6-C7 which were degenerative in nature with no evidence of effacement and only minimal foraminal stenosis. Dr. Singh testified that it was his opinion that the Petitioner's lumbar and cervical conditions were unrelated to the accident. He felt Petitioner could return to full duty without any restrictions. He further felt Petitioner was at maximum medical improvement and required no additional treatment. (RX 11)

On June 13, 2008, Dr. Reed wrote that Petitioner was at maximum medical improvement with conservative care. Dr. Reed referred Petitioner for consultation with a spinal surgeon. The Spanish progress report indicates continuing worsened ("empeorado") pain in the right shoulder and neck and the onset of Petitioner's shoulder blade falling asleep. (PX 2)

Petitioner returned to Dr. Malek on June 4, 2009. Dr. Malek noted that Petitioner had a lumbar discgram performed by Dr. Pareja on May 20, 2009. The discogram reportedly reproduced concordant pain at the L4-5 level. The post-discogram CT scan showed grade IV annular tears at L3-4 and L4-5 levels and a small midline disc protrusion at L4-5. Dr. Malek recommended an updated lumbar MRI and an orthopedic evaluation of his knee. (PX4)

Petitioner returned to Dr. Malek on June 18, 2009. Dr. Malek noted that the new MRI showed a 2-3 millimeter disc protrusion elevating the posterior longitudinal ligament and indenting the thecal sac. Dr. Malek thought this was consistent with findings from the 2008 MRI, as well as with the earlier EMG/NCV findings. Dr. Malek recommended a L4-L5 fusion. He also continued to recommend an orthopedic evaluation for the knee. (PX 4)

At Respondent's request Petitioner underwent a Section 12 examination with Dr. Alexander Ghanayem on October 29, 2009. Dr. Ghanayem provided that Petitioner's primary complaint was low back pain. He also noted Petitioner complained of cervical symptoms which was not the main problem. Also noted was a knee injury which the doctor did not address. Dr. Ghanayem reviewed Petitioner's MRI scans and diagnosed a central disc herniation at the L4-L5 disc level. He also causally connected those findings to Petitioner's February 7, 2008 accident and recommended surgery which he described as an anterior fusion at the L4-L5 disc level. (PX 10 and RX 10)

Dr. Malek performed the fusion on January 12, 2010 at Our Lady of the Resurrection Hospital. (PX5) Dr. Malek noted that Petitioner was doing well at the post-operative visit on February 11, 2010. He also noted that although Petitioner's pre-operative symptoms had resolved, Petitioner continued with neck and knee pain. The doctor felt Petitioner could start a physical therapy program twelve weeks after the surgery and then an eight-week work conditioning program and then a functional capacity evaluation. (PX 4)

On March 11, 2010, Dr. Malek reported that Petitioner was feeling excellent from a low back standpoint. He also noted that the neck pain was worsening and radiating into the scapular region and upper extremities. Dr. Malek referred Petitioner for a repeat cervical MRI which when completed on April 6, 2010 was reported to show mild to moderate right foraminal narrowing at C6-C7 secondary to a rightward predominant disk-osteophyte complex. There was mild disc bulge and endplate spurring at C5-C6 contributing to early foraminal narrowing. Also noted was reversal of the normal cervical spine lordosis which was felt to contribute to partial effacement of the anterior CSF space particularly at C5-C6. Lastly, it was reported that overall there was no advanced spinal stenosis present. (PX 4)

Petitioner commenced physical therapy for his low back at ATI on April 12, 2010. (PX 8) Petitioner testified that his low back "was fine" while going through therapy. However, his neck and knee was problematic.

Throughout his treatment with Dr. Malek, there are references regarding Petitioner's complaints of knee pain.

Consistent with Dr. Malek's referral, Petitioner saw Dr. Silver for his knee complaints on May 6, 2010. Petitioner provided a history that he injured his knee in February of 2008 "when he slipped and fell twisting and striking his right knee." Dr. Silver's records also contain a copy of the May 8, 2008 MRI of Petitioner's right knee which found a right lateral tibial contusion, but an otherwise normal MRI of the right knee. An examination revealed mild swelling and medial joint line tenderness. Dr. Silver was concerned about articular cartilage damage of the right knee. The doctor prescribed a course of therapy and anti-inflammatory medication. Dr. Silver also restricted Petitioner from work. (PX 6)

On May 10, 2010, Petitioner had his initial evaluation for knee therapy at ATI. The admitting diagnosis was right knee torn cartilage with pain. (PX 8)

Petitioner returned to Dr. Malek on May 20, 2010. Dr. Malek noted Petitioner was doing well but therapy had set his symptoms backwards. As a result, the doctor placed therapy on hold with the thought to reassess in two (2) weeks. (PX4)

At Respondent's request, Petitioner was examined by Dr. Michael Stover for an independent medical examination regarding the right knee on June 2, 2010. Dr. Stover recorded a history that Petitioner injured his low back, knee and neck two years prior when he fell on ice. Petitioner presented with complaints of an aching pain in the right knee. Petitioner reported that his knee pain had increased in intensity, especially with exercises over the last couple of months. The pain got worse with 10 to 15 minutes of walking or exercise and he had some locking in the knee. Dr. Stover assessed right knee pain. The doctor causally related the knee condition to the February 7, 2008 accident. Dr. Stover wrote, "The patient reports to me that he has had pain in his knee since the slip and fall. There is documentation of right knee pain of a April 1, 2008 note within the chart. Therefore, I believe his knee pain is work related…I think his complaints of pain are temporally related to his injury. He reports no history of pain in the knee prior to the fall at work…" Dr. Stover recommended a new MRI and a steroid injection for the knee. He also released Petitioner to light duty work. (PX 10) Respondent did not provide light duty work to Petitioner.

Petitioner returned to Dr. Malek on June 3, 2010. Dr. Malek reported that the recent cervical MRI showed evidence of two (2) disc herniations at the C5-6 and C6-7 level with reversal of the normal cervical lordosis. He also noted there was spinal stenosis at C5-6 with C6-7 right disc osteophyte complex and moderate right and early left foraminal narrowing. Dr. Malek diagnosed cervical radiculopathy bilateral with preponderance of neck pain with right sided symptoms worse that left. Dr. Malek opined that Petitioner's condition of ill-being in the cervical spine was causally related to the February 7, 2008 accident. He noted Petitioner had an underlying degenerative condition that was asymptomatic until the February 2008 accident. A cervical steroid injection was recommended. (PX 4)

Petitioner also returned to Dr. Silver on June 3, 2010. Petitioner reported an increase in his knee pain with the therapy. Dr. Silver curtailed therapy and administered a cortisone injection into the knee. The doctor noted that if no improvement was noted, surgery would be considered. He also continued Petitioner's work restrictions. (PX 6)

On June 24, 2010, Dr. Silver reported that the injection provided only mild temporary relief of the knee pain. The knee pain was severe by the time of the visit. Dr. Silver recommended an arthroscopic procedure. He also prescribed Vicodin for pain, Mobic for inflammation and Omeprazole for gastrointestinal protection. Work restrictions were continued. (PX 6)

Therapy records show that by July 2, 2010, Petitioner was reporting continuing symptoms into his low back and cervical spine which were waking him at night. (PX8) Amongst other findings, the therapist recorded Petitioner's complaints of tenderness to palpation along the cervical paraspinal muscles and bilateral upper trapezius muscles. The subsequent therapy notes reported some improvement in Petitioner's continuing cervical complaints. His lumbar complaints did not show real improvement with the therapy. (PX8)

At Respondent's request, Petitioner underwent a repeat Section 12 examination with Dr. Ghanayem on July 30, 2010. Petitioner reported that he had developed numbness in the left forearm while lifting buckets in therapy and fatigue in his right arm. Dr. Ghanayem reviewed the cervical MRI and felt same demonstrated cervical spondylosis at C5-6 and C6-7 which were degenerative disc osteophyte complexes with no evidence of any acute changes. He noted that while there was some stenosis, the cord was well maintained with no significant abnormalities. He felt Petitioner appeared to have developed some neck pain and some nerve root irritation while in physical therapy. The doctor stated that Petitioner probably over did it during therapy and should avoid the exercises. Dr. Ghanayem indicated Petitioner's cervical complaints were muscular at that time. The doctor noted that an old pain diagram which indicated Petitioner had pain over the trapezial muscle and right shoulder. He felt those were slightly different complaints than what Petitioner had after the therapy exercises. He did not believe Petitioner's cervical radiographic findings were aggravated from the work injury. He indicated that they may have been temporarily aggravated from some of the therapy activities, but according to the neurologic examination, that aggravation had resolved. The doctor recommended against additional epidural steroid injections given the lack of response to the first injection. He felt Petitioner that any work restrictions would be related to Petitioner's low back injury and not his degenerative cervical condition. (PX 10 and RX 10)

Petitioner underwent the right knee MRI on July 30, 2010. The study showed borderline, partially discoid lateral meniscus with intrasubstance mucinous degeneration without a definite discrete meniscal tear. The cruciates and collaterals were intact. There was mild, grade II chondromalacia along the inferior pole of the patella without a discrete, full-thickness cartilage defect. (PX 6)

Petitioner returned to Dr. Silver on August 6, 2010. Dr. Silver felt the MRI showed damage to the articular cartilage of the patella. Dr. Silver recommended an arthroscopic procedure indicating that all conservative measures had been exhausted. The doctor restricted Petitioner from any work pending his surgery. (PX 6) Respondent refused the surgery.

Petitioner returned to Dr. Malek on August 19, 2010. Dr. Malek noted that Dr. Ghanayem opined that Petitioner's neck condition was temporary and that it had resolved by the time of the IME examination. To the contrary, Dr. Malek noted that the injury had not resolved as Petitioner was still complaining of neck pain and the epidural steroid injection had not provided relief. Dr. Malek provided that he agreed with Dr. Ghanayem in that there was a spondylosis at C5-6 and C6-7 and it was precisely the spondylosis that pre-disposed Petitioner to the radiculopathy. The doctor stated the spondylosis was asymptomatic and became symptomatic as the result of the work injury. Dr. Malek continued to recommend a C5-C7 fusion. (PX 4)

On August 31, 2010, Dr. Stover authored a second Section 12 report after reviewing additional medical documentation which included the initial MRI scan and the scan from July 2010. Also reviewed were the records from Dr. Silver. Dr. Stover felt the recent MRI showed some degenerative changes within the meisci but no definite tears. He also noted the articular cartilage of the medial and lateral compartment appeared intact. Dr. Stover felt Petitioner sustained a knee contusion at the time of his injury. He disagreed with the surgical recommendation indicating Petitioner did not appear to have a significant amount of arthrosis based on the MRI scans; there were no loose bodies nor was there evidence of any changes in the menisci other than the degenerative changes noted. The doctor stated, "I have concerns for the benefit of arthroscopy for a diagnosis of continuing pain in the knee without any documentation findings on the MRI consistent with the physical

examination." Dr. Stover felt Petitioner was at maximum medical improvement and recommended a functional capacity evaluation. (PX 10)

On February 4, 2011, Dr. Ghanayem re-examined Petitioner. At that time, Petitioner was complaining of some neck pain and intermittent numbness in the left forearm. During the examination, Dr. Ghanayem recorded Petitioner had a good cervical range of motion and a negative foraminal compression test. According to Dr. Ghanayem, Petitioner had a condition of cervical spondylosis which was temporarily aggravated at one time with physical therapy. He felt Petitioner appeared to have had intermittent symptoms related to cervical arthritis. He did not feel Petitioner was a surgical candidate relative to any aggravation that may have occurred during physical therapy. The doctor stated Petitioner did have an aggravation which responded favorably to conservative care. The doctor provided that he would not recommend surgery, absent issues of causation, based on the medical issues. The doctor added that Petitioner remained at maximum medical improvement relative to the lumbar spine and recommended a FCE for the low back. (PX 10 and RX 10)

Petitioner was reexamined by Dr. Stover on February 9, 2011. Petitioner's right knee complaints were unchanged. Again, Dr. Stover diagnosed right knee pain. He felt Petitioner's complaints were "possibly" not intra-articular in nature. He did not think surgery was reasonable. Dr. Serrano wrote, "...I believe that any therapeutic effect of an arthroscopy would be short-lived and would not improve his long-term pain and/or function based on my review of his complaints, examination, plain radiographs and MRI...I believe Mr. Serrano may have a degree of minor arthrosis of the knee joint without significant degenerative change and/or injury to the cartilage or menisci. Therefore, I do not believe that an arthroscopy would be of benefit to the patient." Dr. Stover went on to offer an opinion that, "If Mr. Serrano has minimal arthrosis of the joint as diagnosed by examination and plain films, I do not believe that his injury sustained at work would cause an acceleration of this arthrosis, and therefore I do not believe that the injury would be linked to any need for arthroplasty in the future." Lastly, Dr. Stover felt Petitioner could return to work with some restrictions with respect to squatting, kneeling and standing. (PX 10)

On May 13, 2011, Petitioner underwent the Functional Capacity Evaluation recommended by Dr. Ghanayem. According to the evaluation, Petitioner could function at the heavy physical demand level even though his effort was inconsistent. (RX 9)

Petitioner returned to Dr. Malek on May 18, 2011. Dr. Malek noted that Petitioner experienced severe aggravation of his pain from the FCE. The doctor felt the FCE did not reflect Petitioner's capabilities as evidenced by the aggravation of his symptoms after the FCE. He noted same "certainly" could not be taken as indicating Petitioner could do heavy work four hours a day. He stated that under ideal circumstances, absent the cervical spine condition, Petitioner would be limited to a lifting capacity of 40 lbs. (PX 4)

On June 8, 2011, Dr. Malek noted that the delay in authorizing treatment had adversely affected Petitioner's potential outcome from a cervical fusion. The doctor recommended proceeding with his surgical recommendation. (PX 4)

On July 5, 2011, Dr. Malek performed the C5-6, C6-7 cervical fusion at Provena St Joseph's Hospital. (PX7) In a follow-up visit on August 17, 2011, Dr. Malek reported that Petitioner's cervical spine was excellent. Petitioner continued to complaint of low back pain from the functional capacity evaluation and also complained of continuing right knee pain. The doctor recommended the commencement of physical therapy (PX 4)

On September 21, 2011, Petitioner reported continued knee and lower back symptoms. Dr. Malek was concerned that the FCE may have aggravated the level above Petitioner's lumbar fusion causing a return of the

lower back pain. Dr. Malek ordered a repeat lumbar MRI and recommended an orthopedic evaluation for the right knee. (PX4)

The repeat MRI was carried out on September 29, 2011 revealing broad based disc bulge along with facet hypertrophic changes at L3-L4. There was no spinal canal or neuroforaminal stenosis. At L5-S1, there was a minimal broad-based disc bulge along with marked right facet hypertrophic changes. There was associated mild effacement of the right lateral recess. There was no spinal canal or neuroforaminal stenosis. A CT scan was also performed on September 29, 2011 revealing a solid fusion at L4-5, and retrolisthesis of L5 over S1. (PX 4)

Consistent with Dr. Malek's referral, Petitioner saw Dr. Ellis Nam on October 8, 2011. Petitioner provided a history of persistent right knee after falling at work in February 2008. Petitioner was complaining of swelling, catching and giving away of the right knee. Dr. Nam read the July 30, 2010 MRI as showing evidence of probable discoid lateral meniscus without obvious tearing. The doctor noted there was some edema along the prepatella bursal region with some cartilage irregularity along the trochlear surface. Upon examination, the doctor noted severe medial joint line pain; a positive McMurray's sign medially and some lateral joint line as well. Dr. Nam assessed right knee pain, rule out internal derangement and recommended an updated knee MRI. The MRI when completed on October 11, 2011 was read to show 1.) diffuse stellate tear in the anterior horn of the lateral meniscus and 2.) Grade I chondromalacia patella medial facet. (PX 9)

Petitioner returned to Dr. Nam on October 15, 2011to discuss the updated MRI. Dr. Nam provided that the official report noted a stellate tear in the anterior horn of the lateral meniscus. Dr. Nam was not sure he saw obvious meniscal tearing on the scan. He indicated the cartilage surface appeared to be grossly intact. He also stated the cruciate and collateral ligaments appeared to be grossly intact. His impression was possible right knee anterior horn tear and the lateral meniscus with persistent pain. Dr. Nam thought there might be a need for an arthroscopic procedure. However, he wanted to see how a cortisone injection worked before making that recommendation. (PX 9)

At the request of Dr. Malek, Petitioner underwent an EMG/NCV on October 17, 2011. At his office visit on October 19, 2011, Dr. Malek indicated the EMG/NCV found mild right L4, L5 and S1 radiculopathy. Dr. Malek offered transforaminal injections on the right side at L4-5 and L5-S1. (PX4) These injections provided partial relief of Petitioner's complaints as reported in Dr. Malek's November 30, 2011 note. (PX4)

Petitioner returned to Dr. Nam on December 3, 2011, reporting no significant improvement in his knee pain with the cortisone injection. (PX9) Petitioner also reported that he was not able to live with the knee pain and wanted to proceed with diagnostic arthroscopy. Dr. Nam wrote, "He understands that I do not see any definitive pathology. He would like to proceed. We will thus plan on proceeding with right knee diagnostic arthroscopy with possible meniscectomy and chondroplasty." (PX 9) Petitioner testified that Respondent would not authorize the procedure.

Petitioner returned to Dr. Malek on December 7, 2011. Dr. Malek noted the CT scan of September 2011 showed next level disease at L3-4. He also indicated the recent lumbar MRI showed desiccation at L3-4. Dr. Malek recommended discography at L3-4 with control and a post discogram CT scan. The discogram was done on December 9, 2011 revealing that the primary pain generator was now at L3-4 level with no contribution at L2-3. The CT scan showed grade IV tears in the discs at L2-3 and L3-4. (PX 4)

On Decmber 21, 2011, Dr. Malek noted the results of the discogram and CT scan. He felt that L3-4 was wearing out and that the pain was related to that level. A discussion was held regarding the possibility of an exploration L4-5 fusion with extension to L3-4. On Decemeber 23, 2011, Petitioner reported that his main

problem was cramping in the lower extremity. Dr. Malek recommended a course of Baclofen prior to surgery. Dr. Malek also recommended 6 to 8 weeks of therapy, followed by work hardening and a repeat FCE. (PX4)

Petitioner was reevaluated by Dr. Ghanayem on March 1, 2012. Petitioner reported ongoing low back pain. He also reported referral pain into the right leg. Upon examination, Dr. Ghanayem noted some tenderness in the lumbar base. Petitioner's range of motion was 20 degrees of extension and 30 degrees of lumbar flexion. His lower extremity exam revealed no focal motor deficits. Tension signs were negative for radicular pain until his knee was in full extension. Then he had some pain over the fibular head on the right side. Dr. Ghanayem provided that he reviewed the update MRI scan which he felt revealed some disc degeneration at L3-4 and L2-3, and facet arthritis at L5-S1. The doctor reviewed the discogram results noting same was felt to be positive at L3-4 and negative at L2-3. He also indicated the CT scan demonstrated a solid fusion at L4-5. He noted there was facet joint arthritis at L5-S1 as seen on the CT scan and degenerative changes in the lumbar spine which were not severe. Dr. Ghanayem's impression was ongoing low back pain. He indicated that the retrolisthesis at L5-S1 is a component of degenerative arthritis at that level. He stated that as the L5-S1 disc space narrows, a retrolisthesis develops at that level. He provided that Petitioner had arthritis radiographically at L5-S1 and degenerative changes at L3-4. Also noted was that there was no neurologic compression. Dr. Ghanayem added that the symptoms reported at the lateral aspect of the calf on the right side was not a L3-4 distribution and that he saw noting that gave Petitioner radiculopathy on the MRI or CT scans. (PX 10 and RX 10)

With respect to the FCE performed in May 2011, Dr. Ghanayem stated, "One cannot fraction out the cervical and lumbar issues on an FCE; it tests the body in total…" The doctor noted Petitioner graded out at a heavy demand level with an inconsistent effort. He felt Petitioner was at maximum medical improvement and could return to work consistent with the FCE findings. Lastly, Dr. Ghanayem stated, "The patient has a solid fusion at L4-5 and does not need that fusion explored. There is no evidence of any technical failure of the fusion or pseudarthrosis. Extending his fusion up to the L3-4 level is not medically indicated." (PX 10 and RX 10)

Records submitted show Petitioner last saw Dr. Malek on April 23, 2012. Petitioner complained of discomfort in the back and cramps at night. Dr. Malek noted Petitioner was not taking his medications and his condition was stable. Surgery was deferred. Petitioner also reported difficulty raising himself from a kneeling position which the doctor felt would be expected given Petitioner's prior history and delay in surgery. Dr. Malek again recommended 6 to 8 weeks of therapy, followed by work hardening and a repeat FCE. He renewed the prescription for Baclofen and restricted Petitioner to sedentary duty with permanent weight restrictions of 10 lbs of lifting. (PX 3)

With respect to issue F- Is Petitioner's Current Condition of Ill-Being Causally Related To The Injury, the Arbitrator finds as follows:

Lumbar Injury

The Arbitrator finds that a causal relationship exists between the accident sustained on February 7, 2008 and Petitioner's lumbar spine injury and the resulting surgery. The Arbitrator relies on the timeline of symptoms following the accident, the course of treatment and the testimony of both Drs. Malek and Ghanayem.

Dr. Michel Malek,a board certified neurosurgeon, testified via deposition in this matter. He first saw Petitioner on May 7, 2008. Petitioner reported falling twice on ice on February 7, 2008, landing on his buttocks and hitting the back of his head in the second fall. Petitioner felt jarred the day of the accident but did not have intense pain. By the next morning, Petitioner felt pain in his neck radiating into the upper extremity on the right side associated with numbness. He also had low back pain with pain radiating down both lower extremities, worse on the right side. Petitioner also complained of right knee pain, but he had not been evaluated by an

orthopedic doctor for the knee. (PX 1, p.5) Dr. Malek was not able to reproduce Petitioner's radiculopathy through his examination. (PX 1, p.29) Dr. Malek diagnosed the lumbar injury as lumbar radiculopathy with a preponderance of back pain. (PX 1, p.6) The EMG/NCV showed L5-S1 radiculopathy on the left side. (PX 1, p.6) The April 2, 2008 lumbar MRI showed evidence of an annular tear at L4-5. (PX 1, p.7) Dr. Malek recommended epidural steroid injections for Petitioner as of the May 7, 2008 visit, but only if Petitioner could stop using the blood thinner. (PX 1, p.26)

Dr. Malek noted that Petitioner's examination by June 4, 2009 was pretty much the same as his examination in 2008. (PX 1, p.25, 31) By that time, Petitioner had already undergone a discogram by Dr. Pareja to assess whether any particular disc was a pain generating disc. (PX 1, p.7) The discogram reproduced concordant pain at the L4-5 level. (PX 1, p.7-8) The post-discogram CT scan showed grade IV annular tears at L3-4 and L4-5 levels and a small midline disc protrusion at L4-5. (PX 1, p.8) Based on the results of testing, Dr. Malek recommended a bilateral L4-5 laminectomy, discectomy, posterior segmental interfixation with interbody fusion, using an open approach. (PX 1, p.8) Dr. Malek explained that surgery was warranted as conservative treatment had failed and Petitioner was unwilling to live with the level of symptoms he was experiencing. A fusion was needed as Mr. Serrano's problem was mechanical in addition to compressive. (PX 1, p.9) Dr. Malek decided that a single level required fusion rather than two levels. Petitioner had mechanical instability at L4-5 and his symptoms and EMG/NCV findings were consistent with that distribution. (PX 1, p.10) The intraoperative findings also suggested that the L4-5 level was likely the source of the majority of the problem. As a result, there was no need to extend the fusion to an additional level. (PX 1, p.11)

Petitioner initially did well after the fusion. (PX 1, p.11) Dr. Malek reexamined Petitioner on February 11, 2010 following the surgery. Petitioner reported that his preoperative symptoms had resolved and Dr. Malek reported that Petitioner was doing excellent. (PX 1, p.32-33) Dr. Malek recommended therapy, work conditioning and eventually a functional capacity evaluation. (PX 1, p.33) By September 16, 2010, Dr. Malek thought Petitioner had reached MMI for the back and he was not expecting additional treatment. (PX 1, p.35) Petitioner transitioned into a home exercise program. (PX 1, p.36)

A functional capacity evaluation was performed on March 14, 2011 which increased Petitioner's lower back pain. (PX 1, p.40-41) A repeat MRI on September 21, 2011 showed dessication at the L3-4 and L5-S1 levels with retrolisthesis at L5 on S1. (PX 1, p.12) Petitioner underwent a repeat discogram which revealed L3-4 as the pain generator. (PX 1, p.12) Dr. Malek recommended extension of the fusion to the L3-4 level. (PX 1, p.12) Dr. Malek explained that Petitioner had all indications for that surgery. (PX 1, p.12) Petitioner decided to defer surgery. (PX 1, p.13) By April 23, 2012, Dr. Malek noted that Petitioner appeared to be stable with respect to his lumbar spine, but he had a residual cramp in his lower extremity. (PX 1, p.13) At that point, Dr. Malek released Petitioner to work with a permanent lift restriction of 10 lbs indicating the work restrictions were reasonable necessary to contend with the symptoms Petitioner was having from his work accident. (PX 1, p.17) Dr. Malek felt that Petitioner's pre-existing degenerative spine condition became symptomatic as a result of the February 7, 2008 accident resulting in the need for treatment he provided. (PX 1, p.14) Dr. Malek also related the need for the fusion extension to the original surgery, through a phenomenon known as next level disease. (PX 1, p.15) Dr. Malek explained that when a level is fused, the stresses borne by that level are redistributed to adjacent spinal levels and primarily the level above the fusion. (PX 1, p.16) By the time of the deposition, Petitioner had deferred the additional fusion.

At Respondent's request, Petitioner saw Dr. Alexander Ghanayem for a Section 12 examination on October 29, 2009. Dr. Ghanayem testified via deposition. Dr. Ghanayem testified that the examination was focused on the back, although Petitioner complained of some discomfort in the back of the neck and into the right shoulder blade. (RX 10, p.7) The MRI revealed a central disc herniation at L4-5. Dr. Ghanayem thought surgery was a reasonable recommendation. (RX 10, p.8) He also recommended work restrictions in the 10 to 15 lbs range along with restrictions against bending and stooping. (RX10, p.8-9) Dr. Ghanayem examined

Petitioner again on July 30, 2010. (RX10, p.9) Petitioner had undergone surgery by that time and had progressed from water therapy to land therapy. (RX 10, p.10) Dr. Ghanayem agreed that the February 7, 2008 accident resulted in the lumbar injury and the need for the fusion. (RX 10, p.18) However, Dr. Ghanayem cautioned against extending the fusion to an adjacent level, noting that same would be sending the stresses of a two level fusion up into upper spinal levels which are already arthritic. (RX 10, p.42-43) Dr. Ghanayem thought that Petitioner would have to live with the condition and his low back pain would not go away. (RX 10, p.43)

Respondent also requested Petitioner undergo a Section 12 examination with Dr. Kern Singh on June 4, 2008. The doctor also testified via deposition in this matter. Dr. Singh felt that Petitioner's complaints were out of proportion to his examination findings and the MRI results. Dr. Singh diagnosed the injury as involving cervicomuscular strain, lumbar muscular strain and degenerative disc disease at C5-6 and C6-7. (RX 11, p.15) Dr. Singh did not believe Petitioner required additional treatment or work restrictions. He also felt there was symptom magnification on examination. (RX 11, p.19) The Arbitrator is not persuaded by the opinions of Dr. Singh. Dr. Singh thought that the injury caused strains, which would have resolved within six weeks of the accident. (RX 11, p.21-22) Petitioner's complaints were still present at the time of his evaluation four months after the accident and the complaints continued until surgery was performed years later. It is apparent that Dr. Singh felt Petitioner's condition was less severe than what was ultimately diagnosed and treated. He did not have the benefit of reviewing the years of treatment as did the surgeon and Respondent's second examiner. The treating surgeon and Dr. Ghanayem offered their pro-causation opinions after reviewing all the medical treatment which took place during the years preceding their evaluations.

Cervical Injury

Petitioner has also proven a causal relationship between the February 7, 2008 accident and injury to his cervical spine, further resulting in cervical surgery. Causation is supported by the timeline of symptoms following the accident, the course of treatment, the testimony of Dr. Malek and the success of the surgery.

Dr. Malek recorded cervical spine injuries at his original visit. (PX 1, p.18) Petitioner had bilateral cervical radiculopathy with a preponderance of neck pain. (PX 1, p.18) Dr. Malek noted that Petitioner's cervical spine had also failed to respond to conservative treatment. (PX 1, p.18-19) A May 2, 2008 MRI showed reversal of normal cervical lordosis with disc artifact complex, especially at C5-6 and C6-7, but also at C3-4 with spinal stenosis. (PX 1, p.19) On July 5, 2011, Petitioner underwent a fusion at C5-6 and C6-7 and Petitioner reported an excellent response with the surgery. (PX 1, p.19) Dr. Malek explained that the light duty restrictions were also required for the cervical injury, as well as for activities involving excessive bending, twisting, arching of the neck, working in hazardous environments such as stocking shelves, looking up and looking down, working in a vibratory environment. (PX 1, p.20) Dr. Malek also felt Petitioner's pre-existing degenerative condition in the cervical spine became symptomatic as a result of the February 7, 2008 accident resulting in the need for the surgery he performed. (PX 1, p.21) Petitioner's prognosis for the cervical spine was excellent, although he had 20% limitation in his cervical flexion and extension. (PX 1, p.23-24)

As noted above, Dr. Ghanayem examined Petitioner again on July 30, 2010. (RX 10, p.9) Petitioner had undergone surgery by that time and had progressed from water therapy to land therapy. Dr. Ghanayem noted Petitioner's history of onset of numbness into the left forearm while lifting buckets of water in therapy. Dr. Ghanayem described the numbness as non-radicular. (RX10 p.10) Dr. Ghanayem's examination at the July 30, 2010 visit revealed muscular discomfort in the right side of his trapezial and levator scapula muscles. Petitioner's cervical range of motion was good and Petitioner had a negative compression finding and Lhermitte's sign. (RX 10, p.11) The remainder of Petitioner's examination was unremarkable. (RX10 p.12) Dr. Ghanayem also read the cervical MRI as showing a degenerative disc osteophyte complex with nothing acute going on. (RX 10, p.13) Dr. Ghanayem felt Petitioner overdid it in therapy and he developed some neck

pain and nerve irritation while in therapy. (RX 10, p.14) Dr. Ghanayem felt Petitioner irritated his degenerative process during therapy but that such aggravation was temporary. (RX 10, p.14) Dr. Ghanayem also noted Petitioner had right sided cervical complaints from the initial accident and he aggravated the condition with the therapy. (RX 10, p.15) He did not think it was a permanent problem, nor a surgical problem. (RX 10, p.15)

Respondent again sent Petitioner to Ghanayem on February 4, 2011 for another cervical exam. Dr. Ghanayem felt that the aggravation from therapy had resolved. While petitioner had underlying cervical arthritis, it was a nonsurgical matter. (RX 10, p.17) Dr. Ghanayem did not believe the cervical problem as of February 4, 2011 was related to either the therapy or the original accident. (RX 10, p.17-18) On cross, Dr. Ghanayem admitted that there was no evidence that Petitioner had problems with his cervical spine prior to the accident. (RX 10, p.28) He also admitted that Petitioner injured his neck in the February 7, 2008 accident, stating it was an aggravation there. (RX 10, p.26) That injury resulted in an irritation of the nerve root feeding the neck muscles or a direct injury to the muscles. (RX 10, p.26) Dr. Ghanayem admitted that Petitioner also reinjured that area while lifting buckets in therapy. (RX 10, p.27) At that time, Petitioner reported fatigue in his right arm during the exercise and he had neck discomfort. (RX 10, p.27)

Petitioner was reporting minimal neck discomfort by Dr. Ghanayem's examination on July 30, 2010. Dr. Ghanayem also recommended an FCE which was performed in May of 2011. Dr. Ghanayem did not know whether Petitioner further injured his neck during that FCE. (RX 10, p.28-29) Dr. Ghanayem was also not aware of Petitioner's response to the cervical fusion. (RX 10, p.31) He did not know whether Petitioner's complaints resolved with the procedure. (RX 10, p.31) Dr. Ghanayem also disputed whether Petitioner was having radiation of pain from the cervical spine. However, he did not dispute that Dr. Malek thought Petitioner was having bilateral arm radiculopathy. (RX10 p.34-35)

In conclusion, based on the timeline of symptoms following the accident, the course of treatment, the testimony of Dr. Malek and and the successful surgery, the Arbitrator finds that a causal relationship exists between Petitioner's cervical condition of ill-being and the accident sustained on February 7, 2008.

Right Knee

The Arbitrator finds that Petitioner has also proven a causal relationship between the February 7, 2008 accident and the condition of ill-being in the right knee. Petitioner's unrebutted testimony show that his knee pain appeared at the time of the accident and persisted through the time of the hearing. Drs. Silver, Nam and Stover all causally related the knee injury to the February 7, 2008 accident. The central dispute over the knee is whether surgery is appropriate for the knee.

On March 5, 2008, Petitioner saw Dr. Jose Castellanos with complaints of low back pain that radiate into the right thigh. Dr. Castellanos assessed lumbosacral pain with radiculopathy. The doctor referred Petitioner to pain management and recommended an EMG/NCV. Petitioner underwent the EMG/NCV on April 1, 2008. Amongst other complaints, the presenting complaints noted on the report was pain in right knee.

On May 7, 2008, Petitioner reported to Dr. Michel Malek, an orthopedic surgeon. Dr. Malek recorded a history of neck pain radiating down right upper extremity associated with numbness after the accident. Petitioner also reported low back pain with pain down both lower extremities as well as knee pain. Dr. Malek diagnosed cervical radiculopathy, lumbar radiculopathy and knee pain. Dr. Malek recommended an orthopedic evaluation for the right knee noting had not had an orthopedic evaluation for his knee. (PX 1, p.5 and PX 4)

On May 8, 2008, Petitioner underwent a left knee MRI revealing a lateral tibial contusion. (PX 6)

Throughout his treatment with Dr. Malek, there are references regarding Petitioner's complaints of knee pain. The Arbitrator notes that during the Section 12 examination with Dr. Alexander Ghanayem on October 29, 2009 Petitioner also complained of a knee injury. Consistent with Dr. Malek's referral, Petitioner saw Dr. Silver for his knee complaints on May 6, 2010. Examination revealed mild swelling and medial joint line tenderness. Dr. Silver suspected articular cartilage damage of the right knee for which he prescribed a course of therapy and anti-inflammatory medication. Dr. Silver also restricted Petitioner from work. (PX 6) On May 10, 2010, Petitioner had his initial evaluation for knee therapy at ATI. (PX8) A thorough examination was performed and the admitting diagnosis was right knee torn cartilage with pain. At Respondent's request, Petitioner was examined by Dr. Michael Stover for an independent medical examination regarding the right knee on June 2, 2010. Dr. Stover recorded a history that Petitioner injured his low back, knee and neck two years prior when he fell on ice. Petitioner presented with complaints of an aching pain in the right knee. Petitioner reported that his knee pain had increased in intensity, especially with exercises over the last couple of months. Dr. Stover assessed right knee pain. The doctor causally related the knee condition to the February 7, 2008 accident. Dr. Stover wrote, "The patient reports to me that he has had pain in his knee since the slip and fall. There is documentation of right knee pain of a April 1, 2008 note within the chart. Therefore, I believe his knee pain is work related...I think his complaints of pain are temporally related to his injury. He reports no history of pain in the knee prior to the fall at work..." Dr. Stover recommended a new MRI and a steroid injection for the knee. He also released Petitioner to light duty work.

On July 30, 2010 a right knee MRI was performed. Dr. Silver read the MRI as showing damage to the articular cartilage of the patella. (PX 6- 8/6/10 note) Dr. Silver recommended an arthroscopic procedure and restricted Petitioner from any work pending his surgery. On August 31, 2010, Dr. Stover again related the knee contusion to the accident but he disagreed with the surgical recommendation. He also clarified that the injury was a contusion from the accident and that he had no pre-existing problem in the knee. He thought that Petitioner should go for a functional capacity evaluation. Dr. Stover's follow-up examination took place on February 9, 2011. At this visit, Dr. Stover explained that relief from a scope procedure would be temporary at best. When asked whether Petitioner's injury was intra-articular in nature, he stated "possibly". In any event, he did not believe a scope procedure would provide lasting relief for the injury. He also felt Petitioner should be released to work with restrictions against squatting, kneeling and standing.

Petitioner underwent a FCE on March 13, 2011. Post FCE, Petitioner saw Dr. Malek who noted that Petitioner experienced severe aggravation of his pain from the FCE. (PX4) During the interim, Petitioner underwent the cervical fusion on July 5, 2011. (PX7) Petitioner obtained significant relief of his cervical complaints with the surgery, although he reported continuing back and knee pain. (PX4- 8/17/11 note)

Dr. Malek then referred Petitioner to Dr. Nam to address the continuing knee complaints. Petitioner saw Dr. Nam on October 8, 2011. (PX9) Dr. Nam read the July 30, 2010 MRI as showing a probable discoid lateral meniscus without obvious tearing. (PX9) He did note edema along the prepatellar bursal region with some cartilage irregularity along the trochlear surface. Dr. Nam recommended an updated MRI of the knee. That MRI was done and Petitioner returned to Nam on October 15, 2011 to review the new MRI. The official report noted a stellate tear in the anterior horn of the lateral meniscus. However, Dr. Nam was not sure he saw obvious meniscal tearing on the scan. His impression was possible right knee anterior horn tear and the lateral meniscus with persistent pain. (PX9) Dr. Nam thought there might be a need for an arthroscopic procedure. However, he wanted to see how a cortisone injection worked before making that recommendation. That injection was done.

Petitioner returned to Dr. Nam again on December 3, 2011, reporting no significant improvement in his knee pain with the cortisone injection. (PX9) Petitioner also reported that he was not able to live with the knee pain was having. Dr. Nam noted that although he informed Petitioner he did not see any definitive pathology, the doctor recommended a right knee diagnostic arthroscopy with possible meniscectomy and chondroplasty.

Based on all the above, the Arbitrator finds that a causal relationship exists between Petitioner's right knee condition of ill-being and the accident sustained.

With respect to issue J- Were The Medical Services That Were Provided To Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges For All Reasonable And Necessary Medical Services, the Arbitrator finds as follows:

Having found that a causal relationship exists regarding Petitioner's lumbar, cervical and right knee conditions of ill-being, the Arbitrator finds Respondent is liable for the following charges: Dr. Gerald Reed's bill in the amount of $ 19,911.00. (PX3); Michel Malek MD for $ 127,364.00 (PX4); Illinois Bone & Joint (Ronald Silver MD) for $ 1,086.24 (PX6); Provena Saint Josephs Medical Center for $ 98,340.03; Chicago Orthopaedic & Sports Medicine (Dr. Nam) for $ 898.00; ATI for $ 582.48 (PX8); Midwest Hospitalists LLC (Dr. Venkataraman) for $ 609.00 (PX11) and Instant Care Medical Group in the amount of $1,125.00 (PX11).

To the extent that any of the bills were paid by group insurance, Respondent shall hold Petitioner harmless from demands for reimbursement by the group carriers.

With respect to issue K- Is Petitioner Entitled To Any Prospective Medical Care, the Arbitrator finds as follows:

At the time of hearing, Petitioner outlined all the persisting limitations and complaints he had in the right knee. Petitioner still wished to have the surgery recommended by Drs. Silver and Nam, a right knee diagnostic arthroscopy with possible meniscectomy and chondroplasty. While Dr. Stover disagreed with a surgical prescription, he conceded that Petitioner might obtain some relief from a surgery, although he thought the relief would be temporary. There is an agreement on the course of treatment between the two treating physicians and a disagreement by the Section 12 examiner. The Arbitrator relies on the opinions of Petitioner's treating physicians and finds Respondent shall authorize the prescribed surgery.

With respect to issue L- What Temporary Total Disability Benefits Are Owed, the Arbitrator finds as follows:

Petitioner returned to work for several days following his accident. By February 12, 2008, he was admitted to Provena Mercy Center through February 14, 2008. (PX2) Petitioner was released from that facility with recommendations for bed rest, therapy and pain management. Petitioner next started treating with Dr. Reed on February 27, 2008 who continued the restriction from work while Dr. Reed worked up the lumbar, cervical and injuries. (PX3) Thereafter, Petitioner came under the care of Dr. Malek who kept him restricted until treatment came to a halt on April 23, 2012. By this point, Petitioner deferred additional surgery, and Dr. Malek released Petitioner with permanent sedentary restrictions with lifting restricted to less than 10 lbs. In all, Petitioner was restricted from work and was working from February 12, 2008 through the date of the hearing on February 6, 2013. Given the findings on causation, Petitioner was temporarily and totally disabled from February 12, 2008 through February 6, 2013.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JEFFREY KILPATRICK,

Petitioner,

15IWCC0124

vs.

NO: 13 WC 9466

LABOR READY,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent disability, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 24, 2014, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 1 1 2015
o1/28/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Daniel R. Donohoo

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

15IWCC0126

KILPATRICK, JEFFREY Case# **13WC009466**

Employee/Petitioner

LABOR READY

Employer/Respondent

On 7/24/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4342 REHN & SKINNER LLC
JOHN REHN
5 E SIMMONS ST
GALESBURG, IL 61401

2593 GANAN & SHAPIRO PC
JESSICA BELL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

15IWCC0126

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

- [ ] 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)

Jeffrey Kilpatrick
Employee/Petitioner

v.

Labor Ready
Employer/Respondent

Case # **13** WC **9466**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas McCarthy, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on June 25, 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. [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. [x] Other **Approval of Prospective Medical Treatment**

FINDINGS

On the date of accident, **01/21/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**7,779.72**; the average weekly wage was $**149.61**.

On the date of accident, Petitioner was **49** years of age, *single* with **0** dependent children.

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

Respondent shall be given a credit of $6,819.70 for TTD.

ORDER

Respondent shall pay Petitioner total disability benefits of $149.61 per week for 59 1/7 weeks commencing May 8, 2013, through June 25, 2014, as provided in Section 8(b) of this Act. Respondent shall receive credit in the amount previously paid, referenced above.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of all medical bills related to the January 21, 2013 accident up through July 11, 2013 pursuant to the stipulation of the parties and also to pay OSF Healthcare for bills of the OSF Galesburg Clinic for treatment on October 1, 2013 in the amount of $347.00 and treatment on the date of February 21, 2014 in the amount of $128.00, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's request for authorization for the surgery proposed by Dr. Potaczek is denied as not being reasonably necessary to cure or relieve the Petitioner from the effects of his accidental injuries.

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.

D. Dylan McCarthy
Signature of Arbitrator

July 15, 2014
Date

ICArbDec19(b)

JUL 24 2014

FINDINGS OF FACT

On January 21, 2013 Petitioner was employed as a temporary laborer for Respondent. On January 21, 2013 Petitioner had been assigned to a job at the Peoria Civic Center where Petitioner was washing dishes. As part of his dishwashing duties he was standing on a raised floor mat that was approximately one inch above the level of the surrounding floor. While washing the dishes he stepped partially off the mat and twisted his knee while rotating his body. He felt pain in his knee immediately but continued to work for 30-45 minutes before his employer took him to Proctor First Care in Peoria, Illinois.

Proctor First Care notes from January 21, 2013 reflect that Petitioner came to the office with left knee pain after twisting it while working. The visit notes state that the Petitioner had heard a noise in the knee followed by pain [Petitioner's Exhibit 5 (herein "PX") page 126]. The Prompt Care records further reflect that the knee had a symptom of the feeling of locking and of giving way (PX 5 page 127). The doctor diagnosed knee effusion noting that Petitioner may need a MRI and ordered a re-check at the end of the week (PX 5 page 128). Petitioner was released to return to work with a sedentary restriction (PX 5 page 125).

Kilpatrick returned to Proctor First Care on January 24, 2013 with ongoing complaints of knee pain. Petitioner indicated his knee was locking and he continued to have the sensation of his knee giving away (PX 5 page 122-123). The doctor ordered an MRI and continued to place him on sedentary work. The records from January 31, 2013 at Proctor First Care showed that Kilpatrick continued to have weakness with weight bearing while walking and a sensation of giving away with the knee (PX 5 page 118-119). The Proctor First Care doctor wanted to refer Kilpatrick to an orthopedic doctor and continued to keep Kilpatrick on a restriction of sedentary duty only.

On February 12, 2013 Kilpatrick presented to OSF Galesburg Clinic in Galesburg, Illinois at the office of Dr. Steven Potaczek. February 12, 2013 medical records from the Galesburg Clinic note that Kilpatrick injured his knee at work when he twisted the knee as he stepped off of the mat washing dishes (PX 3 page 60). The records also reflect that Kilpatrick had issues with walking and felt like his knee would give out (PX 3 page 60). On February 14, 2013, Petitioner saw Dr. Potaczek who reviewed the MRI. The doctor's records reflect that the MRI showed edema along with a bruised femur and hemarthrosis. The doctor noted mild arthritic changes in the knee and the doctor diagnosed an occult fracture of the left knee with hemarthrosis and drained the knee of fluid (PX 3 page 60). Potaczek kept Kilpatrick off work because Kilpatrick could not bear weight and issued crutches (PX 3 page 60). The doctor also ordered Naproxen for Kilpatrick (PX 3 page 61).

Kilpatrick continued to treat with Dr. Potaczek through March and April of 2013 during which time the doctor prescribed Tramadol and Medral Dosebak. Kilpatrick continued to have problems with pain in the knee and the sensation of his knee giving out (see doctor's note from April 23, 2013 at PX 3 page 79). As of April 16, 2013, Dr. Potaczek was indicating that diagnostic arthroscopy would be appropriate (PX 3 page 80).

In February 21, 2013, Petitioner was seen by Dr. Jerome Kraft for an IME scheduled by Respondent. Kraft found that Petitioner had an acute injury superimposed on a chronic pre-existing knee condition and that the cause effect relationship appears to have been established for Kilpatrick's injuries [see page 8 of Respondent's Exhibit (RX) 1]. On May 2, 2013, Jerome Kraft issued a supplemental report after reviewing the additional records from Dr. Potaczek. At that time, Kraft felt that diagnostic

arthroscopy would be appropriate and that the surgery was related to Kilpatrick's work injury on January 21, 2013 (RX 2 page 4).

On March 8, 2013, Dr. Potaczek performed surgery on Petitioner's knee at OSF St. Mary Medical Center. The surgical report shows a post operative diagnosis of a left knee loose body medial meniscus tear and synovitis (PX 4, page 100). The surgical report also noted that the lateral compartment of Kilpatrick's knee was "pristine" (PX 4 page 101).

On May 10, 2013 Kilpatrick had his first post op visit and the records reflect that he was still having pain, popping in the knee but he could bear a small amount of weight. Kilpatrick was referred to physical therapy. Initial notes at Azer Physical Therapy from May 13, 2013 record that Petitioner had a hard time going from sit to stand and toileting (PX 2 page 40). The records also noted that he had significant decrease in weight bearing on his left lower extremity but he required use of furniture with walking revealing severe left antalgic gait (PX 2 page 41). The impression section of the physical therapy intake notes show that Petitioner had decreased standing balance and increased pain with difficulty performing activities of daily living (PX 2 page 41). Petitioner returned to physical therapy on May 14, 2013 and notes from that visit show that Petitioner was asking as to when the weak feeling would go away (PX 2 page 39). On May 23, 2013 the physical therapy notes from Azer Clinic note that Petitioner still had issues with his knee giving out (PX 2 page 36). A note from Azer Clinic on May 28, 2013 notes that Petitioner thought something was wrong with his knee due to the swelling and a time when Petitioner was squatting down on the toilet when his knee collapsed inward (PX 2 page 35).

A June 4, 2013 visit note from Dr. Potaczek's office shows that on May 20, 2013, Petitioner was in the bathroom when as he got up and Petitioner's left knee rotated and he felt a sharp pain (PX 2 page 77). Azer physical therapy records from June 3, 2013 show obvious left quad weakness revealing shaking of the upper thigh with quad contraction (PX 2 page 31). Physical therapy records from June 5, 2013 show that the patient continued to benefit from exercises to strengthen the muscles around the hip and knee and to continue to progress balance exercises (PX 2 page 30). Azer records from June 7, 2013 show that Petitioner felt discomfort with walking (Petitioner's Exhibit 2 page 28). Physical therapy records from June 12, 2013 show that Petitioner would continue to benefit from physical therapy addressing left knee pain and deficits in strength and function of the knee (PX 2 page 26). On June 13, 2013 a record from the orthopedic surgeon notes that Petitioner was still wearing the brace and using crutches and he had swelling and pain in the knee (PX 3 page 75-76).

A note from Potaczek on June 18, 2013 shows that Potaczek considered another MRI because of the set back Petitioner experienced when he was going to the bathroom (PX 3 page 75). June 19, 2013 records from the physical therapist show continuing pain in the left knee along with hip extension weakness and left hamstring weakness (PX 2 page 23). The nurse's note from Dr. Potaczek on June 20, 2013 reflects that Petitioner still had discomfort of the knee with walking (PX 3 page 75). A June 28, 2013 Azer physical therapy record noted that Petitioner showed considerable favoring of the leg during weight bearing tasks such as walking and noted that Petitioner had the sensation as though fluid was building up beneath the knee (PX 2 page 20).

On July 9, 2013, Petitioner returned to Potaczek at which time Potaczek noted that Petitioner was having trouble with his left knee (PX 2 page 73). On July 9, 2013 Potaczek ordered another MRI for the knee noting that Petitioner aggravated the knee when he was home getting off the toilet (PX 2 page 73). A nurse's note from the Galesburg Clinic on July 19, 2013 notes that Petitioner was at the doctor for the results of the MRI. This note also shows that the Petitioner fell last week, tripped over stuff in garage

and his knee was still sore (PX 2 page 72). This quote from the nurse appears to be the basis for Respondent's denial of the request for surgery. Respondent concedes that Petitioner was hurt at work and the first surgery was related. However, Respondent seems to suggest that a fall in the garage was not related to the work injury.

At trial, Kilpatrick testified that his knee gave out on him when he was walking in the garage. The medical records as detailed above confirm, that after the time of the accident at work in January and continuously through July 2013, Kilpatrick had difficulty with swelling in the knee, loss of strength in the leg and the sensation of his leg and knee giving out. The knee gave out when the 6'6" Petitioner got off of the toilet and Respondent concedes that this giving out and pain was related to the knee surgery which was related to the work injury. Respondent's argument that the knee giving out in the garage is not related to the surgery is undermined by the extensive medical records showing problems with the knee and the testimony of the doctor's discussed below.

Currently, the Petitioner continues to seek treatment fromDr. Potaczek who has requested surgical intervention on the knee which is the subject of the present hearing.

TESTIMONY OF DR. STEVEN POTACZEK – MAY 27, 2014

On May 27, 2014, Dr. Potaczek was deposed by the parties in this case. Dr. Potaczek testified that Kilpatrick came to him on February 12, 2013 and at that time Kilpatrick related his knee injury to stepping off a mat and twisting and popping his knee while at work (PX 1 page 1-2). Petitioner presented to Dr. Potaczek with stiffness and swelling and indicated that he had a feeling his knee would give out (PX 1 page 2). Dr.Potaczek on the day of the initial visit drained blood out of Kilpatrick's knee which he explained was obviously significant for trauma (PX 1 page 2). Dr. Potaczek then gave Petitioner a shot of Novocain and steroid to give Petitioner pain relief (PX 1 page 2). Dr. Potaczek diagnosed Hemarthrosis or blood in the joint (PX 1 page 2). The doctor also reviewed the MRI on the date of the initial injury and indicated that the MRI showed definite bone bruising consistent with injury and noted that Kilpatrick pinched something off in the knee because the knee had blood in it (PX 1 page 2).

Dr. Potaczek had Petitioner come back in a month and held him off of work (PX 1 page 2). He saw him again on March 12, 2013. At that time, Dr. Potaczek told Kilpatrick to keep going to therapy and noted that Kilpatrick had an occult fracture of the knee (PX 1 page 2). The doctor explained that the occult fracture caused Kilpatrick to have pain and also required Kilpatrick to use crutches. Petitioner saw Dr. Potaczek on April 23, 2013 and was complaining about the knee giving out (PX 1 page 3). Dr. Potaczek explained that there would be multiple reasons why a person would feel like their knee was giving out including pain which causes a person's knee to give out or mechanical problems where a ligament could be ruptured or strained (PX 1 page 3).

Dr. Potaczek performed surgery on May 8 2013 (PX 1 page 3). During surgery the doctor found inflammation in the knee with breakdown on the interior (medial) side of the knee and a torn meniscus which was trimmed and taken care of (PX 1 page 3). The doctor also found multiple loose bodies which was cartilage that was flaked off at the end of the bone and congealed together which can cause a patient to have a knee give or lock (PX 1 page 3). Kilpatrick then returned to the doctor's office on May 17, 2014 and was provided a brace to keep his leg from giving out (PX 1 page 4).

When asked about whether Kilpatrick's fall in the garage was related to the initial work injury, Dr. Potaczek explained that Kilpatrick had arthritis in his knee and then he had an acute event where they tore the

meniscus and then when you remove the meniscus the arthritis flares up and then a person just has pain until you have to go to the next level of treatment (PX 1 page 5).

Dr. Potaczek noted that Kilpatrick had arthritis in his knee and explained that the arthritis can be aggravated by a trauma and made worse by partial removal of the cartilage such as the procedure performed in May on Kilpatrick (PX 1 page 9). Dr. Potaczek further explained that Kilpatrick started with blood in his knee that turned over to fluid with chronic swelling and that the complaints and symptoms of Kilpatrick were typical for a guy who is border line arthritic who then has a surgery that pushes him over the edge (PX 1 page 11). Dr. Potaczek explained that Kilpatrick would not have had any problems with the knee if he had not gotten hurt at work and the knee problems started with the issue at work (PX 1 page 12). Dr. Potaczek explained that Kilpatrick had a mild case of arthritis and then he lost his meniscus which aggravated the arthritis and the menisectomy aggravated the arthritis and Kilpatrick would have his current problems irrespective if he fell in the garage or the bathroom or where ever (PX 1 page 12).

As of December 17, 2013, Dr. Potaczek was recommending a high tibial osteotomy (PX 1 page 23). He explained that this is a procedure where the doctor reconfigures the bone so the weight goes on the lateral side and not on the "bad" medial side explaining that Kilpatrick was in perfect condition on the lateral side (PX 1 page 5-6). This procedure puts all the pressure on the healthy side of the knee (PX 1 page 5-6).

DEPOSITION OF JEROME KRAFT – JANUARY 22, 2014

On January 22, 2014, Dr. Kraft was deposed by the parties in this case. Dr. Kraft testified that his initial IME report dated February 21, 2013 provided that Kilpatrick's complaints as of February 2013 relating to his knee were related to his work injury (RX 4 page 35). Dr. Kraft believed Kilpatrick had underlying pre-existing conditions that were aggravated by his work injury (RX 4 page 36). As of the February 21, 2013 IME, Dr. Kraft was concerned that Kilpatrick may have worsening mechanical symptoms (RX 4 page 39-40). Dr. Kraft conceded that the surgery performed by Dr. Potaczek was related to Kilpatrick's work injury (RX 4 page 40). Dr. Kraft believed that knee replacement surgery would be recommended for Kilpatrick at this time (RX 4 page 43).

Dr. Kraft explained that Kilpatrick's knee giving out on Kilpatrick in June after the May 8, 2013 surgery could be related to the surgery Dr. Potaczek performed because the quad muscle could weaken and cause a hamstring muscle to go into spasm and cause the knee to buckle (RX 4 page 47). Dr. Kraft also conceded that he did not know what caused Kilpatrick to fall in the garage (RX 4 page 59). Dr. Kraft conceded that a knee injury or joint injury can cause deterioration of the muscles around the joint which in turn could cause a person to have less support or less strength in that joint if they were to lose their balance (RX 4 page 60).

CONCLUSIONS OF LAW

1. On the Issue of Whether the Petitioner's Condition of Ill Being is Causally Related to the Accident (F), the Arbitrator Hereby Finds:

The arbitrator finds that Jeff Kilpatrick's current condition of ill being in Petitioner's knee is causally connected to his accident on January 21, 2013. The Petitioner was in a state of good health prior

to January 21, 2013 and did not have any complaints of knee pain and/or his knee giving out prior to his work injury. After the injury he required extensive treatment for his knee including arthroscopic surgery.

Both Dr. Potaczek and Dr. Kraft agreed that Kilpatrick injured his knee at work and that the initial arthroscopic surgery in May 2013 was related to the work incident. Both orthopedic doctors note that Kilpatrick had asymptomatic arthritis in his knee prior to the injury. Dr. Potaczek explained that the injury to the knee and the surgery to the knee ultimately caused ongoing problems which have led to the current need for additional surgery.

The Respondent's claim that the current problem with Kilpatrick's knee is related to a fall Kilpatrick had after the knee surgery is undermined by the medical records which show a history of weakness in the knee and the knee giving out from the date of the initial injury through the current date. Dr. Potaczek explained that all the problems with the knee giving out relate to the initial injury and the aggravation of the underlying arthritis. Dr. Kraft also agrees that complications from the knee surgery could cause weakness in the leg and/or swelling around the knee which could cause buckling in the knee. Kilpatrick explained that any fall after the surgery was related to his knee giving out consistent with his medical records.

Therefore, the Arbitrator finds that the current condition of Petitioner's knee is causally related to the January 21, 2013 work accident.

II. On the Issue of Respondent's Liability for Unpaid Medical Bills (J), the Arbitrator Hereby Finds:

There is no dispute in this matter that the Petitioner sustained an accident that arose out of and in the course of his employment in January 2013. Furthermore, as found above the current condition of ill being in the Petitioner's knee is causally related to that January 21, 2013 accident.

The arbitrator notes that the Respondent in this case offers no evidence or testimony to dispute the reasonableness or necessity of the Petitioner's medical treatment. When offered into evidence at trial, Respondent had no objection to the medical bills contained in Petitioner's Exhibit 7.

During his deposition testimony, Dr. Potaczek stated that he believed all medical treatment the Petitioner had received has been reasonable and necessary (PX 1 page 7). The Respondent has stipulated that they will pay all reasonable and necessary services pursuant to the medical schedule of all medical bills related to the January 21, 2013 accident up through July 11, 2013 pursuant to the stipulation of the parties. After July 11, 2013, Petitioner incurred medical expenses on October 1, 2013 in the amount of $347 and treatment of February 21, 2014 in the amount of $128 at the OSF Galesburg Clinic.

After reviewing all evidence and testimony in this matter, the arbitrator hereby finds that all the Petitioner's knee treatment to date has been reasonable and necessary to cure the Petitioner of his conditions of ill being and hereby orders the Respondent to pay all reasonable and necessary medical costs as reflected in Petitioner's Exhibit 7, to the extent required by the Fee Schedule, including the bills to OSF Galesburg Clinic for the October 1, 2013 service in the amount of $347, the February 21, 2014 service in the amount of $128 to OSF Galesburg Clinic and pursuant to the stipulation entered at hearing to pay all medical bills related to the January 21, 2013 accident up through July 11, 2013.

III. On the Issue of Temporary total Disability Benefits (L), the Arbitrator Hereby Finds:

Following his accident, the Petitioner was placed on a work restriction of sedentary duty by Proctor First Care. (PX 5) The Respondent then offered him work within that restriction. (RX 7) He was to work 18.25 hours and be paid $8.25 an hour, totaling $150.56 per week. He accepted the offer and began light duty work on January 28, 2013. (Id) He then worked approximately three and one-half days. He testified that he then decided to move about fifty miles away from Peoria and no longer went to his light duty job. He said that he had to move because he could no longer afford to live in Peoria, as he was only making a light duty wage. The Arbitrator does not believe his testimony was credible on the issue. He testified that he was only a part time worker prior to the accident, and stipulated that his average weekly wage was only $149.61. Inasmuch as the Respondent offered the Petitioner work within his restrictions which he elected not to perform, the Arbitrator finds that the respondent is not liable for any temporary total disability benefits prior to May 8, 2013, the date of surgery.

After surgery, the Petitioner was only able to ambulate with crutches and could not immediately perform any type of work. His pain did not improve, and Dr. Potaczek placed him on Norco, a narcotic, on June 4, 2013. (PX 3 at 77) Dr.Potaczek's office records, which end with treatment in January of 2014, indicate that he has remained on Norco. (PX 3) The doctor's notes and his testimony further establish that the Petitioner has not reached maximum medical improvement from his accident related injuries, as the doctor has recommended an osteotomy. Dr. Kraft, in his testimony of January 22, 2014, agrees that the Petitioner has not reached MMI and could need a total knee replacement. (RX 4 at 43)

By the time of his surgery, the Petitioner had been terminated by the Respondent. He had no light duty job to return to while recovering from said surgery. Moreover, Ms. Jean Marie Shoultz, the Respondent's recruiter, testified that the Petitioner would not have been allowed to work light duty anyway, as he was taking narcotics for his pain.

Under the existing facts referenced above, the Arbitrator believes that the Petitioner has been entitled to TTD benefits from May 8, 2013 through the date of arbitration, a period of 59 1/7 weeks.

IV. On the Issue of Prospective Medical Treatment (O), the Arbitrator Hereby Finds:

Dr. Potaczek recommends a high tibial osteotomy, which would result in a refiguration of the tibia so that more weight would be borne by the lateral aspect of the Petitioner's knee. (PX 1 at 21) He said the procedure would provide the Petitioner five to seven more years a good function before he would need a knee replacement. (Id) He suggested that the Petitioner could return to work with such a procedure and implied that he would not be able to work with a total knee replacement. (PX 1 at 51, 52)

Dr.Kraft, on the other hand, felt that the Petitioner was not a candidate for a high tibial osteotomy. He explained that the surgery used to be a common treatment for arthritic knees prior to the advancement in technology with total knee replacements. He said the procedure was only indicated for patients who were younger than the Petitioner, not obese and who had a unique single compartment disease. The Petitioner is not young, is obese and, according to the Radiologist who performed the most recent MRI, had moderately severe osteoarthritis in two compartments and mild osteoarthritis in a third. (RX 4 at 27, 28) Dr. Kraft suggested the Petitioner would be a candidate for a total knee replacement, a procedure which he said produced more predictable outcomes. (Id at 28, 43)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RUTH A. McHUGH,

Petitioner,

vs. NO: 11 WC 22880

15IWCC0127

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation and temporary total disability ("TTD") and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission affirms and adopts the Arbitrator's findings with regard to Petitioner sustaining an accident arising out of and in the course of her employment on June 1, 2011. The Commission also affirms and adopts the Arbitrator's findings with regard to the causal relationship of Petitioner's bilateral knee injuries to the June 1, 2011 accident. However, we find that the Petitioner's alleged low back injury is not causally related to the work accident.

Petitioner testified that she slipped and fell on an outdoor stairway while on her way from Respondent's offices to her assigned truck in the parking lot, indicating she fell on her hands and knees. She testified that after she was able to get up from the ground, continued working, and while walking a couple of hours after the fall, her right knee went out, resulting in her falling on her buttocks.

The Commission notes that Petitioner reported the laborer on her truck that day, Tisha Smith, helped her up when she fell the second time. While Petitioner did call Myrna Garcia to testify, she did not call Tisha Smith to testify regarding this second alleged fall.

The accident report that was prepared for the Respondent (Petitioner's Exhibit 1) indicated that the Petitioner slipped and fell down two or three stairs, and while she didn't feel immediate pain, as the day progressed her knee gave out. It also noted that "at time of accident back was not mentioned". There is no indication in this report of Petitioner reporting a second fall on June 1, 2011, or of Petitioner injuring her low back.

Petitioner initially sought treatment on June 1, 2011 at MercyWorks, and the report from that visit (Petitioner's Exhibit 2) states nothing with regard to Petitioner having a second fall that day, nor anything regarding a low back injury or low back pain. No diagnostic testing was performed with regard to the lumbar spine. The MercyWorks patient information form also notes only the fall on the stairs. Subsequent visits to MercyWorks in June 2011 similarly fail to mention any low back complaints or injury.

Petitioner testified that she reported low back pain at the emergency room of Palos Community Hospital on June 5, 2011. A review of the reports from that visit (Petitioner's Exhibit 3) reflects that she reported only the slip and fall accident where she landed on her knees. She did not complain of low back pain, but rather reported that her left knee pain was now radiating upwards towards her left hip and buttocks. The report also specifically states that there was no neck, back, chest or abdominal pain. There was no diagnostic testing of the lumbar or cervical spine, and no diagnosis involving the low back or neck. Petitioner's past medical history was remarkable for arthritis.

The first indication of low back pain in the medical records was in chiropractor Dr. Dabbah's June 9, 2011 note, wherein he notes bruises over the left paraspinals at the L2 to L4 levels. The June 13, 2011 note of Dr. Peters (Petitioner's Exhibit 12 and 13), Petitioner's primary care provider, also indicates bruising on the left low back and diagnosis that includes low back pain. The Commission does not see how the mechanism of Petitioner's fall on the stairs, onto her hands and knees, could have resulted in bruising to the low back. The reports of both MercyWorks and Palos Community Hospital support the description of falling forwards onto her hands and knees.

While Respondent's examining physician, Dr. Carl Graf, opined that the Petitioner likely exacerbated her preexisting lumbar degenerative condition on June 1, 2011, the Commission notes that he relied on the Petitioner's statement that she sustained a second fall on June 1, 2011 onto her buttocks. Respondent's Exhibit 2. We find no contemporaneous evidence indicating such a fall occurred, and further find that Petitioner's testimony in this regard was not credible. Other than her testimony at hearing, there is no indication in any of the medical records in evidence indicating a second fall occurred on June 1, 2011.

Based on the above noted findings, the Commission finds that the Petitioner has failed to prove, by a preponderance of the evidence, that her low back/lumbar condition of ill-being is causally related to her June 1, 2011 accident. We believe this is supported by the lack of evidence of initial low back complaints, the fact that the condition of her back was preexisting per Dr. Malek (Petitioner's Exhibit 7), the gap between the accident and the initial complaints of low back pain, and the lack of facts supporting the second fall Petitioner testified occurred on

15IWCC0127

June 1, 2011. While Dr. Malek opined that the accident aggravated the preexisting condition, the Commission disagrees based on the preponderance of the noted evidence.

The Commission also notes with interest that the records of Dr. Dabbah (Petitioner's Exhibit 6), including the complaints and pain drawings. These records themselves vary with regard to complaints in one versus both legs, with regard to various locations within the spine, and with regard to whether there was radiating pain between the knees and back or not. Additionally, they vary significantly from the Petitioner's initial complaints contemporaneous to the accident. This adds further questionability to the Petitioner's testimony, which seeks to support a causal connection of her spinal complaints to the accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $899.64 per week for a period of 121-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner 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: FEB 1 1 2015
TJT: pvc
o 12/16/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

McHUGH, RUTH A
Employee/Petitioner

Case# **11WC022880**

15IWCC0127

CITY OF CHICAGO
Employer/Respondent

On 1/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

2221 VRDOLYAK LAW GROUP LLC
MICHAEL P CASEY
741 N DEARBORN ST 3RD FL
CHICAGO, IL 60610

0766 HENNESSY & ROACH PC
BRANDON DeBERRY ESQ
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
19(b)

15IWCC0127

Ruth A. McHugh
Employee/Petitioner
v.
City of Chicago
Employer/Respondent

Case # **11** WC **022880**

An *Application for Adjustment 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 **October 3, 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 ______

FINDINGS

On the date of accident, **June 1, 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 $**70,171.92**; the average weekly wage was $**1349.46**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**899.64**/week for **121 1/7th** weeks, commencing **June 6, 2011** through **October 3, 2013**, as provided in Section 8(b) of the Act.

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

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

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

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

Milton Black

Signature of Arbitrator

January 13, 2014
Date

ICArbDec19(b)

JAN 13 2014

FACTS

Petitioner testified that she was a motor truck driver for Respondent on June 1, 2011, the accident date, and that she has worked in that capacity since 1986. Petitioner testified that she underwent a right knee arthroscopy in 1997 and an ankle surgery 1999. Petitioner testified that after her 1997 right knee arthroscopy she had no problems with or treatment to her knees until the date of the accident. Petitioner testified that she had no treatment for or complaints of back pain before June 1, 2011.

Petitioner testified that she drives a flatbed truck for Respondent. Petitioner testified that she has to step two feet off the ground and grab a handle to step into the cab of the truck. Petitioner testified that before the accident she did so every day using both legs without complaints or problems.

Petitioner testified that she delivers garbage containers or tools and is assisted by a laborer. Petitioner testified that she would drive into the alleys of residences receiving new garbage containers, that a laborer would take a new garbage container off the truck and leave it in the alley, and that the laborer would remove the old container and place it on the back of the truck.

Petitioner testified that when she arrived in the alley she would get out of the truck to see if she had the right house. Petitioner testified that she would have to document her work. Petitioner testified that she would operate the truck lift gate, keep track of the items, and make sure that all was secure.

Petitioner testified that on June 1, 2011 she arrived at work at 5:30 AM at the 2350 South Ashland, the Respondent's Streets and Sanitation facility. Petitioner testified that the public is not permitted in the facility and that her truck was kept there. Petitioner testified that she was scheduled to begin work at 6:00 AM. Petitioner testified that she stayed in her car and that an employee can swipe in at 5:50 AM only. Petitioner testified that after getting out of her car she went upstairs into the closed facility. Petitioner testified that she proceeded up to the second floor of the three floor building. Petitioner testified that those stairs are inside the building and are not the stairs where she fell.

Petitioner testified that on the second floor, a supervisor handed her the paperwork for the delivery of tools and garbage containers. Petitioner testified that she was handed at least 40 sheets of paper. Petitioner testified that she then got the keys for and proceeded to the truck. Petitioner testified that the keys were in the supervisor's office.

Petitioner testified that she began to go down to the first floor and then to the truck. Petitioner testified that she was carrying her assigned paperwork, the truck keys, and two bags. Petitioner testified that the two bags contained a clipboard, chalk for garbage containers, pens, and a light jacket. Petitioner testified that she was required to carry a 14 inch by 16 inch bag, which was like a duffel bag. Petitioner testified that the other bag contained fluids, including water with ice. Petitioner testified that she carried the bigger bag on her left shoulder and that she carried the other bag on her left arm. Petitioner testified that she was holding her paperwork in her left hand. Petitioner testified that she was holding her keys in her right hand. Petitioner testified that she is right handed.

Petitioner testified that she proceeded to stairs which are located outside the building on the side of a dock. Petitioner testified that a set of six stairs lead from the dock to the parking lot. Petitioner testified that she walked down one or two stairs, felt liquid under her foot, fell forward, and landed on both knees and hands. Petitioner testified that she was not holding onto handrails, because her hands were full. Petitioner testified that

she believes she fell down three or four steps to the bottom of the stairs. Petitioner testified that after she fell people came running to her. Petitioner testified that the papers she had been carrying flew into the air.

Petitioner testified that she had seen debris or spilled liquid on those outside stairs from a second floor cafeteria. Petitioner testified that she sat at the bottom of the stairs for about five or ten minutes and that she was shaken up, in shock, and embarrassed. Petitioner testified that she continued sitting there after people at the scene had told her not to get up. Petitioner testified that after 10 to 15 minutes she proceeded with her work.

Petitioner testified that she drove to her first assignment at 900 East103rd Street. Petitioner testified that when she arrived, she felt weaker in her knees and that her back hurt a little. Petitioner testified that she did not finish the day. Petitioner testified that a couple of hours after she had fallen, she was walking back to the truck, her right knee gave out, and she fell down on her buttocks. Petitioner testified that she sat there for a minute. Petitioner testified that a coworker, Tisha Smith, and another laborer helped her up and that Tisha Smith helped her on to the truck. Petitioner testified that she then called her supervisor.

Petitioner testified that she left that location, returned to the 2350 South Ashland facility, went upstairs and talked to her supervisor, who then drove her to Mercy Works. Those records state that she gave a history of going down the stairs and then slipping, falling down two or three stairs, hitting both knees against the stairs, not feeling any pain immediately, but as the day progressed the left knee gave out causing pain. Diagnosis was contusion of both knees left more than right. She was prescribed medication, returned to work full duty, and told to return to clinic on June 6, 2011(PX2, pp 8-9).

Petitioner went to the Palos Community Hospital emergency room on June 5, 2011. Those records state that she gave a history of slipping on stairs, falling forward, complaining of pain in both knees with the left knee worse, and shooting of the left leg to the left hip and buttocks (PX3, p12). Petitioner was diagnosed with acute left knee pain, told to ice and elevate, she was told to take prescribed medications, and she was referred to a Dr. Peters (PX3, p16).

Petitioner returned to Mercy Works on June 6, 2011. Petitioner was ordered off work and told to return to clinic the next day. Petitioner returned to Mercy Works on June 7, 2011, was kept off work, and was told to return to clinic of June 20, 2011 (PX2, p9).

Petitioner went to Burbank Medical Center June 9, 2011.Those records state that Petitioner gave a history of a fall at work and that Petitioner complained of low back pain, left hip radiating pain, left leg pain, and bilateral knee pain worse on the left. Physical therapy was ordered, and a lumbar spine MRI was recommended (PX6, pp10-11).

Petitioner underwent a lumbar MRI at Preferred Open MRI on June 13, 2011. The report includes an impression of: 1) L3-L4 demonstrates a prominent left frontal protrusion compromising the L4 exiting nerve root; 2) L1-L2 demonstrates a broad-based left central protrusion; 3) Disc bulging is identified, L2-L3 and L4-L5; 4) Central protrusion L5-S1 (PX4, pp6-7).

Petitioner returned to Mercy Works on June 20, 2011. She was kept off work, recommended for a left knee MRI, and told to the return to clinic (PX2, p9).

Petitioner went to Dr. Michel Malek, a neurological surgeon, on June 27, 2011 upon a referral from Dr. Dabbah, a chiropractic physician at Burbank Medical Center. Dr. Malek's records state that Petitioner gave a

history of an injury at work on June 1, 2011 at about 6:15 AM when walking down the ramp to get to her truck, losing her footing, falling two to three steps, and landing on her knees in a twisted position (PX7, p6). Diagnosis included thoracolumbar musculoligamentous sprain, bilateral lumbar radiculopathy, and bilateral knee pain. Recommendations included completion of physical therapy, medication as needed, caudal epidural steroid injection, possible surgery, EMG testing, and bilateral knee MRI scan (PX7, p8). Petitioner was kept off work. Dr. Malek opined that petitioner had an underlying degenerative condition that was silent and asymptomatic until she was injured (PX7, p9).

Petitioner underwent a left knee MRI at Preferred Open MRI on July 30, 2011. That report includes an impression of: 1) Suggesting chronic full thickness tear of the anterior cruciate ligament; 2) Degenerative joint disease, patellofemoral and femoral tibial compartments; 3) Complex tear posterior horn of the medial meniscus with an oblique tear suggesting within the posterior horn of the lateral meniscus; 4) Prominent popliteal cyst is identified (PX4, pp9-10).

Petitioner underwent EMG/NCV testing on August 10, 2011 at MRI Lincoln Imaging Center, as ordered by Dr. Malek. The report includes an impression that states bilateral L4 through S1 lumbar radiculopathy without sensory disruptions (PX5, pp5-6).

Petitioner also underwent a right knee MRI on August 10, 2011 at MRI Lincoln Imaging Center on a referral of Dr. Malek. That report includes an impression of: 1) Chronic appearing full thickness ACL tear with significant associated scarring/fibrosis. Please correlate with clinical findings; 2) Lateral and medial meniscal tears, the medial meniscus is extruded into the medial gutter; 3) Grade 1 MCL sprain; 4) Advanced tricompartmental osteoarthritis with significant associated tricompartmental chondromalacia, mild diffuse narrow edema within the lateral femoral condyle and proximal tibial epiphysis. This is nonspecific and may be reactive or posttraumatic; 5) Moderate knee joint effusion; 6) Medial Baker cyst measuring at least 6.7 cm in length; 7) Prominent popliteus bursitis; 8) Quadriceps and patellar tendinitis (PX5, pp7-8).

Petitioner underwent a caudal epidural steroid injection administered by Dr. Malek on August 12, 2011(PX7, pp9-10). On August 24, 2011, Petitioner returned to Dr. Malek, who recommended additional steroid injections and continued Petitioner off work (PX7, pp15-16).

Petitioner went to Dr. Ellis Nam, an orthopedic surgeon, on August 13, 2011 upon a referral from Dr. Dabbah. Dr. Nam did not recommend knee surgery. Dr. Nam administered a left knee cortisone injection and restricted Petitioner to a desk job position (PX10, pp3-4).

Petitioner went to Dr. Daniel Troy, an orthopedic physician, on September 14, 2011 upon a referral from Dr. Peters. Those records state that Petitioner gave a history of being injured at work on June 1, 2011 walking down a flight of stairs, slipping landing on her knees, and injuring both knees as well as her low back area (PX 14, p56). Treatment has included additional examinations, medications, physical therapy, imaging studies, and steroid injections. On June 22, 2013, Dr. Troy noted that Petitioner continues to complain of symptoms and that she would benefit from a two-level lumbar fusion with instrumentation (PX15, p21).

Petitioner testified that she has remained off of work in accordance with her treating physicians' instructions and that Respondent has not offered any work accommodations.

Myrna Garcia testified pursuant to subpoena as a witness for Petitioner. She testified that she is a coworker. She testified that employees arrive between 5 AM and 5:30 AM and begin work at 6 AM. She

testified that on the date of the accident she saw employees leave with food or drink purchased on the second floor canteen of Respondent's building. She testified that when she went down the same outside stairwell where Petitioner fell. She testified that she had almost slipped on those same stairs but caught herself on a rail. She testified that she did not see Petitioner fall but that she heard Petitioner say "oh". She testified she then turned around and saw Petitioner on the floor.

Petitioner saw Dr. David Raab regarding her knees on November 14, 2011, at Respondent's request. Dr. Raab opined that Petitioner has pre-existing degenerative arthritis of both knees and that the alleged fall did not cause those current maladies (RX1, p3).

Petitioner saw Dr. Carl Graf regarding her low back on May 14 2012, at request Respondent's request. Dr. Graf opined that Petitioner had an exacerbation of a pre-existing lumbar spondylolisthesis causing low back and radicular leg pain. Dr. Graf opined that Petitioner could return to work at the light physical demand level (RX2, pp17-19).

Petitioner agreed to defer all medical issues for further proceedings, when it became apparent that all proper medical evidence had not been obtained (AX1, paragraph 7).

ACCIDENT

Petitioner testified that she fell as she was walking down a slippery stairwell where the public is not permitted. She testified that she was carrying items necessary to do her job while walking down those stairs. Petitioner was credible when she testified about the fall. Petitioner was specific about the time, the place, and the names of the persons at work. The post-occurrence witness did not see the actual fall but did hear Petitioner say "oh" and then saw Petitioner lying on the floor. There were no witnesses presented to contradict the testimony regarding the fall on the stairway. Medical records refer to a fall while walking down stairs, although one record refers to a ramp.

The Arbitrator finds that Petitioner has carried her burden of proof on this issue.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of employment.

CAUSATION

Petitioner testified that her current medical problems are as a result of her accident. Petitioner's treating doctors are consistent and corroborating. Dr. Graf has opined that Petitioner's low back condition is related to the accident. Dr. Raab has opined that Petitioner's knee complaints are not related to the accident. However the Arbitrator is not persuaded by Dr. Raab's opinions.

Based upon the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being causally related to the injury.

TEMPORARY TOTAL DISABILITY

Petitioner testified that she has been kept off of work or placed on restricted work by her treating physicians. The medical records are corroborative. Dr. Graf opined that Petitioner could return to work at the light physical demand level.

Based upon the foregoing, the arbitrator finds that the claimed temporary total disability shall be awarded.

PENALTIES AND FEES

Petitioner claims penalties and attorneys fees based upon Dr. Graf's report. That report is dated May 14, 2012. Petitioner did not proceed to a hearing until October 3, 2013, almost 17 months later. There is no explanation for Petitioner's attorneys' long period of delay in proceeding to a hearing of a denied claim. Petitioner could have, but did not, proceed far sooner.

Additionally, it was reasonable for Respondent to rely on Dr. Malek's history that a fall occurred on a ramp. Although the Arbitrator has discounted that inaccuracy, Respondent had a right to rely upon it when assessing whether or not an accident had occurred.

Petitioner has not carried the burden of proof that the delay in paying temporary total disability has been unreasonable.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

WILLIAM CLAVETTE,

Petitioner,

vs. NO: 05 WC 41656

15IWCC0128

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON ON §19(h) AND §8(a) PETITION

This case comes before the Commission on Petitioner's §19(h) and §8(a) Petition, alleging a material increase in his work related disability since the January 11, 2008 hearing held before the Arbitrator, requesting additional medical expenses and an increase in his permanent disability award. The previous decision on arbitration (issued on February 11, 2008) awarded Petitioner 60% of the man as a whole pursuant to Section 8(d)(2) of the Act. On Review, the Commission on September 22, 2008 reduced this award to 50% of the man as a whole. Hearings on the pending petition were held before Commissioner Thomas Tyrrell on May 28 and July 10, 2014, in Chicago, Illinois, and a record was made.

Section 19(h) of the Act states that

> ". . . as to accidents occurring subsequent to July 1, 1955, which are covered by any agreement or award under this Act providing for compensation in installments made as a result of such accident, such agreement at any time within 30 months, or 60 months in the case of an award under Section 8(d)1, after such agreement or award be reviewed by the Commission at the request of either the employer or the employee on the ground that the disability of the employee has subsequently recurred, increased, diminished or ended."

The Commission, having considered the entire record, finds that Petitioner has shown a material increase in disability, is entitled to additional permanency of 15% of the man as a whole, for the reasons set forth below.

HISTORY OF THE CASE

Petitioner worked, and continues to work, for the Respondent as a bridge operator. He was 41 years old at the time of his injury, and was 50 years old at the time of the recent Section 19(h) hearings. The Arbitrator previously found Petitioner had sustained the loss of use of 60% of the man as a whole. This was based significantly on Petitioner undergoing a posterior fusion surgery at L5/S1, subsequent hardware removal surgery, and having ongoing complaints and permanent restrictions. The restrictions did not prohibit him from returning to his regular job. On review, the Commission reduced the award to 50% of the man as a whole.

The Petitioner continued to work as a bridge operator, but alleged that at some point his voluntary overtime was reduced due to his restrictions and/or ongoing symptoms. After his medical release in 2007, he indicated that in 2008 his symptoms again increased and he began treating again, and he ended up undergoing a revision of the prior fusion, this time in an anterior fashion, with his original surgeon, Dr. Deutsch. Petitioner appears to have had some limited relief as a result, as he continues to note low back pain into the left leg. He also now alleges erectile dysfunction, retrograde ejaculation and a hernia are related to this last surgery.

Between the May 28 and July 10, 2014 hearing dates, the parties resolved outstanding issues with regard to medical expenses and temporary total disability, and thus the only current issue before the Commission is the causal relationship of any ongoing condition to the August 18, 2005 accident, and if such causal relationship exists, whether the Petitioner sustained a material increase in disability since the January 11, 2008 arbitration hearing.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The prior arbitration and Commission decisions were entered into evidence as Respondent's Exhibit 3. Hearing on the pending petitions was held pursuant to Sections 19(h) and 8(a) before the Commission on May 28 and July 10, 2014 in Chicago.

Petitioner testified that following his August 18, 2005 injury, he underwent March 2006 posterior lumbar fusion surgery, followed by a revision hardware removal surgery in February 2007. He was released to return to work with permanent restrictions and returned to his regular job as a bridge operator in 2007. He continued to have back problems after returning to work, and returned to Dr. Deutsch in September 2008, undergoing a February 2009 lumbar MRI. On October 12, 2009 Dr. Deutsch noted left leg pain in an L5 dermatomal distribution, that the new MRI showed scar tissue encroaching on the left neuroforamina at the S1 level, and that non-operative measures had failed. He recommended a revision L5/S1 anterior fusion. Petitioner

initially was taken off work on March 22, 2010 and underwent the surgery on June 1, 2010. He subsequently remained off work and on October 29, 2010 was referred for pain management. Petitioner saw pain specialist Dr. Jaycox at Rush. Petitioner initially saw Dr. Jaycox on December 29, 2010 reporting bilateral buttock pain radiating into the left leg to the foot, noting surgery did improve his back pain but had no effect on his leg pain. Dr. Jaycox performed an initial epidural on February 25, 2011. (Tr. 5-10; Petitioner's Exhibits 1 & 3).

Dr. Deutsch released Petitioner to remain under the care of Dr. Jaycox on March 4, 2011. To Petitioner's recall, Dr. Deutsch released him with restrictions at the final visit of March 4, 2011, however the records of Dr. Deutsch indicate the release was to unrestricted duty. On March 24, 2011 Dr. Jaycox released him with restrictions including no lifting over 25 pounds, no standing or walking more than 2 hours or sitting more than 4 hours without a break. Respondent accommodated the restrictions and Petitioner returned to work on March 28, 2011. Petitioner underwent second and third epidurals on April 8 and April 22, 2011 but continued to have problems. Dr. Jaycox injected the sacroiliac joint on June 13, 2011, but Petitioner reported on July 11, 2011 that this did not help. Dr. Jaycox found Petitioner had reached maximum medical improvement ("MMI") at that time, indicating he would need permanent restrictions, injections and physical therapy in the future. Petitioner returned on October 12, 2011, reporting increased low back pain that was exacerbated at work while clearing debris and lifting metal from a car wreck. Petitioner underwent a fourth epidural on January 25, 2012. On February 22, 2012 he referred Petitioner for a urology consultation for complaints of retrograde ejaculation since his surgery. (Tr. 10-12, 34-36; Petitioner's Exhibits 1 & 3).

Petitioner saw urologist Dr. Levine at Rush on April 27, 2012. He testified that he had no erectile dysfunction issues prior to the June 2010 surgery. Dr. Levine noted Petitioner had no sexual problems for three to six months after surgery, and then developed first retrograde ejaculation, followed by erectile dysfunction. After multiple tests, Dr. Levine believed the problem could be low testosterone due to chronic narcotic pain medication usage, and recommended testosterone replacement therapy, which began in September or October 2012 (Tr. 12-14; Petitioner's Exhibit 2).

On October 22, 2012 Petitioner went to the Rush emergency room with complaints of a three week history of chronic headache and more recent neck stiffness. After hearing news reports regarding epidurals Petitioner was concerned he may have contracted meningitis, however this was ruled out by Rush. He returned to Dr. Levine on February 5, 2013, and advised he wanted to discontinue testosterone replacement due to side effects with the headaches and neck stiffness. (Tr. 14-16; Petitioner's Exhibits 2 & 4).

Petitioner was examined pursuant to Section 12 of the Act by Dr. Candido on April 16, 2013, and he agreed with Dr. Jaycox's February 11, 2013 recommended treatment plan, including another round of epidurals. A fifth epidural on May 31, 2013 didn't help. On June 24, 2013 Dr. Jaycox recommended a new round of three epidurals, which were performed between August 14, 2013 and January 31, 2014. Petitioner believed he had an additional injection after

this, and had undergone a total of at least 8 epidurals and the sacroiliac joint injection since the June 2010 surgery (Tr. 16-19; Petitioner's Exhibit 3; Respondent's Exhibit 1).

Dr. Jaycox on March 24, 2014 found Petitioner had reached maximum medical improvement, and prescribed a back brace, medications (Norco, Elavil, Voltaren and Lunesta), a TENS unit and renewed the permanent restrictions (Tr. 19-20; Petitioner's Exhibit 3).

Petitioner has continued working since March 28, 2011, but still had low back pain. He testified: "It's a chronic pinch that's with me all the time", which radiates into his leg to the foot with numbness at the inner thigh, side of shin and top of foot. He also indicated pain across the plane of his back and the upper muscles with overexertion. The pain was at a constant 5 out of 10 and would worsen with weather and prolonged sitting, walking or standing. He uses prescription medications, heat, stretching and rest when it gets bad. He testified he was only taking prescription strength ibuprofen and had not been prescribed a brace and TENS unit when he last testified in January 2008. He was still working as a bridge operator at his regular pay, and he uses sick or vacation time if he has a bad day. (Tr. 20-29).

Petitioner testified on cross examination that he was working his regular bridge operator job after the January 2008 hearing, but at a reduced level in that he didn't volunteer for any overtime, and didn't participate in "trials and boat runs and stuff . . . I would just do my regular assigned assignment." He otherwise has been earning the same money and working the same hours since 2008. He agreed that his current complaints were similar to what they were prior to the last hearing date, but that the symptoms were worse and more constant. He agreed that Dr. Jaycox's March 24, 2011 release to restricted duty was at the medium work duty level, and that is the level at which he was currently working (Tr. 29-38). While Petitioner did report an October 2011 incident involving lifting steel debris from the roadway, he testified he's had no new accidents involving his low back. He was not currently treating for erectile or retrograde ejaculation problems, indicating he felt the prior treatment contributed to his headaches and neck pain, and so he still had to decide what he was going to do about this problem in the future. He takes daily amitriptyline for anxiety, and it serves to help with his nerve pain and sleep. He can drive and drives to work daily (Tr. 39-47).

Based on the above noted treating medical provider evidence, as well as the opinion of Respondent's examiner Dr. Candido, Petitioner's lumbar condition remained causally related to the August 18, 2005 accident. Since the prior arbitration hearing of January 11, 2008, Petitioner had an increase in pain and underwent revision fusion surgery, along with numerous injections, with limited benefit. He also continues to work under physical duty restrictions. While they do not prevent him from working his regular job, they do contribute to an increase in his disability, as he now must take breaks from prolonged standing and sitting. It also appears that he is having urological issues that, according to Dr. Levine, stem from either his last fusion surgery or from chronic use of narcotic pain medications. The Commission finds that the Petitioner has sustained an additional loss of 15% of the man as a whole since January 11, 2008.

As this matter involves the City of Chicago as Respondent, pursuant to Section 19(f)2 of the Act, no bond is required to be filed if this decision is appealed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) is hereby granted; Petitioner's Petition under §8(a) was withdrawn based on both parties indicating that medical expenses had been resolved prior to final hearing.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $497.29 per week for a period of 75 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused the loss of an additional 15% of the man as a whole subsequent to the January 11, 2008 hearing on arbitration.

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

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: FEB 1 1 2015
TJT: pvc
o 12/16/14
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Phillip Griffin,
Petitioner,

vs. NO: 11 WC 34831

Schatz Building, LLC,
Respondent.

15IWCC0129

DECISION AND OPINION ON REMAND

This case comes before the Commission on remand from the Circuit Court of Cook County in case number 13 L 50215. On May 31, 2012, Arbitrator Kelmanson issued a decision finding that on March 1, 2011, Petitioner did suffer an accident arising out of and in the course of his employment with Respondent, but denying all benefits based upon her finding that Petitioner's current state of ill-being is not causally connected to that accident. On review, the Commission majority affirmed and adopted the Arbitrator's decision, and Petitioner timely appealed to the Circuit Court of Cook County.

On September 24, 2013, Judge Robert Lopez Cepero entered an Order, finding that the Arbitrator and Commission had failed "to articulate a credibility determination in their written opinions. . .[in] an improper attempt to insulate them from judicial review." The Court further found that "a credibility determination requires a weighing and there is no sign of any weighing process such that the reviewing court can 'follow the footprints' of the trier of fact on an essential credibility determination." Judge Cepero vacated the Commission's decision and remanded the matter to the Commission "for a new hearing on all issues."

The facts as contained in the Record are set out below for clarification of the Commission findings and determinations.

Petitioner alleged that on March 1, 2011 he sustained injuries to his left elbow, shoulder, arm, wrist, and hand while moving a "toter" containing steel, plaster and other scrap. According to Petitioner, the load inside the1500 to 1800 pound toter shifted and began to flip over as he rolled it down a ramp to the alley. Petitioner testified that the toter "karate chopped" his arm at the elbow, skidded down his arm, knocked him to the ground, and cut his left arm in about 60 places. He testified that he cried out in pain, and his left arm was bleeding profusely.

Petitioner's two co-workers, Hernandez and Sbigniew, were in the alley before and after the accident, moving their own toter down the ramp to the alley, but they did not witness Petitioner's accident. A garbage collector, Steuben, was in the alley at the time of the accident and assisted Petitioner to his feet. Co-worker Hernandez brought paper towels for Petitioner, and Steuben assisted the two in wrapping Petitioner's arm with the towels. Petitioner testified that he went to the building's basement, washed his arm with soap and water, and again wrapped it in paper towels. He estimated that he spent between an hour and a half and two hours, trying to bring the bleeding under control. However, Petitioner also testified that within 20 to 25 minutes of the accident, he went to Ms. McElligott's cubicle to report the accident. He completed his shift and went home, although Northwestern Memorial Hospital's Emergency Room was only a hundred yards from Respondent's building. Petitioner's wife, a registered nurse, cleaned the cuts and wrapped his arm with an ACE bandage.

Petitioner reported for his shift the following day wearing a bandage and continued to work full duty, while wearing some sort of bandage, for several months until he underwent surgery in August 2011. Petitioner testified that there were some job activities he could not perform independently due to his left arm injury, and he asked for help from his co-workers, as needed. Respondent offered job logs completed by Petitioner as evidence that he was able to perform his job assignments through August 2011. Petitioner admitted that he continued to hunt and fish recreationally after his accident.

On April 15, 2011, Petitioner sought treatment from Dr. Koh, an orthopedic surgeon with whom he had previously treated for bilateral leg and right arm problems. Dr. Koh noted that Petitioner had developed a left elbow injury, lateral epicondylitis, on March 1, 2011. Dr. Koh administered a steroid injection into the left elbow and prescribed physical therapy. Petitioner did not return to Dr. Koh until August 2, 2011, explaining he was trying to get the workers' compensation paperwork numbers. On August 1, 2011, Petitioner saw Dr. Figuerres, a resident working with Dr. Koh, and reported that his elbow became symptomatic only two days after the steroid shot. Petitioner returned to Dr. Koh's office the following day, and Dr. Koh recommended surgery.

Petitioner continued to work for Respondent until August 17, 2011 and underwent left elbow surgery on August 18, 2011. On September 2, 2011, Dr. Koh's physician's assistant released Petitioner to restricted duty, effective September 12, 2011. Petitioner advised Ms. McElligott of the release and understood that he could return to light duty, organizing keys. However, on September 8, 2011, Noah Schatz, one of Respondent's managers, terminated Petitioner's employment, as of September 11, 2011.

Petitioner continued to treat with Dr. Koh and underwent physical therapy. On September 29, 2011, Petitioner complained of pain around his left shoulder and frequent dislocations of that shoulder. Petitioner told Dr. Koh that his shoulder had dislocated at the time of the accident and frequently thereafter. On October 25, 2011, an MRI of the left shoulder showed a SLAP tear, rotator cuff tendinopathy, mild subacromial/subdeltoid bursitis, and mild acromioclavicular joint arthrosis. Dr. Koh recommended shoulder surgery. Petitioner also complained of left wrist pain, and the doctor referred him to a hand specialist, Dr. Levitz. A left wrist MRI revealed degenerative changes. Dr. Koh performed shoulder surgery on December 23, 2011.

Dr. Koh testified by deposition that, based upon the history Petitioner provided, his left elbow, shoulder and wrist conditions were causally connected to his work injury. However, the doctor admitted that Petitioner did not provide a specific history of injury until September 29, 2011, and he noted that Petitioner had not complained of shoulder pain on April 15, 2011, because the doctor had neither noted those complaints nor ordered shoulder x-rays at that time. He could not recall whether he observed any scratches or cuts on Petitioner's left arm, but none are noted in his office notes.

Dr. Biafora, a hand and upper extremity surgeon, performed a §12 exam at Respondent's request on February 2, 2012. Dr. Biafora noted Petitioner's description of work injuries to his left shoulder, elbow and wrist on March 1, 2011. Dr. Biafora agreed with Dr. Koh's diagnosis of epicondylitis and recommendation for surgery. He also agreed that the accident described by Petitioner could cause or aggravate epicondylitis. However, Dr. Biafora noted that he questioned Petitioner's attribution of his left upper extremity injuries to his alleged work accident, based upon his delay in reporting the specific injuries.

Noah Schatz testified that Petitioner's job duties required the use of ladders, Sawzall, and jackhammer, as well as overhead work. He did not recall being advised of Petitioner's March 1, 2011 accident, but did recall seeing some type of wrap on one of Petitioner's arms below the elbow. Petitioner took off no time for health reasons and did not report any problems with his left arm or elbow to Schatz. In August 2011, Petitioner advised Schatz that he was having elbow surgery for an ongoing condition and would be off work for a week. Schatz testified that Petitioner had suffered health problems in the past, and Respondent had paid his regular salary while he was off work. On September 8, 2011, Schatz spoke with Petitioner by phone and expressed his disapproval of the building's condition: alarms were going off, keys were in disarray, and the elevator wasn't working. Schatz suggested the parties part ways, and, according to Schatz, Petitioner agreed. Had Petitioner desired to stay employed by Respondent, Schatz testified that he could have accommodated Petitioner's light duty restrictions.

Rachel Schatz, Noah's sister, testified that she operated a business in Respondent's building, but was not an employee. She testified that on April 30, 2011, she had observed Petitioner moving a heavy chest of drawers by lifting it off the ground. He also moved several chairs. Rachel testified that he did not wear a bandage and did not appear to have any problems lifting or carrying the furniture.

Louise McElligott, Petitioner's supervisor and Respondent's operations and design coordinator, testified that Petitioner did demolition work, removed and installed pipes, and performed electrical and maintenance work for the tenants. His job was heavy, requiring climbing and overhead work. McElligott recalled that on March 1, 2011, Petitioner came to her office with something like a towel covering his forearm. He reported that something from the toter fell on his arm, but did not request medical attention. He continued to perform his regular jobs for Respondent, although he wore either a light colored bandage covering a four inch area below his left elbow or a black bandage with Velcro. Sometime in April 2011, Petitioner told McElligott that he was going to see a doctor because his left elbow had been bothering him. He continued to work full duty and did not advise McElligott that he had any difficulty performing his job duties. In mid-August of 2011, Petitioner took time off work for elbow surgery, and Respondent paid his regular salary. McElligott testified that she received a copy of Petitioner's release to return to work light duty on September 2, 2011, but learned that Petitioner had been terminated before he

returned to work. She recalled that Petitioner had begun wearing a black Velcro bandage two weeks after his accident.

Adan Hernandez testified via a Spanish interpreter that his duties were primarily janitorial, whereas Petitioner's duties were heavy maintenance. The two did not work together except on heavy duty projects. Hernandez testified that he did not see Petitioner's accident, but saw Petitioner bleeding from a scratch on his right forearm. He saw only one scratch, and there was no debris to clean up from the alleged accident. He denied that he had supplied paper towels for cleaning up the injury. Hernandez testified that Petitioner had worn a light colored bandage on his left arm before March 1, 2011. Sometimes he wore another kind of bandage and sometimes he asked Hernandez to assist him with heavy work because his left arm was bothering him. Hernandez testified that Petitioner often complained about his left forearm, even before March 1, 2011.

David Steuben, the garbage truck driver, testified by deposition that he recalled Petitioner, Hernandez and another employee taking construction debris out of Respondent's building. He recalled that a container filled with construction debris started to tip over as Petitioner was pushing it down the ramp. He heard Petitioner yell that it was falling and turned to see Petitioner trying to stop the toter from falling off the ramp. He noted that the debris included plaster with wire mesh inside and that the wire had cut Petitioner's right arm. He described the scratch as three to four inches long with a puncture wound in the middle of it. Petitioner went inside, and Hernandez and the co-worker continued to load the garbage truck with construction debris. Before Steuben drove his truck away, he saw Petitioner return with a gauze wrap around his injured right arm. Steuben confirmed that he was certain the scratch was located on Petitioner's right forearm.

Arbitrator Kelmanson found that Petitioner had proved that he suffered a laceration injury to one of his forearms on March 3, 2011, and that the injury arose out of and in the course of his employment with Respondent. However, she denied all benefits based upon her further finding that Petitioner had failed to prove that his current condition of ill being was causally related to his work accident. She then issued her decision which included nine pages containing a comprehensive statement of the facts and evidence presented at hearing. Arbitrator Kelmanson concluded that Petitioner had failed to prove a causal connection between his condition of ill-being and his work accident on March 1, 2011. In support of her denial of benefits, she cited the following facts, which comprise her credibility determination:

1. Petitioner alleged injuries to his left upper extremity, yet Respondent's witnesses, Steuben and Hernandez, testified that the laceration suffered by Petitioner when the construction debris struck him was to his right upper extremity.

2. Dr. Koh, who treated Petitioner for his alleged work injuries, admitted that he did not recall seeing any scratches or bruises on Petitioner's left arm on April 15, 2011, when Petitioner first sought treatment for his injuries. Dr. Koh's office note for that date contains no mention of scratches or bruises.

3. The Arbitrator explained that she found Petitioner's testimony "incredible," when he testified that a large piece of debris struck his left forearm and elbow, causing injuries to his left shoulder, elbow, forearm, wrist, and hand, including approximately 60 cuts that bled profusely, yet he chose not to seek medical treatment at the emergency room located in the immediate vicinity of his workplace.

4. The Arbitrator also noted inconsistencies between the testimony of Petitioner and Steuben and Hernandez:
   - Petitioner testified he walked backward and pulled the toter down the ramp, whereas Steuben testified that Petitioner was walking forward, pushing the toter in front of him down the ramp.
   - Petitioner testified that the toter tipped and dumped construction debris off the ramp. Both Steuben and Hernandez testified that there was no debris on the ground that needed to be removed after the accident.
   - Petitioner testified that his left arm was bleeding profusely; both Steuben and Hernandez recalled it was his right arm that was injured, and there was only a single scratch and puncture wound, certainly not the 60 cuts which Petitioner described.

5. The Arbitrator also noted that Petitioner did not describe his work accident to any medical provider until after he had been terminated from his position with Respondent. Although he vaguely alluded to a left elbow injury on April 15, 2011, when he first sought treatment from Dr. Koh, there was no detailed description of the alleged accident until after his phone conversation with Schatz on September 8, 2011, during which the parties agreed to part ways. Petitioner filed his Application for Adjustment of Claim describing injury to his left elbow, shoulder, arm, wrist, and hand while "moving a container of steel, plaster and other scrap and it fell on him." The first time Petitioner described the accident to a medical provider was on September 14, 2011, when he gave a description consistent with his testimony at hearing.

The inconsistencies between Petitioner's testimony and that of Hernandez and Steuben, as well as Petitioner's delay in describing his work accident until after his termination and Rachel Schatz's testimony that Petitioner was able to lift and move furniture with no apparent difficulty and without benefit of bandages, were sufficient to call Petitioner's credibility into question. Contrary to the Circuit Court's determination, the Commission finds that the Arbitrator carefully considered all of the evidence and provided a comprehensive discussion of her determination of Petitioner's credibility within her ten pages of findings of fact and conclusions of law.

Respondent appealed the Arbitrator's Decision to the Commission, which, after reviewing all of the evidence, testimony, and relevant law, affirmed and adopted the Arbitrator's carefully reasoned decision. Petitioner timely appealed the Commission's Decision to the Circuit Court of Cook County, which by Order of September 24, 2013, remanded the matter to the Commission with instructions to conduct "a new hearing on all issues." The Court expressly found that "the failure of the arbitrator and Industrial Commission to articulate a credibility determination in their written opinions was an improper attempt to insulate them from judicial review."

Before the Commission took action on the Circuit Court's Order, Respondent filed a Petition for Leave to Appeal to the Appellate Court, First Judicial District, Workers' Compensation Commission Division. On November 27, 2013, the Court denied Respondent's Petition. On January 8, 2014, Respondent filed a "Motion for Action on Circuit Court Order for New Hearing on All Issues" before the Commission, requesting that the Commission "take further action as it deems fit in response to this Order," and Petitioner filed a "Petition for New Hearing," seeking an Order granting his a "new" §19(b) hearing pursuant to the Circuit Court's mandate, as

15IWCC0129

Section 19(e) of the Act provides that no additional evidence shall be introduced by the parties before the Commission on review of the decision of the Arbitrator. This prohibition of the introduction of additional evidence applies to all cases heard by Arbitrators after December 18, 1989 and clearly applies in this case. If the Commission is barred from considering evidence offered after the initial arbitration hearing, it certainly is not empowered to conduct "a new hearing on all issues," as ordered by the Circuit Court. Moreover, the Circuit Court may consider a case only on the record made before the Commission and has no authority to consider evidence not presented therein. *Gunthrop-Warren Printing Co. v. Industrial Comm'n,* 74 Ill. 2d 252, 255, 384 N.E.2d 1318, 24 Ill. Dec. 160 (1979). This limitation on what the Circuit Court may consider in reviewing a Commission decision would appear to eliminate the possibility of the Court remanding the matter for another trial.

The Commission concludes that the Order of the Circuit Court vacating the Arbitrator's Decision of May 31, 2012 and the Commission Decision of February 15, 2013, which affirmed and adopted the Arbitrator's Decision, and instructing the Commission to re-try the matter on all issues is null and void, as it exceeds the statutory authority of the Court in its appellate capacity. As the September 24, 2013 Order of the Circuit Court is null and void, the Commission re-affirms its adoption of Arbitrator Kelmanson's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 31, 2012 is hereby affirmed and adopted.

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

DATED: FEB 1 1 2015

o-1/14/15
drd/dak
68

Daniel R. Donohoo

David L. Gore

Ruth W. White

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF PEORIA	)		

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Kinison,

Petitioner,

vs. NO. 11WC 47410

15IWCC0130

Domino's Pizza,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, temporary disability, causal connection, medical expenses, prospective medical care, notice, benefit rates and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 3, 2014 is hereby affirmed and adopted.

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

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

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

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

DATED: FEB 1 1 2015
SJM/sj
o-1/29/15
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

KINISON, MICHAEL
Employee/Petitioner

Case# **11WC047410**

DOMINO'S PIZZA
Employer/Respondent

15IWCC0130

On 6/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0190 LAW OFFICES OF PETER F FERRACUTI
MORGAN KLEIN
110 E MAIN ST
OTTAWA, IL 61350

2506 BETTY NEUMAN & McMAHON PLC
MARK A WOOLLUMS
1900 E 54TH ST
DAVENPORT, IA 52807

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Michael Kinison
Employee/Petitioner

v.

Domino's Pizza
Employer/Respondent

Case # **11** WC **47410**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **4/22/2014**. 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. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On the date of accident, **December 2, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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, as explained in the decision referencing causation.

In the year preceding the injury, Petitioner earned $**4613.73**; the average weekly wage was $**191.12**.

On the date of accident, Petitioner was **41** years of age, *married* with **1** dependent children.

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

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

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

ORDER

.

Respondent shall pay reasonable and necessary medical services for treatment through March 30, 2012, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner's request for prospective medical care is denied.

Petitioner's request for temporary total disability benefits, not addressed in his proposed decision, is also denied. No evidence was offered to show the Petitioner unable to work as a result of is injuries.

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.

D.D. McCarthy
Signature of Arbitrator

May 28, 2014
Date

JUN - 3 2014

STATEMENT OF FACTS

Petitioner, Michael Kinision, testified that he was employed by the Respondent, A to Z Khan d/b/a Domino's Pizza (Domino's), on December 2, 2011. Petitioner further testified that he was employed as a pizza delivery driver and had been employed by Domino's for about a year as of December 2, 2011.

Petitioner testified that on Friday, December 2, 2011, he was undertaking his regular duties at the Domino's Pizza in Sterling, Illinois. Petitioner testified that on December 2, 2011, as he was walking out of the backdoor of Domino's, with a few boxes of pizza and a bottle of pop in his hands, he slipped on a piece of broken tile and fell. Petitioner further testified that as he was falling, he attempted to grab a hold of the backdoor door handle with his left hand in order to break his fall. Petitioner testified that his attempt to break his fall was unsuccessful, and that he ultimately landed on his left shoulder.

Petitioner introduced two photographs that depicted the status of the broken tiles at the Sterling Domino's where the accident occurred. The photos show that all but one of the tiles in the last row of tiles as you exit the backdoor of Domino's was missing. PX2.

Petitioner testified that as a result of the fall he had immediate pain in his left arm, elbow, and shoulder area. He testified that his left arm, elbow, and shoulder were in a lot of pain as a result of this fall. He testified that immediately after the fall he had a hard time lifting his left hand any higher than elbow height.

Petitioner testified that he had a prior rotator cuff tear that was successfully operated on by Dr. Romeo out of Rush. Petitioner testified that this occurred back in 1994. Petitioner testified that this was a completely successful operation and that he did not have any issues or limitations. Petitioner testified that the last time he had any kind of issue with his left arm was back in 2008. In early 2008, the Petitioner sustained a distal fracture of the left clavicle. Treatment records show treatment through April 16 of that year. No records of any subsequent left shoulder treatment until after the alleged accident date of December 2, 2011 were offered.

Petitioner testified that the accident was witnessed by two other employees at Domino's, including Lydia Walker. Petitioner testified Lydia Walker came over to him while he was on the ground to see if he was alright. Petitioner testified that he told Lydia Walker that he was hurt. Petitioner testified that he was then told to go home and take care of his injury.

Petitioner was able to accurately testify as to the names of all of the other employees who were working at the Sterling Domino's on December 2, 2011. He said Lydia Walker and another woman named Breanna were working when he fell. Petitioner testified that Arif Khan (Mr. Khan), the owner of the Sterling Domino's, was not present when he fell. Petitioner further testified that Mr. Khan had actually gone to some kind of walk with his family about an hour or so prior to the accident occurring.

Lydia Walker testified that she was working at Domino's on December 2, 2011 as a cook making pizzas. Lydia testified that she had been working at Domino's for about a year at that point.

Lydia testified that she observed the Petitioner fall out of the corner of her eye. She testified that the Petitioner fell at the backdoor area of Domino's while he was in the process of taking out some deliveries. Lydia testified that she saw the Petitioner attempt to stop his fall by grabbing a hold of the backdoor door handle with his left arm. Lydia testified that she heard a loud noise as she saw the door handle break due to the Petitioner attempting to grab said door handle in an attempt to stop his fall. Lydia testified that she found the Petitioner on his back by the time she got to him to check if he was ok. Lydia testified that she asked the Petitioner if he was alright and the Petitioner told her that he was hurt.

Lydia further testified that there were several other employees working at Domino's at the time. Lydia was able to correctly give, via memory, the names of all the other individuals that working at Domino's that day. She also testified that Breanna was working. Lydia testified that Mr. Khan was not one of the individuals that was working at Domino's at the time the accident occurred. Lydia testified that Mr. Khan had been at Domino's earlier in the day, but that Mr. Khan had left Dominos' about an hour or two prior to the accident happening. Lydia testified that Mr. Khan was not at Domino's when the accident occurred. Payroll records offered by the Respondent identified Breanna Ruggles as an employee working on December 2 from 12:33 PM to 8:25 PM. (RX 2)

Lydia also testified that she told Mr. Khan of what had happened. Lydia testified that when the Petitioner came back on Sunday, December 4, 2011 to let Mr. Khan know he had had this accident on Friday, December 2, 2011, that Mr. Khan told the Petitioner that he was a liar and to leave the premises. Lydia further testified that she was also present when the Petitioner called into Domino's that same day to again let Mr. Khan know what had happened, and that Mr. Khan began yelling and cussing at the Petitioner on the phone and told the Petitioner that he was fired.

Mr. Khan testified that he is the franchisee of Domino's. He testified that he regularly only spends about an hour or two (2) at any one of the three Domino's that he owns. He testified that he is always at one of the three Domino's that he owns and that he never has a day off.

Mr. Khan testified that he was working on December 2, 2011. Mr. Khan testified that on said date, he was at the Sterling Domino's the entire day, from open to close. He explained that Ms. Walker, whom he said was also a shift manager, had asked for the day off to help her father. He said she was given the day off, and he worked a double shift from 10:30 AM to 1:00 AM. Mr. Khan testified that he never saw the Petitioner fall. Mr. Khan testified that the Petitioner did not report any injury on that day. He said he did have a discussion with the Petitioner that day wherein the Petitioner told him that his delivery truck would not run, but no reference was made to any accident.

When asked on cross-examination who was working at the Sterling Domino's on December 2, 2011, Mr. Khan was unable to answer. Mr. Khan indicated that he did not remember but that they would be in the consolidated payroll report. When asked if he had any independent recollections of any other employee who worked that day, Mr. Khan stated that he did not and could not provide the name of any other employee working at Domino's at the time.

The Responded introduced a consolidated payroll report which was generated by Mr. Khan purporting to show that Lydia Walker did not work on December 2, 2011. (RX2)

On cross-examination, Mr. Khan first testified that he did not have any ability to change or alter the consolidated payroll report and that it was completely controlled by corporate. When asked how mistakes are handled in the consolidated payroll report, such as extra overtime, Mr. Khan testified that he can just go into the program and make a change to correct the error. Upon further cross, Mr. Khan than admitted that he in fact was able to modify and alter the contents of the consolidated payroll report. Mr. Khan further testified on cross that he could even delete certain parts of the consolidated payroll report if need be.

Mr. Khan further testified that the Petitioner never fell, was never injured, and never came in on Sunday, December 4, 2011, to tell him about his fall on December 2, 2011. Mr. Khan testified that the Petitioner was making the whole thing up. He did however acknowledge that he and the Petitioner had a discussion on Sunday. He said that the Petitioner was requesting a day off to see a doctor. He also said that the Petitioner told him that he had been injured at work. He says he requested a doctor's excuse from the Petitioner, but was not given one. He said the Petitioner told him he was going to quit

his job and sue him. He was unclear as to whether this conversation occurred in person at the store or by phone.

The aforementioned payroll records offered by the Respondent show that the Petitioner clocked in at 4:22 PM and out at 7:00 PM on December 2. The same exhibit shows that Mr. Kahn clocked in and out at 10:53 AM, and later clocked in at 5:53 PM, leaving at 8:55 PM. When asked about the pay records, Mr. Kahn said that he in fact never clocked out that morning. He gave no explanation as to why a second period of time appeared on the time sheet.

Petitioner testified that he went the hospital shortly after the accident to get his left arm, elbow, and shoulder looked at. Petitioner testified that he was having trouble moving his left arm and that he had a lot of pain on the left side.

The medical records indicate that on December 4, 2011, Petitioner went to the Emergency Department of CGH Medical Center in Sterling, Illinois, due to his fall at work on December 2, 2011. PX 4, at 409. Petitioner indicated to the staff that the slipped on ceramic tile at work while going to deliver pizza. PX 4, at 409. Petitioner further indicated that because of said fall he now has left shoulder pain. PX 4, at 409. An examination of the Petitioner's shoulder/elbow showed swelling, tenderness, and limited range of motion. PX 4, at 410. Petitioner was given pain medication and told to follow-up with Dr. Defranco. PX 4, at 410.

Petitioner testified that he has gone to several treatment providers in regard to the injury that he sustained at Domino's on December 2, 2011. Petitioner testified that all his doctors believe that he has as recurring rotator cuff tear in his left shoulder due to the fall. Petitioner testified that an MRI was done of his left shoulder but was inconclusive due to the fact that he could not fit into the machine, but he thought it still showed a tear.

Petitioner testified that he does not have any health insurance and cannot afford pay for the additional necessary doctors' visits. As a result, Petitioner testified that he has had to go to the Emergency Room for treatment and pain medications for his left shoulder.

Medical records indicate that on December 7, 2011, Petitioner went to the ER department of CGH Medical Center in Sterling, Illinois, due to the pain that he was having as a result of his slip and fall at work and the resulting left shoulder pain. PX 4, at 360. Petitioner was given pain medication and told to follow up with Dr. Defranco.

On December 13, 2011, Petitioner saw Dr. Michael J. Defranco at the CGH Medical Center in Sterling, Illinois, for a consultation regarding his left shoulder injury. PX 6, at

25. Dr. Defranco notes in the record that this was a work-related injury in which the Petitioner reported that he fell on some tile at Domino's and sustained an injury to his left shoulder. Dr. Defranco notes that date of the injury as December 2, 2011. PX 6, at 25.

Dr. Defranco further noted that the Petitioner was eleven (11) days removed from the date of the injury but still continued to have pain in his arm. Specifically, Petitioner complained of severe, constant, and sharp pain in the injured area that is exacerbated by lifting, reaching, and overhead activity. Dr. DeFranco's examination revealed decrease strength in forward elevation and external rotation, and his diagnosis was left shoulder pain, possible rotator cuff tear. PX 6, at 25; PX 3 at 12 .

On December 29, 2011, an MRI was done at CGH Medical Center. PX 4, at 237. However, the MRI was poor due to Petitioner not being able to fit within the MRI scanner due to his size. PX 4, at 237. Nevertheless, the MRI that was done showed possible tears in the left shoulder. PX 4, at 237. Specifically, the MRI impression was "suspicious for a rim-rent tear of the supraspinatus, as well as a portion the infraspinatus anteriorly" and a likely "slap tear." PX 4, at 238.

While seeing Dr. DeFranco during the above time frame, the Petitioner made several trips to the CGH emergency room. He was seen on December 25, 28 and 31 was complaints of severe left shoulder pain. On the first visit, he was injected with dexamethasone. On the second and third visits, he requested Norco, saying he had run out of the drug. The December 31 record notes the Petitioner denying narcotic abuse. (PX 4)

On January 4, 2012, Petitioner went to the Emergency Department of Katherine Shaw Bethea Hospital in Dixon, Illinois, due to the pain in his left shoulder. PX 10, at 82. Petitioner indicated to the treatment providers that the injury occurred because of a slip and fall where he was holding onto the door with his left hand. PX 10, at 82. Petitioner was diagnosed with a shoulder injury, possible rotator cuff tear, and arm sprain. PX 10, at 82. Petitioner was given some pain medication and told to follow up with his other physicians.

The doctor's records for Dr. Sikander Hayat on this day, and for January 17 and January 30, 2012, note that the injury occurred at home when the Petitioner slipped on some tiles. Petitioner testified that he never told Dr. Hayat that he fell anywhere but at work on December 2, 2011. Petitioner testified that he never fell at home and that he did not have any kind of intervening injury from December 2, 2011.

The nurse's notes from the January 4, 2012, visit to Dr. Hayat indicate that the Petitioner stated that "I slipped on tile and fell, while I was still holding onto the door with my left hand. I then fell onto my left shoulder." PX9, at 65. The nurse's notes further indicate that the Petitioner told the nurse on January 4, 2012, that the injury occurred on December 2, 2011.

Petitioner testified that he has no idea why Dr. Hayat would put down anything other than what he told him and the nurse at the time, which was that the accident occurred at work on December 2, 2011.

Furthermore, on January 4, 2012, that same day, the Petitioner followed up with Dr. Defranco for his left shoulder injury. PX 6, at 15. Dr. Defranco noted that there were problems with obtaining the requested MRI because the Petitioner had trouble fitting into the machine. PX 6, at 15. Dr. Defranco indicated that the image quality on the MRI was not ideal for assessing his shoulder. PX 6, at 14. Nevertheless, the MRI revealed that the rotator cuff was intact, but that there was some signal within his bicep labral complex suggesting a possible tear. PX 6, at 15. In addition, Dr. Defranco felt that the Petitioner may also have a partial thickness rotator cuff tear. PX 6, at 15. However, Dr. Defranco again emphasized that the imaging quality on the MRI was not ideal. PX 6, at 15. After reviewing the MRI and completing a physical examination of Petitioner, Dr. Defranco diagnosed Petitioner with left shoulder pain, a rotator cuff strain, and possible biceps labral injury. PX 6, at 15. Physical therapy was recommended since the Petitioner did not wish to have a Cortisone injection. PX 6, at 15.

On January 6, 2012, Petitioner saw Dr. Tyler G. Gunderson at KSB Medical Group in Dixon, Illinois, for further evaluation on his left shoulder injury. PX 7, at 13. Petitioner indicated that this was a workman's compensation claim. PX 7, at 13. Petitioner also indicated that he was working when he slipped. PX 7, at 13. Petitioner told Dr. Gunderson that he tried to catch himself as he was falling but instead caught his hand on the door as he fell, causing his left arm to be twisted and hyperextended. PX 7, at 13.

Dr. Gunderson noted that the Petitioner complained of persistent pain. PX 7, at 13. Petitioner informed Dr. Gunderson that he had had a previous rotator cuff repair, done by Dr. Romeo, which the Petitioner indicated was very successful and that Petitioner had not had any issues with activities, including regular sports and sports involving throwing, since that repair. PX 7, at 13. This prior rotator cuff surgery was back in 1994.

After conducting a physical examination of the Petitioner, Dr. Gunderson noted atrophy of the deltoid area of the left arm, along with numbness in his axillary nerve distribution. He suggested a possible rotator cuff tear, but his bigger concern was for brachial

plexopathy. As a result, Dr. Gunderson ordered an EMG to evaluate for brachial plexopathy. PX 7, at 13.

On January 12, 2012, Petitioner went to the ER department of CGH Medical Center in Sterling, IL. The reason for the visit was due to left shoulder pain that has been ongoing since his fall at work in December. PX 4, at 113. Petitioner was given pain medications and told to follow up with his doctor. PX 4, at 184.

On February 15, 2012, Petitioner returned to Dr. Gunderson for a follow up. Upon examination, Dr. Gunderson noted that the Petitioner's left shoulder showed some left upper deltoid atrophy, and that the Petitioner has relative grip weakness in his left hand. PX 7, at 8. Dr. Gunderson again stated that Petitioner might have a recurrent rotator cuff tear, but was more concerned with a possible brachial prexopathy. PX 8, at 9. Dr. Gunderson recommended a follow up once an EMG was obtained. PX 7, at 8.

On March 30, 2012, Petitioner once again returned to Dr. Gunderson following the EMG. The EMG results were negative for brachial plexopathy but did show some evidence of both carpal tunnel and cubital tunnel at the wrist and elbow. PX 7, at 6. A physical examination showed that the Petitioner had pain with his range of motion on his shoulder, but that his range of motion had improved somewhat. PX 7, at 6. Dr. Gunderson diagnosed Petitioner with left elbow cubital tunnel syndrome and carpal tunnel syndrome. He also said that his shoulder was still an issue, but did not reference the shoulder in his impression. He did later refer the Petitioner to Midwest Orthopedics at Rush on April 24, 2012. On that referral slip he said that the petitioner had a possible recurring rotator cuff tear from a left shoulder injury, along with the previously mentioned nerve entrapments. (PX 8)

Subsequent medical treatment for the left shoulder consists of an ER trip to the KSB Hospital on July 9, 2012 and an ER trip to the CGH Hospital on August 8, 2012. On each visit, the Petitioner complained of uncontrolled pain for which he sought narcotics.

Petitioner testified that his symptoms all started as a result of the accident on December 2, 2011. Petitioner testified that he has pain in the left shoulder area, and that his left arm/shoulder area is much weaker as a result of the accident on December 2, 2011.

Petitioner testified that he is currently still able to use his left hand/shoulder, but that he is limited on the duration of use and the amount of force that he can apply in using his left hand. Specifically, the Petitioner testified that he can still use his left hand to clean the glass of cars at his current employment but only for about ten (10) or fifteen (15) minutes before the pain is too great to continue. Petitioner further testified that when

he does use his left arm for these periods of time he pays for it later that night, or the next day, because he would experience intense pain in his left shoulder.

Specifically, Petitioner testified that before the accident on December 2, 2011, he was able to use a drill to punch through concrete walls, carry a couple hundred pounds of piping, do extended overhead lifting, and carry chains weighting over a hundred pounds without any issues in his left arm/shoulder area. However, Petitioner testified that now he can't do any sustained overhead lifting, can't carry or lift over fifty (50) to seventy (70) pounds, and can't do any drilling for any sustained periods of time due to the pain and weakness in his left shoulder.

Respondents introduced video surveillance of the Petitioner that showed the Petitioner playing basketball, lifting and shaking the basketball pole and rim, and carrying some plastic shelving about three months after the accident on February 22, 2012. The Petitioner was using his dominant left arm in all of the above activities, including using the arm at or above shoulder height. He did not appear to be favoring the shoulder as he performed the activities. RX4.

Petitioner testified that he still attempts to remain active. Petitioner testified that the injury has not rendered his shoulder completely useless, rather it has weakened it, has caused pain, and limited his ability to do sustained or heavy work/activities with his left shoulder. Petitioner testified that he still plays basketball, but can only do it for about ten (10) to fifteen (15) minutes before his shoulder pain becomes overwhelming, and that he pays for it later. Petitioner further testified that he coaches his kid's softball team and that he even throws the ball and takes a few attempts at batting from time to time, but again only for a very limited period of time before his shoulder pain becomes too great, and again he pays for it later. Petitioner testified that this injury has been going on for over three (3) years and that he has had to just learn to live with the pain.

Lastly, Petitioner testified that there were no intervening accidents or injuries to his left shoulder. He testified that the current issues with his left shoulder were directly related to accident that he had at work on December 2, 2011. Petitioner testified that because of the work injury his left shoulder gets weaker as more time goes by. Petitioner testified that all he wants is for a visit to be approved so he can go see Dr. Romeo, who fixed shoulder back in 1994, in order to see what the issue is with his shoulder.

In support of the Arbitrator's Decision as to WHETHER AN ACCIDENT OCCURRED THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT, the Arbitrator finds the following:

Petitioner testified that he slipped and fell on broken tile as he was exiting the backdoor of Domino's on December 2, 2011. He testified that he was in the process of making a delivery and had pizza and pop in his hands when he slipped while attempting to exit the door.

Petitioner provided photographs of the state of the broken tile which showed all but one of the tiles, on the last row of tiles as you exit the backdoor, to be missing.

Petitioner was able to describe, in detail, exactly how he fell and how he caught his left arm on door handle in his attempt to prevent his fall. Furthermore, Petitioner was able to give the names of all of the employees who were working on December 2, 2011, by memory. Petitioner further testified that one of those employees who was working at the time was Lydia Walker.

The Arbitrator believes that both the Petitioner and Respondent have serious credibility problems which affect not only this issue but the other issues discussed later in this decision.

After reviewing all of the Petitioner's medical records both before and after the accident, the Arbitrator notes evidence of drug seeking behavior. Dating back to 2000, the Petitioner repeatedly used opiates for pain despite being advised by a number of his treating physicians to use the drug judiciously. In 2000, he was seen by Dr. Neiween, an orthopedist, for left shoulder pain. He was given vicodin after reporting that he had ran out of the drug. In April 2002, Dr. Jundi gave him vicodin for lower back pain after first discussing its dangers. The same doctor gave him another script for vicodin in July2002 after the Petitioner reported its effectiveness. In July, he requested and was given vicodin for scrotal pain. PX 6

On July 27, 2007 he began treating with a physician's assistant at the Sterling Clinic for a possible Achilles tear. He was given vicodin and the prescription was renewed eight times through September 25 of that year. On October 1, the PA discussed trying to wean the Petitioner off the drug, but he was renewed an additional four times. On October 30, the treatment notes indicate that the drug was being used too often.

On February 22, 2008, the Petitioner was again prescribed vicodin following his left clavicle fracture. He received seven renewals through April 16. He was again given

vicodin by a podiatrist in August 2009, and later prescribed norco, another opioid, by the same podiatrist for a different condition on August 10, 2011. PX 6

Following his alleged accident of December 2, 2011, he again was prescribed opioids. He received an injection at the CGH facility on December 4, along with a prescription for twelve norco tablets to be taken every six hours. On December7, he was back at the facility reporting that he was out of medication. Again on December 28 and December 31 he was seen requesting norco. Finally, on January 17, 2012, he was told by CGH that he needed a personal physician to handle his chronic pain issues. PX 4

At KSB Hospital, where he was treated by Dr. Gunderson, he was prescribed vicodin and norco through July 9, 2012. PX 9.

The Petitioner's repeated complaints of severe pain and his request for opioid medications also does not match up with his actions seen on surveillance done February 22, 2012. On February 7, he reported pain at the "10" level at KSB and said he was having trouble getting access to pain relievers. Just fifteen days later, he is viewed playing basketball, lifting the basketball goal and standard, and lifting some shelves while primarily using his dominant left arm with no apparent difficulties. While the video does not necessarily mean the Petitioner was not involved in an accident as claimed, it certainly calls into question the extent of his injury at that time.

The testimony of Mr. Khan also raises credibility issues. He indicated that on December 2, 2011, he worked at the Sterling Domino's from open to close, a period of about fifteen hours. However, when questioned on cross as to who else worked at the store on December 2, 2011, since he was there the whole day, Mr. Khan could not provide a single name. In fact, Mr. Khan indicated that he needed to see the payroll report in order to be able to give an answer to that question. Mr. Khan's testimony on this issue was completely at odds with the Petitioner's and Lydia's testimony, both of whom correctly recited the names of the other employees on that day by memory. Also, Mr. Kahn had a vivid recall of his supposed conversation with Lydia Walker prior to December2 when he said she asked for the day off.

In addition, when asked about the repair done on the broken tile in question a few days after the Petitioner's claimed injury, Mr. Khan seemed confused. When shown the photos depicted in Petitioner's exhibit 2, Mr. Kahn said he did not recall whether the store had broken tiles, did not recall whether they had been repaired and did not even recall if they were photos from one of his stores. He said he does not keep track of repairs.

With respect to the payroll report presented by the Respondent, Mr. Khan initially testified that he had absolutely no ability to edit the presented payroll report and that it was all done by corporate. However, when asked as to how any errors are corrected, Mr. Khan stated that he can just go into the program and make the change. When pressed, Mr. Khan testified that he can go into the program and make changes, even delete items in the report, if need be, but that the change would be reflected in the report. This was completely contrary to his prior statement that he had no control of the payroll reports and that it was all done by corporate.

Finally with respect to the payroll report, Mr. Kahn had no explanation as to why he appeared to have clocked in and out in the morning and later clocked in for about three hours in the evening. He had testified that he was at the store for almost fifteen hours on December 2, 2011.

Given the hesitation in giving his answers to questions posed, his clear interest the outcome of this case, the lack of independent memory as to what other employees where working on the day in question, and his glaring inconsistency as to what control he had over the payroll report, the Arbitrator finds Mr. Khan's testimony not be credible.

The Arbitrator also finds that the testimony of Lydia Walker as the most credible testimony presented. Lydia is a disinterested eye witness to this event who not only testified that she was working on the day in question, but was able to give the first and last names of all the employees who were also working on that same day via memory. Lydia was able to describe the accident on December 2, 2011, in detail and was also able to describe the conduct of Mr. Khan on the subsequent Sunday when the Petitioner was fired.

Mr. Kahn testified that Ms. Walker was a shift manager and was a good employee, at times. The time sheets which he offered into evidence match up with Ms. Walker's testimony concerning the accident date. She said that Mr. Kahn was at the store early and then left. She said he was not there when the Petitioner was injured, but returned later. Her testimony matches the payroll records as they pertain to Mr. Kahn's attendance that day

Lastly, the medical records presented lend credibility to the Petitioner's and Lydia Walker's testimony that the Petitioner had an accident on December 2, 2011. The records from CGH Medical Center in Sterling, Illinois, on December 4, 2011, two days after the accident, indicate that the Petitioner's shoulder/elbow showed swelling, tenderness, and limited range of motion. Furthermore, the records from Dr. DeFranco on December 13 show an examination consistent with an acute injury.

Therefore, given the credible testimony of Lydia Walker, and the early treatment records showing a condition which was acute, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment with the Respondent.

In support of the Arbitrator's Decision as to WHETHER TIMELY NOTICE WAS GIVEN TO RESPONDENT, the Arbitrator finds the following:

Petitioner testified that the accident was observed by Lydia Walker. Petitioner testified that was asked to go seek treatment after his fall by Lydia Walker. Petitioner testified that he returned on Monday, December 5, 2011, in order to tell Mr. Khan about the accident. Petitioner testified that he told Mr. Khan about the accident on December 5, 2011, and that Mr. Khan called him a liar and told him to leave the premises. Petitioner further testified that he also tried to call Mr. Khan later that same day to again explain to him that he fell on December 2, 2011, only to have Mr. Khan cuss him out and tell him that he was fired.

Lydia Walker testified that she was working on Monday, December 5, 2011, when the Petitioner came in to tell Mr. Khan about the accident. Lydia testified that Petitioner told Mr. Khan about the accident and was told the leave the premises. Lydia further testified that she was present when Mr. Khan was on the phone with Petitioner and cussed him out because the Petitioner was attempting to let Mr. Khan know about the accident.

Based upon the greater weight of the evidence and the credible testimony of the Petitioner and Lydia Walker, the Arbitrator finds that Respondent had proper notice under the Act.

In support of the Arbitrator's Decision as to WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, the Arbitrator finds the following:

There is no medical evidence showing the petitioner with any left shoulder treatment between April 16, 2008, when he ended his care for the fractured clavicle, and the date of accident. Payroll records show the Petitioner worked as a delivery man for the Respondent for about five months prior to that date. RX 6 He had an accident with findings consistent with an acute injury in December 2011. Dr. DeFranco saw him twice between December 13, 2011 and January 4, 2012. At his second visit, the doctor

commented on the poor quality of the MRI which he had ordered. He said it did suggest some injuries, but his diagnosis at that time was shoulder pain, a rotator cuff strain and possible biceps and labral injuries. He recommended physical therapy, and there is no indication that his recommendation was ever followed. Instead, the petitioner went to a second orthopedist, Dr. Gunderson on January 6, 2012.

Dr. Gunderson's findings a somewhat revealing. First of all, he noted atrophy of the Petitioner's left deltoid region. There was never a suggestion in any of his notes that the atrophy, seen just over a month from the accident, was causally related to that accident. He thought there was a brachial plexus injury, based upon the petitioner's complaints and his findings. He came to the same conclusions at his second exam on February 15, 2012, and order nerve studies. Once they were completed he saw the Petitioner for the third and last time on March 30, 2012. He noted the Petitioner's shoulder pain and crepitance with motion, but his diagnosis did not reference the shoulder. Instead, he ruled out a brachial plexus problem and noted peripheral nerve issues in the elbow and wrist. While he did author a referral slip to Midwest Ortho in April partly in reference to the shoulder, there is no indication he ever saw the Petitioner for additional treatment.

Meanwhile, the video of February 22, 2012 is not consistent with any ongoing left shoulder issues. Other than a few visits to the emergency rooms in July and August 2012, where the Petitioner complained of pain and sought narcotic medications, there is no record of any other shoulder treatment. The Petitioner was seen again on three occasions in the emergency room in March and April 2013, seeking medication for problems with his teeth, his elbow and bouts of syncope. PX 5 He testified that he has been working at a quick lube shop for about the past year.

Based upon the above evidence, and taking into account the credibility issues discussed earlier in this decision, the Arbitrator finds that the Petitioner sustained sprain type injuries consistent with the opinions of Dr. DeFranco. He further finds those injuries reached a point of maximum medical improvement as of March 30, 2012.

In support of the Arbitrator's Decision as to WHAT SHOULD BE AWARDED FOR REASONABLE AND NECESSARY MEDICAL SERVICES, the Arbitrator finds the following:

Petitioner's Exhibit #1 is a compilation of itemized medical expenses related to the Petitioner's care following the accident on December 2, 2011. Subject to the limitations of the medical fee schedule of Section 8.2 of the Act, the Arbitrators awards al of the

medical incurred through March 30, 2012. The additional charges are denied as not being for causally related treatment.

In support of the Arbitrator's Decision as to WHAT PROSPECTIVE MEDICAL CARE THE PETITIONER IS ENTITLED TO, the Arbitrator finds the following:

Consistent with this decision, the Arbitrator denies the Petitioner's request for prospective medical care.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Sutton,

Petitioner,

vs. NO. 11 WC 6416

15IWCC0131

Research Services, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of medical expenses, causal connection, vocational rehabilitation, and maintenance and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 19, 2014 is hereby affirmed and adopted.

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

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

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

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

DATED: FEB 1 1 2015
SJM/sj
o-1/29/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

SUTTON, WILLIAM
Employee/Petitioner

Case# **11WC006416**

15IWCC0131

RESEARCH SERVICES INC
Employer/Respondent

On 5/19/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2593 GANAN & SHAPIRO PC
CASEY MATLOCK
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
15IWCC0131
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)

William Sutton
Employee/Petitioner

v.

Research Services, Inc.
Employer/Respondent

Case # 11 WC 6416

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 **Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **March 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. ☐ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☒ Other **Vocational Rehabilitation**

FINDINGS

On the date of accident, **January 7, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$63,000.00**; the average weekly wage was **$1,211.54**.

On the date of accident, Petitioner was **57** 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 **$98,307.41** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$90,327.82** for other benefits, for a total credit of **$188,635.23**.

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

ORDER

Petitioner failed to prove that his current conditions of ill-being and Dr. Carmichael's restrictions on decision making and concentration are causally related to his accident of January 7, 2011. Petitioner failed to prove that he is entitled to vocational rehabilitation or maintenance benefits. Accordingly, vocational rehabilitation and maintenance benefits are denied.

Respondent shall pay all reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. Respondent is not liable for medical bills from St. Mary's Hospital for dates of service of June 30, 2011, July 1, 2011, March 20, 2012, and September 16, 2012. Respondent is entitled to a credit for any medical payments made by Respondent.

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

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

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

Signature of Arbitrator

May 13, 2014
Date

MAY 19 2014

15IWCC0131

STATE OF ILLINOIS)
)
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

William Sutton
Employee/Petitioner

Case No. 11 WC 6416

v.

Research Services, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On January 7, 2011, Petitioner was employed with Respondent as a security consultant and private investigator. Petitioner began working for Respondent on October 1, 2001. In his position for Respondent, Petitioner performed surveillance, developed security post orders and instructions, authored reports, and conducted witness interviews, all of which Petitioner testified involved independent decision making. He frequently traveled for work, as one of Respondent's corporate clients, Tate and Lyle, had facilities throughout the United States. Petitioner previously worked for other employers in the security field, and Petitioner's resume was admitted into evidence as Petitioner's Exhibit 7.

On January 7, 2011, Petitioner slipped on a liquid substance on a stairwell and fell down a flight of stairs. When he woke, a gentleman was standing over him and instructing him to lay still. He testified that he had burning and tingling in his hands and arms, and shooting pain in his shoulders down to his elbows.

Petitioner was taken by ambulance to St. Mary's Hospital for treatment. A CT of Petitioner's head showed no evidence of fracture, intracranial hemorrhage, or cerebral edema. Petitioner was discharged with a diagnosis of a cervical sprain and a minor head injury with loss of consciousness. PX 3.

Petitioner presented to his primary care physician, Dr. Tom Kenney, who referred Petitioner to Dr. Edward Pegg, a neurologist. Dr. Pegg ordered an MRI and an electromyographic study. The MRI of Petitioner's cervical spine dated February 15, 2011 revealed diminution in disc height with disc desiccation at C3-4, a small generalized disc bulge without identifiable cord compression at C4-5, a disc osteophyte complex with left paracentral prominence at C5-6, and a right paracentral/foraminal disc protrusion moderately pressing upon the left paramedian ventral cord contour at C6-7. An electromyographic study taken on February 24, 2011 was normal with no evidence of cervical radiculopathy or peripheral nerve injury. PX 2.

Petitioner presented to Dr. John Atwater at McLean County Orthopedics on March 16, 2011 at the referral of Dr. Kenney, with complaints of cervical pain radiating into his bilateral shoulder blades, pain down both arms, and numbness and tingling through his bilateral hands into his middle, ring, and small fingers. Dr. Atwater ordered an MRI of Petitioner's brain, which was taken on April 4, 2011 and revealed no evidence of acute infarct or other acute intracranial findings. An EMG/nerve conduction study of May 4, 2011, ordered by Dr. Atwater, showed a normal nerve conduction study, left greater than right C7 radiculopathies, and no electrophysiological evidence of other upper extremity neuropathy, plexopathy, or radiculopathy. PX 2.

Petitioner underwent a fluoroscopically guided cervical epidural with Dr. Craig Carmichael on May 23, 2011, which resulted in minimal improvement. PX 2.

On August 1, 2011, Petitioner was examined by Dr. Avi Bernstein pursuant to Section 12 of the Act. Dr. Bernstein concluded that Petitioner's treatment to date had been reasonable, necessary and casually related to the work accident of January 7, 2011. Dr. Bernstein opined that Petitioner required an anterior cervical decompression and fusion at least at C5-6. RX 9.

On April 17, 2012, Petitioner underwent an anterior cervical discectomy and fusion at C5-C6 and C6-C7 with Dr. Wellington Hsu at Northwestern Memorial Hospital. PX 2, 9.

Post-operatively, Petitioner reported to Dr. Carmichael no improvement following surgery, and he continued to report complaints of right upper extremity pain, weakness in the right shoulder, pain in his neck, and numbness and tingling down both arms. An MRI of the cervical spine taken on July 20, 2012 revealed degenerative changes at C3-4 with mild central canal stenosis and moderate left neural foraminal narrowing. Thereafter, Dr. Carmichael recommended a cervical epidural injection, which was ultimately unsuccessful in relieving Petitioner's symptoms. PX 2.

Petitioner underwent an examination with Dr. Timothy VanFleet on December 7, 2012 pursuant to Section 12 of the Act. Dr. VanFleet diagnosed Petitioner with chronic pain syndrome, status post-cervical spinal fusion, which he felt was related to Petitioner's work injury of January 7, 2011. He reasoned that "[s]ometimes the central stenosis, if there is a pinching mechanism taking place at the C5-6 or C6-7 level, that can lead to chronic pain." Dr. VanFleet did not believe the pathology at C3-4 was contributing to Petitioner's current symptoms, and noted that Petitioner had some underlying degenerative disc disease. Dr. VanFleet did not believe any further treatment would be helpful to Petitioner, but that Petitioner would benefit from a functional capacity evaluation to determine any work restrictions. RX 2.

Petitioner underwent a Functional Capacity Evaluation on February 7 and 8, 2013, which placed Petitioner in a medium physical demand level. The Evaluation indicated that Petitioner could work eight hours per day, five days a week, with lifting a maximum of forty five pounds from waist to crown, twenty pounds from waist to crown, and bilateral front carry. PX 4.

Petitioner returned to Dr. Carmichael on February 14, 2013, reporting that he was having tremors that were increasing in his arm, as well as increasing pain in his arm. Dr. Carmichael placed restrictions on Petitioner of no lifting greater than ten pounds frequently or twenty pounds occasionally, no repetitive bending, lifting, or twisting, and to sit or stand as needed. Dr. Carmichael referred Petitioner to Dr. Fang Li for issues related to his tremors. PX 2.

On May 28, 2013, Dr. Carmichael continued Petitioner's previous physical restrictions of no lifting greater than ten pounds frequently or twenty pounds occasionally, no overhead work, sit or stand as needed, and also placed a new restriction on Petitioner, stating that he should not be relied upon for decision making or concentration due to pain, loss of sleep, and medication.

The parties stipulated Petitioner was at maximum medical improvement as of June 1, 2013.

Petitioner presented to Dr. Li at McLean County Neurology on June 4, 2013, wherein Dr. Li noted that Petitioner was experiencing difficulty with hand tremors. Petitioner returned to Dr. Li on July 18, 2013, at which time Dr. Li offered Petitioner prescription medication to alleviate the tingling and tremors in his hands, which Petitioner declined. RX 13.

On April 15, 2013, Dr. VanFleet authored a second report pursuant to Section 12 of the Act. After having reviewed the Functional Capacity Evaluation, Dr. VanFleet opined that the restrictions enumerated in the examination represented permanent restrictions for Petitioner resultant from his work injury of January 7, 2011. RX 3.

On August 27, 2013, Petitioner returned to Dr. Carmichael, at which time Petitioner's complaints of poor sleep, poor concentration, and tremors were discussed. Dr. Carmichael noted that he discussed referring Petitioner to a sleep specialist or a tertiary care center, such as Mayo Clinic, though Petitioner was not interested in those treatment options at that time. PX 2.

Dr. Carmichael testified by way of evidence deposition on August 29, 2013. Dr. Carmichael is board certified in physical medicine and rehabilitation, and he practices in nonsurgical orthopedics, particularly the spine. Dr. Carmichael placed restrictions on Petitioner on August 30, 2012, as he testified that he did not believe Petitioner was able to perform his usual duties at work due to complaints of pain, weakness, a slight tremor, and complaints of poor concentration resultant from poor sleep and pain medications. Thereafter, Petitioner continued to have similar complaints. Dr. Carmichael testified that he referred Petitioner to a neurologist for his tremors, as Dr. Carmichael did not understand them. When asked if he believed the tremors were related to Petitioner's original injury, Dr. Carmichael stated that "[i]t was sort of hard to relate. You know, you could always come up with theories about what might have caused it, but there wasn't any real likely great explanation that I had for it." Dr. Carmichael explained that Petitioner's problems with sleep, poor coordination, and tremors are very unusual following the surgery Petitioner underwent, and he "can't say I really know the cause." Dr. Carmichael noted that there was a point in time when Petitioner's tremors were clearly visible, but when he presented for treatment on August 27, 2013, the tremors had essentially resolved. PX 1.

Dr. Carmichael most recently treated Petitioner on August 27, 2013, at which time Petitioner continued to complain of tremors, poor sleep, and poor concentration. Dr. Carmichael recommended a referral to Mayo Clinic or to a sleep specialist, but Petitioner was not interested in pursuing those treatment options at that time. Dr. Carmichael continued to prescribe medications of Duragesic patch, Norco, Baclofen, Neurontin, and Lunesta. Dr. Carmichael stated that these medications have the potential to impair attentiveness and concentration, and that there are no alternative medications that would not do so. He could not determine whether Petitioner's restrictions as of August 27, 2013 were permanent in nature, and was hopeful that Petitioner's condition would improve with time so as to enable Petitioner to reduce the amount of medication he currently takes. Dr. Carmichael testified that he did not originally place restrictions on Petitioner

regarding his poor concentration and decision making, and that it is not his standard practice to impose such restrictions. He testified that Petitioner requested restrictions regarding concentration. Dr. Carmichael believed Petitioner to be lucid when describing his pain complaints, and he was not concerned about Petitioner's concentration capabilities when speaking to him during treatment visits. He indicated that Petitioner's primary complaint with returning to his usual employment was driving a motor vehicle, as he believed he was a risk due to his poor concentration. PX 1.

Dr. VanFleet testified via evidence deposition on September 4, 2013. Dr. VanFleet is board certified in orthopedic surgery, and performed a one-year fellowship in nonoperative and operative spinal conditions. Dr. VanFleet testified that Petitioner's pathology at C3-4 was not contributing to his current condition, as diagnostic imaging did not reveal any impression of the disc osteophyte protrusion upon the spinal cord. He did not feel that Petitioner required any further medical treatment relative to his work injury of January 7, 2011, and believed Petitioner had reached maximum medical improvement approximately a year after his surgery. Dr. VanFleet recommended work restrictions in accordance with the Functional Capacity Evaluation, and he disagreed with the restrictions placed upon Petitioner by Dr. Carmichael, as he stated that Dr. Carmichael's restrictions were much more restrictive than the Evaluation indicated and resumed Petitioner to functioning at a lower demand level. He did not believe Petitioner's tremors were related to the work accident, as he explained tremors were resultant of a cranial-based condition, and not a cervical spinal injury.

At Arbitration, Petitioner testified that despite undergoing surgery, he continues to suffer with throbbing, burning and tingling sensations from his elbows into his hands and arms. Petitioner notices quaking when he lifts, which otherwise is controlled by medication. He can sit as long as he has the ability to adjust, he can walk one and one-half miles to two miles, and he can stand for approximately thirty minutes. Petitioner testified that he presently suffers with difficulties with concentration and focus. He testified that his medications cause drowsiness, dizziness, and sometimes blurred vision. Petitioner cannot remain focused long enough to put instructions together, and he testified that he can focus for only ten minutes, though he acknowledged he can take an activity back up at another time. He has unsuccessfully attempted to play memory games on the internet. Petitioner testified that his difficulty in making decisions depends upon the complexity of the issue, as he believes he can dig a ditch, but he does not believe he can manage a multimillion dollar company. Petitioner denied neck problems, problems with his hands or arms, and difficulties with concentration at work or at home prior to January 7, 2011. He also denied taking any pain medications, anti-inflammatory or muscle relaxing medications prior to that date.

Petitioner also experiences difficulty sleeping due to pain. He sleeps for a maximum of four consecutive hours, and he naps throughout the day. Petitioner testified his medications make him drowsy and dizzy. With regard to driving a motor vehicle, Petitioner testified that he has to make the decision each time he attempts to drive to determine whether it is safe. He recounted driving into Bloomington when he became drowsy and dizzy, and had to pull over for some time. Prior to his work injury, Petitioner drove long distances, but presently only drives twenty five to fifty miles per week. He testified that he sometimes goes weeks without driving. Petitioner testified that if he feels well enough, he may visit a friend who lives ten miles away every two or three weeks. He may also sweep out the garage, wash a car, or mow the lawn with a riding mower. Petitioner does not perform those activities on the same day because he does not feel well. He does not perform chores, laundry, or grocery shop because he testified that he does not feel like doing much.

Petitioner testified that he had a conversation with Mr. Waldrup about his employment in October or November 2010 following the hiring of Ed Smith. Petitioner specifically denied having a conversation with Frank Waldrup in January 2011 about reducing Petitioner from a salaried employee to an hourly one. Petitioner testified that he last worked for Respondent on January 7, 2011. He received a letter from Respondent dated January 31, 2011, which notified him of the separation of his employment from Respondent effective immediately. RX 11. Petitioner confirmed that as of January 31, 2011, he was terminated from his employment. At the time of his employment separation, Ed Smith, Gary Sullivan, and Frank Waldrup also worked for Respondent.

Petitioner acknowledged signing an employment agreement with Respondent in 2001, but testified that he and Respondent signed another agreement in 2003, which provided him with severance pay in the event of termination. He has not received severance pay after his separation with Respondent on January 31, 2011. Petitioner does not recall the amount of severance pay that he deems is owed to him by Respondent under the 2003 agreement, and he acknowledged that there were allegations that the 2003 agreement was forged.

Petitioner also acknowledged writing Dr. Carmichael a letter in an attempt to get Dr. Carmichael to focus less on his physical capabilities, such as lifting, standing and sitting, and more on his cognitive inabilities. In the letter, Petitioner explains to Dr. Carmichael how his medications cause sleep deprivation, and he proposes a solution of a medication combination that controls his pain and tremors, yet allows him to sleep and drive a vehicle. He also encourages Dr. Carmichael to "tell it how it is when dealing with the insurance companies." RX 8. Petitioner testified that if his medications were changed, he would be able to rise at the same time every day, drive a vehicle without concern, and function on a schedule so as to allow him to return to work. Although Petitioner acknowledged that Dr. Carmichael offered a referral to a sleep specialist on August 27, 2013, Petitioner later denied remembering a referral for a sleep study and does not recall rejecting Dr. Carmichael's recommendation. Petitioner testified that he had an in depth conversation with Dr. Li about his concentration difficulties. Although he recalls his physicians placing him at maximum medical improvement, he does not believe he is.

Petitioner is currently receiving Social Security Disability. He testified that he is not looking for work because he does not feel his medications are under control. Petitioner does not believe he can work in any capacity because of the varying hours in his sleep pattern and because he has no way to tell if he is going to feel well enough to drive. Petitioner testified that he cannot return to his position for Respondent because he cannot handle the traveling, report preparation, and "those types of things" due to his lack of focus, concentration, and inability to function on a schedule and drive. He acknowledged that he does not have any current restrictions on driving. Petitioner testified that he would participate in vocational rehabilitation if it were provided to him.

Frank Waldrup was called as a witness on behalf of Respondent. Mr. Waldrup currently resides in Green Cove Springs, Florida, and he is the owner of Respondent. Mr. Waldrup started the business in 1993. Respondent does not currently employ any employees, nor does it have any active contracts. Respondent's last employees were employed in a part-time capacity, and Respondent has not employed anyone since the fall of 2013. Respondent had one contract with Tate and Lyle in Decatur, Illinois in 1999 to provide security work, and Petitioner was assigned to that client. Mr. Waldrup testified Petitioner was responsible for overseeing security guards, security

cameras, the card access system, and responding to the needs of Tate and Lyle. Respondent's contract with Tate and Lyle ended on May 31, 2013.

Mr. Waldrup testified that Tate and Lyle came to him in 2010 and requested security presence from 8:00 a.m. to 4:30 p.m. every day. Mr. Waldrup testified that because Petitioner did not want to work those hours, he hired Ed Smith. In approximately October or November 2010, Petitioner inquired about the hiring of Mr. Ed Smith. Petitioner assumed Mr. Smith was replacing him, and asked Mr. Waldrup if he needed to begin looking for a new job, to which Mr. Waldrup informed Petitioner that if he was going to terminate him, he would give him thirty days notice. On January 3, 2011, Mr. Waldrup and Petitioner had a conversation about reducing Petitioner's role in Respondent's company. Mr. Waldrup called Petitioner on the telephone and informed him that January would be his last month as a salaried employee. Thereafter, Petitioner would be paid by on an hourly basis, and Petitioner would be assigned as many hours as possible. Mr. Waldrup testified that Petitioner was not interested in the hourly position. Mr. Waldrup testified that upon concluding the conversation, Mr. Waldrup and Petitioner understood that the employment relationship would terminate on January 31, 2013.

Following Petitioner's work accident on January 7, 2013, Mr. Waldrup called Petitioner to see how he was feeling, and to see if Petitioner was going to return to work. Petitioner then sent Mr. Waldrup a doctor's off work slip. Mr. Waldrup testified that he was not aware that Petitioner could return to work in 2013, nor did anyone ask whether Respondent had a job available for Petitioner. Mr. Waldrup testified that Respondent would not be able to accommodate Petitioner in a position with Respondent at this time.

Dave Morgan testified on behalf of Respondent. Mr. Morgan is currently employed at Encore Unlimited as a vocational rehabilitation case manager. In that position, Mr. Morgan performs vocational assessments and transferable skills analyses, assists clients with job skills and interviewing skills, and writes reports. He has been employed in the field of vocational rehabilitation for twenty years.

In performing a vocational rehabilitation assessment of Petitioner on behalf of Respondent, Mr. Morgan testified he received Petitioner's medical information, the reports of Dr. VanFleet, records from Dr. Carmichael, and the Functional Capacity Evaluation. He also interviewed Petitioner on May 9, 2013 to ascertain Petitioner's educational background, interests, skill levels, computer capabilities, and personal goals. In forming his vocational opinion, Mr. Morgan relied upon the restrictions documented in Petitioner's medical records, and also took into consideration Petitioner's work history and his interests. At the time he formulated his report of May 3, 2013, Mr. Morgan did not have Dr. Carmichael's restrictions of May 28, 2013, including the restrictions regarding decision making and concentration.

In his report of May 3, 2013, Mr. Morgan opined that Petitioner is able to return to his previous occupation with Dr. Carmichael's restrictions of February 14, 2013 and Dr. VanFleet's restrictions dated April 15, 2013. PX 4. Mr. Morgan testified that Dr. Carmichael's restrictions of May 28, 2013 would change his opinion regarding Petitioner's ability to return to his former line of work. He stated that the restrictions regarding decision making and concentration are difficult restrictions to assess, because it is impossible to measure levels of concentration and decision making, unlike levels or weight of physical activity. Based upon the restrictions of May 28, 2013, Mr. Morgan was unable to think of any job in which Petitioner would not be required to concentrate

or make decisions. To determine if Petitioner could actually perform a job, Mr. Morgan stated that Petitioner would need to perform a job search, and his ability to successfully complete a job within his restrictions would be based on a job by job basis.

CONCLUSIONS OF LAW

The Arbitrator finds Petitioner to be incredible, as he did not appear candid and forthright in his testimony and demeanor at Arbitration. Petitioner's tone was remarkably pessimistic. On cross examination, Petitioner was evasive, and he became unduly irritated at inquiries regarding his ability to return to work and why he has not sought new employment.

Moreover, Petitioner testified that his poor concentration and decision making prevent him from returning to work. Yet, the Arbitrator found that Petitioner was more alert, attentive and engaged at the conclusion of the trial nearly two and a half hours after its commencement than he was during his direct examination shortly after the trial's initiation.

While Petitioner was monotone and languid on direct examination, he became alert and appeared energetic during Respondent's case. Even though Mr. Waldrup's testimony began nearly an hour and a half into the trial, Petitioner's facial expressions and physical gestures exhibited Petitioner's alertness and attentiveness to the proceedings, which contradicted Petitioner's testimony that he cannot focus for more than ten minutes.

During the testimony of Mr. Morgan, Petitioner continued to engage in the proceedings, and appeared to follow Mr. Morgan's testimony and the repeated references to Mr. Morgan's report of May 3, 2013. The Arbitrator noted that Petitioner read documents set out on the table before him and his attorney, and pointed to specific things on the page to his attorney. The Arbitrator also observed Petitioner making notes on a notepad during Respondent's case. The foregoing indicated that even two hours into the trial, Petitioner was able to concentrate, remain alert and engaged, follow the proceedings, and respond to the oftentimes very detailed testimony. At the conclusion of Respondent's case, Petitioner recalled himself as a rebuttal witness. In that capacity, he was questioned by his attorney regarding testimony from Mr. Waldrup nearly an hour before and Petitioner was easily able to recall the information.

Simply put, Petitioner's demeanor at Arbitration severely calls Petitioner's veracity into question. His testimony concerning his ability to focus and make decisions belies credulity when he appeared to become more alert, more attentive, and more engaged the longer the trial proceeded. Therefore, after observing Petitioner and his demeanor, and listening to his testimony, the Arbitrator is not persuaded that his current medications and alleged poor sleep patterns due to pain have hindered his decision making and concentration capabilities.

Based upon the foregoing, the Arbitrator does not find Petitioner to be credible, and accordingly, does not place any weight on his testimony.

The Arbitrator finds Frank Waldrup and Dave Morgan to be credible witnesses. Mr. Waldrup appeared truthful and forthcoming in his testimony and demeanor, even during cross examination. Mr. Morgan similarly appeared open and honest in his testimony and demeanor at Arbitration.

In regards to disputed issue (F), Respondent disputed the causal relatedness of the cognitive restrictions concerning limited decision making and concentration imposed by Dr. Carmichael on May 28, 2013. Under the Workers' Compensation Act, it is axiomatic that a claimant maintains the burden of proving all the elements of his claim by a preponderance of credible evidence. *Hannibal v. Industrial Comm'n*, 38 Ill. 2d 473 (1967). Although medical testimony is not required to establish causation, *University of Illinois v. Industrial Commission*, 365 Ill. App. 3d 906, 912 (1st Dist. 2006), where the question is one within the knowledge of experts, and not within the common knowledge of laypersons, expert testimony is necessary to show that claimant's work activities caused the condition complained of. *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 478 (4th Dist. 1987). It is not necessary for a medical witness to testify positively as to the cause of a health condition, as it is within the province of the Commission to determine the facts and whether there was a causal relationship between the employment and the injury. *See County of Cook v Industrial Comm'n*, 69 Ill. 2d 10, 18 (1977). The Commission is to determine which testimony is to be accepted were medical evidence is conflicting. *Id.*

In the present case, the Arbitrator finds it probative that, although Petitioner elicited opinions from Dr. Carmichael in his deposition regarding such issues as the relatedness of Petitioner's cervical condition to his work accident, no such opinions were forthcoming regarding his current conditions of tremors, poor sleep, poor decision making, and poor concentration. Instead, Dr. Carmichael could not opine as to the cause of Petitioner's current complaints, as he stated that Petitioner's reported difficulties with sleep, poor coordination, and tremors are very unusual following a cervical fusion and that he "can't say I really know the cause" of those conditions. PX 1. Dr. Carmichael explained that "it is somewhat speculation as to whether those tremors are related to the accident in the sense that we really don't know the cause of the tremors." Rather than affirmatively opining as to the cause of Petitioner's tremors and poor concentration, Dr. Carmichael deferred to Dr. Li, explaining that she was the neurologist who evaluated him for his poor concentration and tremors. PX 1. The Arbitrator finds it significant that after treating with Dr. Li on two separate occasions, Dr. Li did not issue any restrictions for Petitioner regarding his perceived cognitive inabilities. Dr. VanFleet testified that he believed any tremors would not be related to Petitioner's work injury because tremors arise from a cranial-based condition, rather than cervical spinal injuries. RX 1. The Arbitrator also notes Dr. Carmichael's testimony that he was unconcerned about Petitioner's ability to concentrate when speaking to him during treatment visits (PX 1) and Dr. VanFleet's testimony that Petitioner appeared engaged and lucid during his examination on December 7, 2013 (RX 1), which echo the Arbitrator's findings above regarding Petitioner's perceived ability to concentrate and remain focused at Arbitration. The preponderance of the medical testimony indicates that Petitioner's current conditions of tremors, poor sleep, and poor decision making and concentration are not related to his work accident of January 7, 2011.

The Arbitrator is further dissuaded from finding the restrictions at issue causally related in this case, as the restrictions appear to have been imposed at the behest of Petitioner. Petitioner wrote a letter to Dr. Carmichael in an alleged attempt to help Dr. Carmichael phrase his cognitive restrictions "for the insurance companies" (RX 8), and Dr. Carmichael likewise testified that Petitioner requested restrictions dealing with concentration. Dr. Carmichael testified that he did not originally place such restrictions on Petitioner, and it is not within his standard practice to do so. PX 1. Dr. Carmichael's imposition of the decision making and concentration restrictions at the request of Petitioner essentially undermines the authority of their medical necessity relative to Petitioner's condition.

Moreover, Dr. Carmichael's basis for imposing the restrictions regarding decision making and concentration are based upon Petitioner's subjective complaints. When asked if he believed Petitioner's skill level of decision making at work may be affected by his concerns of poor sleep and use of pain medications, Dr. Carmichael stated, "I don't have a good basis for forming an opinion on it. I relied largely on his description of his function. Certainly there is a tremendous amount of medication that he is on and would have the potential to impair attentiveness and possibly concentration." PX 1. As the Arbitrator has found Petitioner to be incredible, the Arbitrator assigns little weight to restrictions imposed as a result of Petitioner's description of his functionality.

Based upon the foregoing, the Arbitrator finds that Petitioner's current conditions of tremors, poor sleep, and poor decision making and concentration are not causally related to the accident of January 7, 2011. The Arbitrator finds Dr. Carmichael's restrictions regarding decision making and concentration of May 28, 2013 are not causally related to the accident of January 7, 2011.

In regard to disputed issue (J), the medical bills from St. Mary's Hospital set forth in Petitioner's Exhibit 8 indicate four dates of service with outstanding bills, including June 30, 2011, July 1, 2011, March 20, 2012, and September 16, 2012. PX 8. A review of the bills from June 30 – July 1, 2011 reveals that Petitioner presented for an emergency department visit, which the Hospital classified as a Level 5 involving a procedure. Petitioner, at that visit, received oxygen therapy, a hand nebulizer treatment, albuterol, and underwent a chest radiograph, which suggests Petitioner was treated for an ailment unrelated to his cervical spine condition. On March 20, 2012, Petitioner presented for an emergency room visit, which the Hospital classified as a Level 4, at which time he received drug screenings, and metabolic panels. This visit does not correspond with treatment requested by Dr. Hsu (See PX 9) or Dr. Carmichael. See PX 2. Notably, Petitioner underwent panel testing on February 24, 2012 at the referral of Dr. Carmichael at BroMenn Healthcare, not at St. Mary's Hospital. PX 2. Petitioner presented to St. Mary's Hospital on September 16, 2012 at which time he underwent drug screenings, which do not correspond with any treatment referrals from Dr. Carmichael, who was treating Petitioner at that time for his cervical spine condition. See PX 2. The Arbitrator notes that Petitioner has not tendered any treatment records or notes from St. Mary's Hospital that correlate with the above dates of service for which Petitioner seeks Respondent to pay as part of the present case. Without more, the Arbitrator finds that Petitioner has failed to prove that the outstanding bills from St. Mary's Hospital enumerated in Petitioner's Exhibit 8 are reasonable, necessary and causally related to Petitioner's accident of January 7, 2011, and are accordingly denied.

The $144.00 of out-of-pocket expenses paid by Petitioner to OSF Healthcare arise from Petitioner's treatment with Dr. Gustavo Galue on June 4, 2013 for laboratory tests, as indicated on the bill dated August 6, 2013 from that provider. PX 8. Petitioner's diagnosis at that time was abnormal involuntary movement, but no medical records were offered to correspond with or support the treatment rendered on that date. PX 8. Further, not only was Petitioner at maximum medical improvement as of June 4, 2013, but Petitioner did not treat with Dr. Galue for his cervical spine condition. Therefore, the Arbitrator finds that Petitioner has failed to prove that the bills from OSF Healthcare enumerated in Petitioner's Exhibit 8 are reasonable, necessary and causally related to Petitioner's work accident of January 7, 2011, and are accordingly denied.

In regard to disputed issue (O), or vocational rehabilitation, Petitioner seeks vocational rehabilitation services to determine whether there is a job within his restrictions, as he contends that

due to his restrictions imposed on him by Dr. Carmichael on May 28, 2013, he is not able to return to his former occupation as a security analyst and private investigator.

Pursuant to Section 8(a) of the Act, an "employer shall… pay for treatment, instruction and training necessary for the physical, mental and vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto. 820 ILCS 305/8(a). A claimant is generally entitled to vocational rehabilitation where he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will increase his earning capacity. *National Tea Co. v. Industrial Comm'n*, 97 Ill.2d 424, 432 (1983). "It is widely accepted that the primary goal of rehabilitation is to return the injured employee to work." *Schoon v. Industrial Comm'n*, 259 Ill. App. 3d 587, 594 (1994), quoting *Hartlein v. Illinois Power Co.*, 151 Ill.2d 142, 165 (1991).

In *National Tea*, the Illinois Supreme Court set forth criteria as guidance in determining whether a vocational rehabilitation program is appropriate, including the relative cost and benefits to be derived from the program, the employee's potential loss of job security, the employee's work life expectancy, the ability and motivation of the employee to undertake the program, whether the employee's injury has reduced his earning capacity, evidence that the rehabilitation program will increase the employee's earning power, likelihood of obtaining employment upon completion of the program, unsuccessful previous rehabilitation programs undertaken by the employee, whether the employee is "trainable" due to age, education, training and occupation, and the employee's existing skills which might enable him to obtain employment without more training or education. *National Tea Co.*, 97 Ill. 2d at 432-433. If an injured employee has sufficient skills to obtain employment without further training or education, that may weigh against an award of vocational rehabilitation. *Id.* Also, an injured employee is generally not entitled to vocational rehabilitation if the evidence indicates that he does not intend to return to work. *Schoon*, 259 Ill. App. 3d at 594.

In the present case, Petitioner failed to prove that his work injury of January 4, 2011 reduced his earning capacity or that a vocational rehabilitation program will increase his earning power. Mr. Morgan credibly testified that, in his vocational opinion, Petitioner can return to his pre-injury occupation as a security analyst and private investigator, as that position is within the physical restrictions imposed by Dr. Carmichael. Mr. Morgan indicated Petitioner's previous jobs in the security field to require light physical demand (RX 4), and a Work Description completed by Mr. Waldrup similarly placed Petitioner's previous position with Respondent in a sedentary work classification. RX 9. Petitioner did not dispute this evidence. Rather, Petitioner testified that he believed he could not return to his previous position due to "all the traveling and reports and those types of things…." Yet, Petitioner does not have a medical restriction on driving, Petitioner lists travel as "unrestricted" on his resume (PX 7), and completing reports seemingly falls within Petitioner's physical restrictions. Petitioner also testified that to return to work, he needs to be able to rise at a specific time each day and function on a schedule. Even if the Arbitrator were to award vocational rehabilitation, those services would presumably not be beneficial to him in accomplishing such tasks of daily living. Based upon the credible evidence, the Arbitrator finds that Petitioner's pre-injury capacity as a security analyst and private investigator falls within the physical restrictions imposed by Dr. Carmichael, and that Petitioner is capable of returning to his regular occupation.

The preponderance of the credible evidence indicates that Petitioner has sufficient education, training and skills to obtain employment without further training or education. Certainly, Petitioner's own resume evidences that Petitioner has worked in the field of corporate security for over twenty years, and has remarkable qualifications and skill capabilities, including business

management, data analysis, employee supervision and training, client negotiations, plan and goal setting, problem analysis and resolution, experience in organizing and executing multiple assignments with particular attention to detail, incorporating work processes and systems, interpreting and analyzing market trends reflecting competitive and economic conditions, and excelling in challenging environments. PX 7. Petitioner also has significant training and education, as he attended two years of college, engaged in seminars and continuing education courses, is licensed by the State of Illinois as a security contractor, and is a member of various societies in the field of security. Petitioner presented no evidence at Arbitration that he lacks skills, training or education that would enable to him to obtain employment in his pre-injury occupation, nor did Petitioner proffer any explanation as to how vocational rehabilitation would provide him any benefit or advantage in becoming gainfully employed than he could achieve absent such rehabilitation. Therefore, the Arbitrator finds that Petitioner has sufficient skills to obtain employment in his pre-injury occupation without the need for vocational rehabilitation.

The Arbitrator further finds that, based upon her observations of Petitioner, and his demeanor and testimony at Arbitration, Petitioner appears unmotivated to undertake a vocational rehabilitation program. Although Petitioner testified that he would "absolutely" participate in a vocational rehabilitation program if offered, given the Arbitrator's findings with regard to Petitioner's testimony and demeanor at Arbitration, the Arbitrator is not persuaded that Petitioner is sufficiently motivated so as to render any vocational rehabilitation program successful. In addition, Petitioner testified that he was not looking for work, and no testimony or job logs were offered at Arbitration to indicate that Petitioner has sought employment at any time prior to Arbitration. The Arbitrator, therefore, finds that Petitioner has not attempted to seek employment within his physical restrictions, which the Arbitrator finds significant of Petitioner's apathy in returning to work.

The record likewise evidences Petitioner's apathy in improving his current physical condition, which would seemingly enable Petitioner to return to work. Despite his significant complaints arising from his reported poor sleep patterns, Petitioner refused Dr. Carmichael's recommendation for a sleep study to address his sleep difficulties, and similarly refused a referral to Mayo Clinic. PX 1, 2. Although Petitioner testified that he was unaware of such a referral, Dr. Carmichael testified that Petitioner indicated on August 27, 2013 that he was uninterested in either treatment option. PX 1. Petitioner also declined an alternative prescription medication to his Baclofen prescription suggested by Dr. Li for his tremors. RX 13.

Based upon the foregoing, the Arbitrator finds that Petitioner has failed to prove that he is entitled to vocational rehabilitation benefits. Therefore, vocational rehabilitation benefits are denied.

In regards to disputed issue (K), Petitioner seeks maintenance benefits from June 2, 2013 through March 14, 2014. Arb. X 1. Section 8(a) provides for an award of maintenance benefits while a claimant is engaged in a prescribed rehabilitation program. 820 ILCS 305/8(a); *Nascote Industries, Inc. v. Industrial Comm'n*, 353 Ill. App. 3d 1067, 1075 (2004). A claimant's self-created and directed job searched designed to increase his earning capacity is sufficient to support an award of maintenance. *Roper Contracting v. Industrial Comm'n*, 349 Ill. App. 3d 500, 506 (2004).

Having concluded that Petitioner is not entitled to vocational rehabilitation and given that Petitioner has not engaged in a self-created and directed job search, the Arbitrator concludes that Petitioner is not entitled to maintenance benefits from June 2, 2013 through March 14, 2014. Therefore, maintenance benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Charles Berry,

Petitioner,

vs. No. 11 WC 07970

Gibco Motor Express,

15IWCC0132

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 jurisdiction and wage differential benefits, and being advised of the facts and law, expands, corrects and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a pneumatic tank truck driver and Illinois resident, sustained a work accident in Kentucky. Petitioner testified his work assignments came from Respondent's East St. Louis, Illinois terminal. He started his days at the East St. Louis terminal and drove loads to Missouri, Illinois, Indiana, Kentucky, Pennsylvania and West Virginia. Respondent's headquarters were located in Evansville, Indiana. The Arbitrator found, based on the totality of the evidence, that Respondent was operating under and subject to the Illinois Workers' Compensation Act (the Act). The Commission agrees.

Section 1(b)(2) of the Act provides that where the accident occurred outside of Illinois, the Commission has jurisdiction over workers' compensation claims by "persons whose employment is outside of the State of Illinois where the contract of hire is made within the State of Illinois" or "persons whose employment is principally localized within the State of Illinois." 820 ILCS 305/1(b)(2) (West 2010). "A contract for hire is made where the last act necessary for

the formation of the contract occurred." Cowger v. Industrial Comm'n, 313 Ill. App. 3d 364, 370 (2000). The Commission finds that Petitioner's application for employment constituted an offer to work for Respondent, which Respondent provisionally accepted at its headquarters in Indiana. However, in Cowger the appellate court found that the last act necessary to give validity to a similar contract for hire was the claimant's successful completion of a drug test, and the contract was formed where the drug test took place. Cowger, 313 Ill. App. 3d at 371. Here, as in Cowger, Respondent required a drug test before Petitioner's hire became final. Because Petitioner took the drug test in Illinois, the contract of hire was formed in Illinois.

The Commission further finds Petitioner's employment was principally localized within Illinois. The inquiry as to whether the employment was principally localized within the State of Illinois focuses first and foremost on the situs where the employment relationship was centered. Cowger, 313 Ill. App. 3d at 372. The factors relevant to this determination include: the center from which the employee worked; the source of remuneration to the employee; where the employment contract was formed; the existence of a facility from which the employee received his assignments and was otherwise controlled; and the understanding that the employee would return to that facility after an out of state assignment was complete. Cowger, 313 Ill. App. 3d at 373. Applying these factors, the Commission finds the situs of the employment was in Illinois. Petitioner testified that all of his work assignments came from the East St. Louis terminal. He started and ended his assignments at the East St. Louis terminal and picked up his paychecks there. He dealt with the staff at the East St. Louis terminal with respect to his daily tasks and drove more in Illinois than the other states combined.

Turning to the nature and extent of Petitioner's disability, the Arbitrator found "[t]here is no dispute that Petitioner suffered an intrasubstance tear of his left rotator cuff as well as impingement syndrome." The Arbitrator discussed Petitioner's current deficits in strength and stamina in light of the very physically demanding duties of a tank truck driver. The Arbitrator found "Petitioner's shoulder has failed to return to where it needs to be in order to return to his position as a tank truck driver." The Arbitrator explained: "Petitioner may be able to sit in a dump truck while it is loaded and then drive the truck to a destination and sit in the truck while it is unloaded. That is not the same job that Petitioner applied for. The job duties are different and the pay is substantially different. Petitioner is not able to go and get a job as a tank truck driver somewhere else." The Arbitrator therefore awarded wage differential benefits.

The Commission notes the operative report describes a biceps tendon tear, but no rotator cuff tear. Having carefully considered the entire record, the Commission finds the work accident caused a biceps tendon tear and aggravated preexisting degenerative conditions in the left shoulder. The Commission agrees with the Arbitrator that Petitioner is unable to perform the job duties of a tank truck driver. For the purpose of wage differential benefits, it is of no import that Petitioner could arguably perform the job duties of a dump truck driver, since that job pays the same as Petitioner's current maintenance technician position. Lastly, the Commission strikes the reference to Petitioner's Exhibit 5, which had been rejected.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 13, 2014, is hereby expanded and corrected as stated herein, and otherwise affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 1 1 2015
SM/sk
o-1/29/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BERRY, CHARLES Case# **11WC007970**
Employee/Petitioner

GIBCO MOTOR EXPRESS 15IWCC0132
Employer/Respondent

On 2/13/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% 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:

2888 LAW OFFICE KEITH SHORT
1801 N MAIN
EDWARDSVILLE, IL 62025

LEWIS RICE & FINGERSH L C
DUANE COLEMAN
600 WASHINGTON AVE SUITE 2500
ST LOUIS, MO 63101

15IWCC0132

STATE OF ILLINOIS)
)SS.
COUNTY OF Mt. Vernon)

- [ ] 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

Charles Berry
Employee/Petitioner

v.

Gibco Motor Express
Employer/Respondent

Case # 11 WC 007970

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 **Mt. Vernon**, on **January 8, 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Wage Differential Award**

FINDINGS

On **January 21, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,834.22**; the average weekly wage was $**1049.00**.

On the date of accident, Petitioner was **58** years of age, ***single*** with 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

The Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act.

The Arbitrator finds that Petitioner's left shoulder is permanently disabled and for that reason he will not be able to return to duty as a tank truck driver.

Respondent shall pay Petitioner wage differential benefits including past due benefits which commenced on June 2, 2012, of $319.99/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.

Edward Lee
Signature of Arbitrator

2/10/14
Date

FEB 13 2014

Before the Workers' Compensation Commission
State of Illinois

Charles Berry,	)	
	)	
Petitioner,	)	11 WC 007970
	)	Arb. Edward Lee
v.	)	
	)	
Gibco Motor Express,	)	
	)	
Respondent.	)	

Arbitration Decision

This matter was tried under the Illinois Workers' Compensation Act on January 8, 2014 during the Mount Vernon docket.

The issues presented at hearing were:

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

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

(O) Is the Petitioner entitled to a Wage Differential Award?

One witness testified at hearing: Petitioner

Statement of Facts

The Petitioner, a 58-year-old man was hired as a tank truck driver by Gibco Motor Express in East St. Louis, Illinois, in September of 2010. On January 20, 2011, Petitioner received notice of an assignment to deliver a load of dry bulk to Boston, Kentucky. On January 21, 2011, while in Boston, KY, Petitioner was working under the tank in an attempt to unclog the pipe used to release the dry bulk from the tank. During Petitioner's attempt to lift the 100 lb. pipe, he felt a pop in his left shoulder. Petitioner then returned to the cab of the truck and called Ray, the dispatcher at the East St. Louis, IL depot. The dispatcher called the Evansville,

IN depot, informed Ray of the injury and requested assistance to Petitioner's location. After assistance arrived and fixed the pipe, Petitioner completed the run by driving the tank back to the East St. Louis, IL depot.

On January 28, 2011, Petitioner sought medical treatment at Salem Township Hospital in Salem, IL. X-Rays were performed on Petitioner's left shoulder. Treating provider Janet Mcewen, ANP subsequently scheduled Petitioner to have an MRI on February 15, 2011 at Salem Township Hospital. The results of the MRI showed an intrasubstance tear of the left rotator cuff and impingement syndrome. (Pet. Exh. 2) Petitioner was then taken off work and instructed to attempt physical therapy. After the failure of conservative treatment, Petitioner's treating provider referred him to Dr. Jeffrey B. McIntosh, M.D. at the Nueromuscular Orthopaedic Institute in Mt. Vernon, IL.

Petitioner's first surgery occurred on March 14, 2011 at Crossroads Community Hospital in Mt. Vernon, IL. Dr. McIntosh performed the arthroscopic surgery which consisted of a debridement of Petitioner's biceps tendon as well as a subacromial decompression and acromioplasty. On March 17, Petitioner returned for his first post-operation visit with Dr. McIntosh and also began rehabilitation which included pulley and pendulum exercises. (Pet. Exh. 1) Petitioner completed physical therapy at NovaCare Rehabilitation in Salem Township Hospital from April 5, 2011 through September 16, 2011.

Even with the physical therapy regimen, Petitioner failed to improve. Petitioner underwent a second surgery on his left shoulder on September 19, 2011. Dr. McIntosh performed an open decompression of Petitioner's left shoulder with acromioplasty and distal clavicle resection at Crossroads Hospital. Id. Petitioner then started an aggressive rehabilitation/work conditioning program post-operatively at St. Joseph's Hospital in Breese, IL. This included 43 visits through February, 22, 2012. Petitioner continued work conditioning until May and at the request of Respondent, he received a Functional Capacity Evaluation on May 23, 2012 at St. Joseph's Hospital. (Pet. Exh. 4) The findings in the Material Handling Activity section on pg. 5 illustrate that Petitioner's ability is not a match for the lifting demands of his employment position in four of the six categories. Id.

Petitioner returned to work at Gibco in a limited capacity on June 1, 2012 until August 2, 2013. His work duties included performing maintenance functions in the shop. After the FCE, Dr. McIntosh authored a report dated June 7, 2012 which details his overall opinion of Petitioner's health. (Pet. Exh. 1) Also, Petitioner underwent an Independent Medical Evaluation on July 7, 2012 which was conducted by Dr. Milne. (Pet. Exh. 5).

Analysis

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

Petitioner testified that before he began his employment as a tank truck driver with Gibco Motor Express, he had to do a variety of things, all of which occurred in Illinois. Petitioner testified that he first spoke with a woman from the East St. Louis, IL depot about the details of the position. He met with the woman at that same address to fill out the application. Respondent's argument that IL jurisdiction is not proper only hinges on the fact that Petitioner's application was sent to Indiana. However, Petitioner was not hired until he passed a drug test. He took the drug test in IL. The acceptance of employment on Petitioner's part occurred in IL. The Petitioner took part in training in IL. The training consisted of riding along with route guys in IL.

Petitioner had little contact with the state of Indiana. Petitioner testified that he never had any communications regarding his employment with anyone in Indiana. He testified that in order to get paid for a route, he had to pick the truck up in IL, drive it to the destination, unload the truck and then drive the truck back to East St. Louis, IL. Petitioner did not avail his employment in any manner to Indiana besides when he had to drive the tank truck through the state for the purposes of making a delivery or returning to IL. Frankly, Petitioner was never once told of anything that related his employment to the state of Indiana.

Respondent's assertion of Indiana jurisdiction is without merit. Petitioner was told he was hired in Illinois; was assigned all work out of Illinois; was paid from Illinois; was directed and controlled from Illinois; provided equipment in Illinois and as operating a route starting and ending in Illinois.

Based on the totality of the evidence, the Arbitrator finds that Respondent was operating under and is subject to the Illinois Workers' Compensation Act.

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

The medical evidence and live testimony indicate that Petitioner has suffered a permanent injury to his left shoulder. There is no dispute that Petitioner suffered an intrasubstance tear of his left rotator cuff as well as impingement syndrome. The first surgery that Petitioner underwent was a debridement of his biceps tendon, subacromial decompression and acromioplasty. After an unsuccessful rehabilitation program, Petitioner underwent a second surgery, which included an open decompression of Petitioner's left shoulder with acromioplasty and distal clavicle resection. The evidence illustrates that Petitioner attempted another round of aggressive rehabilitation. However, Petitioner's shoulder has failed to return to where it needs to be in order to return to his position as a tank truck driver. Petitioner's lifting ability as evidenced by the Functional Capacity Evaluation confirms that.

The Arbitrator noted Petitioner's demeanor and presentation. He appeared credible. The medical records also confirm his full, honest and complete effort. He has significant reduced range of motion in his twice operated shoulder. The FCE objectively confirms significantly reduced strength and functional use of the shoulder. This injury places Petitioner outside of his usual and customary employment as a tank driver.

In Dr. McIntosh's June 7, 2012 report, He states that Petitioner "still has deficits in strength and stamina, and at this point he would be placed on permanent restrictions which would include no lifting above his chest or shoulders, 20 pound weight restriction and he cannot do a job which requires repetitive torque type motion on his shoulder." (Pet. Exh. 1). Petitioner testified that he is unable to perform the lifts and movements necessary that are required of a tank truck driver. Dr. McIntosh, in his August 31, 2012 report stated that he felt Petitioner could return to a job as a truck driver; however, his June 7, 2012 report as well as the Functional Capacity Evaluation results and Petitioner's testimony prove that Petitioner would be unable to return to the job of a **tank**

truck driver that Petitioner applied for. The duties of a tank driver are substantially greater than those of a general hourly-paid truck driver. Petitioner testified that a tank driver has to climb up onto the truck and roll and unroll the tarp. It requires him to be able to lift and maneuver all of the hoses to and from the tank. Petitioner must be able to manipulate the product line. This requires Petitioner to drop the middle product line under the trailer. This particular line is a 100 lb. steel pipe that is four inches in diameter. Petitioner must be also be able to lift the pipe back up and reattach it with the sleeve clamp.

The Petitioner does not possesses the strength necessary in his shoulder to be able to perform these responsibilities. Petitioner may be able to sit in a dump truck while it is loaded and then drive the truck to a destination and sit in the truck while it is unloaded. That is not the same job that Petitioner applied for. The job duties are different and the pay is substantially different. Petitioner is not able to go and get a job as a tank truck driver somewhere else. Therefore, the Arbitrator finds that Petitioner's left shoulder is permanently disabled and Petitioner will be unable to return to the position of a tank truck driver.

(O) Is the Petitioner entitled to a Wage Differential Award?

Petitioner testified that he is unable to perform the lifting duties required of a tank truck driver. In addition, the medical evidence and the FCE reflect the same fact, which is why Petitioner did not accept the April 26, 2013 offer of a tank driver. The tank truck driver position paid Petitioner an average weekly wage of $1,049.99. See stipulation sheet. That amount is not disputed. Petitioner's current position is a shift work position, which entitles him to being paid $14.25 an hour for 40 hours a week. That amount places Petitioner's current average weekly wage at $570.00. Therefore, Respondent shall pay Petitioner wage differential benefits including past due benefits which commenced on June 2, 2012, of $319.99/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.

CONCLUSION

Based on the evidence presented, including the medical records and the testimony of the Petitioner and the reasons stated above, the Arbitrator finds for the Petitioner and awards as follows:

In regard to disputed issue A:
The Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act.

In regard to disputed issue L:
The Arbitrator finds that Petitioner's left shoulder is permanently disabled and for that reason he will not be able to return to duty as a tank truck driver.

In regard to disputed issue O:
Respondent shall pay Petitioner wage differential benefits including past due benefits which commenced on June 2, 2012, of $319.99/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.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF DUPAGE	)	☐ 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

Mila Bailey,

Petitioner,

vs. NO. 09 WC 37246

15IWCC0133

Arthur J. Gallagher,

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 disability, causal connection, 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 February 27, 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.

No bond is required for removal of this cause to the Circuit Court.

15IWCC0133

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

DATED: FEB 11 2015
SJM/sj
o-2/5/15
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BAILEY, MILA
Employee/Petitioner

Case# **09WC037246**

15IWCC0133

ARTHUR J GALLAGHER
Employer/Respondent

On 2/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% 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:

0208 GALLIANI DOELL & COZZI LTD
THOMAS DOELL
20 N CLARK ST SUITE 1800
CHICAGO, IL 60602

2337 INMAN & FITZGIBBONS LTD
JACK M SHANAHAN
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

15IWCC0133

STATE OF ILLINOIS)
)SS.
COUNTY OF Du Page)

- [ ] 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

Milagros Bailey
Employee/Petitioner

v.

Arthur J. Gallagher
Employer/Respondent

Case # 09 WC 37246

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 **Wheaton**, on **December 6, 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. What was the date of the accident?
E. Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. X Other **prospective medical**

FINDINGS

On **6/19/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**44,413.72**; the average weekly wage was $**854.11**.

On the date of accident, Petitioner was **57** years of age, married with **0** dependent children.

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

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

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

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

ORDER

Pursuant to the attached Findings of Fact and Conclusions of Law, the Arbitrator finds that petitioner failed to meet her burden of proof and that her 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

02-26-14
Date

FEB 27 2014

FINDINGS OF FACT

Petitioner testified that she was an accountant for Arthur J. Gallagher starting in 1999. In approximately February, 2009, she and her coworkers were relocated to the 16th floor of the building where she worked for respondent in Itasca. She testified that 5 of the 8 people that she worked with were terminated at that time due to management changes.

on June 19, 2009, petitioner was sharing a cubicle with another coworker and testified that she had a very small work space. She testified that near the end of her work day, she went to get up from her desk to go to the copier and her shoe got stuck on the carpet. She fell down on her face, landing mostly on her left side. She testified that she had flat shoes on that were in good condition. She testified that there was carpeting around her desk and that she was on carpeting at the time that she fell. She did not testify to any flaws in the carpeting.

On cross-examination, petitioner specified that she spun her chair around and then successfully arose from the chair. As she started to take a step, her shoe stuck on the carpet and she fell. No other details were provided concerning the circumstances of the accident or how petitioner fell.

Petitioner testified that she yelled when she fell, and a coworker asked her if she was okay. She also reported that her supervisor Katie asked her if she was okay, and she responded that she was. Petitioner testified that she was embarrassed that she fell. She stated that she had pain in her left knee and left shoulder immediately following the occurrence.

The accident happened on Friday, according to petitioner's testimony, and while she was sore over the weekend, she returned to work on Monday and continued working for respondent with no interruption until she was let go approximately three weeks later in early July, 2009. Petitioner made no claim for lost time (Arb. Ex. 1) and did not testify to any time off from work on account of this occurrence.

On direct examination, petitioner did not testify to any other employment at the time of the accident. On cross-examination, however, petitioner testified that in addition to her employment with respondent, she had a second job with FedEx that she had worked for 22 years. She was still in this employment at the time of trial. Despite not losing time from work from respondent following this incident, petitioner testified that she did lose time from the FedEx job following this occurrence. She stated that she returned to that job by the end of July.

Petitioner testified that she went to her personal physician, Dr. Sia, following the occurrence, but no records of her treatment with Dr. Sia were introduced into evidence. She testified that she was advised by the Worker's Compensation claims person to go to Dr. Kuesis at Core Orthopedics. This did not occur until September, 2009, however, and petitioner reiterated that she had been terminated by Gallagher in July 2009. She also confirmed that Gallagher had denied this claim and had not paid any benefits on it.

Petitioner went to see Dr. Kuesis on September 18, 2009 for complaints of left shoulder and left knee pain. The doctor ordered an MRI of the left shoulder and left knee and treated her with injections and therapy until October 30, 2009. She was not discharged at that time according to her testimony and the records of Dr. Kuesis (PX 1), but petitioner stopped treating for her injuries at that time.

Petitioner testified that she stopped treating because she could not afford it since she had been terminated by respondent. Petitioner verified, however, that she continued to work at FedEx from late July 2009 up until the time of trial.

In August 2010, petitioner testified that she secured a second job with Mesirow Financial, and four months later, in December 2010, moved to American Westbrook Services. Petitioner continued to work at both American Westbrook and FedEx at the time of trial.

On direct examination, petitioner testified that after she began working again in 2010 as an accountant, she renewed treatment for her left knee and left shoulder as they had never improved from the time of the work injury. On cross-examination, however, petitioner admitted that she sought no treatment whatsoever for her claimed injuries from the June 2009 incident from any doctor between October 2009 and November, 2012, two years after she started working as an accountant again, when she first went to see Dr. Wong at Reinforce Health Clinic.

Petitioner completed a patient assessment form on her first visit to Dr. Wong on November 17, 2012, and when asked whether the condition for which she was seeking treatment was due to an accident, petitioner answered "no." When asked if she had ever treated for the condition for which she was seeking treatment with Dr. Wong, petitioner answered "none." Although petitioner testified to the persistence and severity of her left shoulder and left knee claims since June, 2009, she answered the question on the form as to "How often do you have this pain?" by circling the phrase comes and goes, as

opposed to circling "constant." Petitioner also admitted that she complained of headaches and low back pain to Dr. Wong upon first seeing him in November, 2012. (RX 1).

In May, 2013, petitioner began treatment with Dr. Luke at Barrington Orthopedics. In her intake form with Dr. Luke, she noted that her left shoulder and low back pain began from a work injury in June 2009. There is no mention of left knee pain on this form. Dr. Luke performed injections and an MRI of her left shoulder, and she testified that she treated with him through September, 2013, when he referred her for further treatment with other specialists to two other doctors at Barrington Orthopedics. Petitioner has not sought this treatment since the referral was allegedly received in September, 2013.

From reviewing petitioner's medical record exhibits, the Arbitrator notes that petitioner has no documentation of any treatment received on account of this injury until September 18, 2009 with Dr. Kuesis. There is no documentation in these records of a referral by "worker's compensation," or her employer. (PX 1, p.5).

The Arbitrator further notes that petitioner failed to introduce any records from Dr. Wong at Reinforce Health & Wellness, but rather only introduced bills reflecting treatment there from May, 2013 through September, 13, 2013. Conversely, despite petitioner's testimony that Dr. Luke has seen her through September, 2013, and referred her to two other specialists, the records introduced from Dr. Luke show treatment only from May 2013 through July 22, 2013, and do not contain documentation of a visit or injection in September 2013 or the referral petitioner testified to. (PX 2). Likewise, the billing exhibit does not confirm treatment at Barrington Orthopedic after July, 2013. (PX 5).

To the contrary, Respondents Exhibit 1 establishes that petitioner first went to see Dr. Wong in November, 2012. This would be at least petitioner's third choice of physicians as she testified to seeing Dr. Sia and there is no documentation of who may have referred petitioner to Dr. Kuesis. Petitioner's billing exhibit attempts to imply that petitioner was referred to Reinforce by Dr. Luke, but RX 1 does not support that.

Petitioner testified that her job at FedEx was as a manager and not physically demanding, but agreed that when she went to see Dr. Wong in late 2012, she complained of the excess demands put upon her by the holidays and by drivers taking time off. She further agreed that she told Dr. Wong in

November 2012 that her low back started bothering her after she was standing all day and cooking on Thanksgiving while at home.

CONCLUSIONS OF LAW

Based on the above, the Arbitrator find the following:

On the issue of accident, petitioner testified merely that after standing up from a seated position, she fell down while attempting to walk from her shoe sticking on the carpet. This is corroborated by her intake form with Dr. Kuesis, though his examination note states that she slipped on carpet. (PX 1, pp. 5, 8). Regardless, petitioner did not testify to any conditions of her employment that increased the risk of her falling while attempting to walk on carpet while at work. Petitioner did not testify to carrying anything, needing to rush to complete an assignment nor to any defect in the carpeting on which she fell. She stated that she wore flat shoes that were in good shape, and there is no evidence that the employer required her to wear certain shoes that might have increased the risk of her shoe getting stuck on carpeting or slipping on carpeting.

Petitioner did testify to a smaller work area than she was used to, but the Arbitrator finds that petitioner failed to demonstrate how this may have contributed to her accident, as she testified that she had simply arisen from her chair, successfully stood up, and simply began to walk when she fell.

To be compensable under the Act, a workplace injury must both arise out of and in the course of the employment. Illinois Bell v. Industrial Commission, 131 Ill.2d 478 (1989). The petitioner bears the burden of proving every element of her claim by a preponderance of the evidence. Arbuckle v. Industrial Commission, 32 Ill.2d 581 (1965). If the risk to which the claimant is exposed at work is equally faced by those in the general population, an injury resulting from that risk will not be said to be compensable under the Act. Reed v. Industrial Commission, 63 Ill.2d 247, 249-250 (1976). The mere fact that the duties take the employee to the place of the injury and that, but for the employment, she would not have been there is not of itself sufficient to give rise to the right of compensation. Caterpillar v. Industrial Commission, 129 Ill.2d 52, 63 (1989).

Here, the petitioner must prove by a preponderance of the credible evidence that the accident of which she complains arose out of and in the course of her claimant. The Arbitrator find that there is

nothing to distinguish petitioner's act of standing up from her chair and beginning to walk on carpeting and falling while at her job from a similar set of actions occurring outside of the workplace. Petitioner provided no testimony that would bring this occurrence as one arising out of or her employment.

Petitioner lost no time from work that she is claiming, despite the testimony that while she continued to work her accounting job for respondent, she was unable to work her managerial job at FedEx for a few weeks. Her exhibits do not support that she sought any treatment for the occurrence until three months later, two months after she was terminated by respondent. Even at that point, the medical records fail to establish anything more than that petitioner slipped or had her shoe get stuck on carpeting, leading to her fall.

It is not until her case was above the trial line at the Commission in 2013, and perhaps not until respondent's attorney, per pre-hearing arguments, was pressuring petitioner's attorney to bring this matter to hearing, that petitioner sought treatment allegedly for this incident with Dr. Luke, and included it in her history again (though failing to do so when she saw Dr. Wong in November, 2012). The Arbitrator therefore finds that petitioner failed to meet her burden of proof and that this claim is therefore denied.

Assuming *arguendo* that the Arbitrator were to find that petitioner proved that her work accident arose out of her employment with respondent, the Arbitrator further finds that petitioner failed to establish that any of the injuries for which she sought treatment are causally related to that occurrence. As noted, while petitioner testified to being in significant pain in her left shoulder and left knee following the occurrence, pain that apparently has not dissipated over the past four years, there is no record that she sought treatment for these injuries whatsoever until more than three months after the accident. Although petitioner testified to seeing her personal physician immediately after the occurrence, no records were introduced to corroborate this.

In addition, while Dr. Kuesis treated petitioner based on her subjective complaints, the Arbitrator notes that the MRIs of her left shoulder and left knee were essentially negative, except for degenerative changes on a 57-year-old claimant, and there is never a clear diagnosis made in his records, much less one that is medically causally related to the work accident. (PX 1). It is further unclear exactly what injury petitioner sustained in her fall, if any, due to the fact that she stopped treating in October 30, 2009, and

did not resume any treatment whatsoever until more than three years had passed. This is despite the fact that petitioner continued working her job at FedEx, and then obtained dual employment starting in August 2010 as an accountant, and has continued working both jobs steadily for the past three years.

In reaching this decision, the Arbitrator also takes petitioner's credibility into account. As already noted, petitioner testified to much more treatment than is demonstrated by the medical documentation introduced in her case. Further, the details of petitioner working two jobs at the time of the accident were conveniently omitted during the course of her direct examination. The Arbitrator finds it not credible whatsoever that petitioner could have continued working her accounting job with the respondent at the accident with no lost time, but that she was somehow unable to continue working her second job with FedEx for three or four weeks in July 2009, particularly when petitioner later testified that that was a managerial job and not physically demanding.

It is clear that the potential value of petitioner's claim as to the nature and extent of her injury is diminished by the evidence that she continued to work one or two jobs almost without interruption since this accident, and it also diminishes the credibility of petitioner's testimony that she stopped treatment for these injuries in 2009 due to the fact that she was terminated from respondent and could not afford the treatment. Petitioner was still working at FedEx in October 2009 when she stopped seeing Dr. Kuesis, and her evening work hours for that job would have allowed continued treatment during normal office hours during the day. (This ignores the fact that petitioner did not start treating with Dr. Kuesis until two months after she was terminated.) If she was truly injured as she claims, the time to seek treatment would have been in June or July. Yet, despite her testimony of seeing her personal physician after the accident, no records of Dr. Sia were put into evidence.

Further, if petitioner were to be believed that she needed to work two jobs in order to afford medical treatment for her work injuries, then there is no explanation offered whatsoever for why petitioner did not seek treatment starting in August 2010 when she secured her second job with Mesirow Financial. Instead, another *26 months* passed before petitioner began seeking treatment with a chiropractor in November 2012.

Petitioner's credibility is also diminished by Respondent's Exhibit 1, in which, completely contrary to her testimony and exhibits, petitioner sought treatment in November 2012 for intermittent pain that was

not related to an accident. This completely contradicts petitioner's testimony that her left shoulder and left knee were constantly in pain and causing her problems following the June 2009 work injury. She also admitted that she sought chiropractic care for her headaches and low back pain, and there is no indication even in the records of Dr. Kuesis that petitioner had low back pain following this accident. Lastly, petitioner told Dr. Wong that she had not sought treatment previously for the conditions for which she was seeking chiropractic treatment in November 2012.

Once again, the petitioner bears the burden of proof on all elements of her claim, and a claimant's credibility is important in assessing the evidence produced on each issue. The Arbitrator finds that petitioner's medical records do not corroborate her testimony, as the amount of treatment and number of treaters she saw following the incident in 2009 and her testimony about the extent of her pain and the reason she began seeking treatment again in 2012 are not supported whatsoever by the contemporaneous medical records. Petitioner failed to introduce any records from Dr. Sia, and the records petitioner submitted from Dr. Wong do not reflect treatment until after she saw Dr. Cole at Barrington Orthopedics.

The intake form from Dr. Wong as submitted by respondent contradicts petitioner's testimony and claim, and the Arbitrator can only assume the missing records from Dr. Sia would fail to support this claim as well. Therefore, even if the Arbitrator were to find that petitioner established a compensable accident in this matter, petitioner failed to prove that the condition for which she began treatment in September 2009 and for which she is currently treating is causally related to that accident.

For the foregoing reasons, compensation is denied in this matter.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Derek Mears,

Petitioner,

vs. NO. 11 WC 41070

Southwest Airlines Inc.,

15IWCC0134

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 3, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $56,600.00.

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: FEB 1 1 2015
SJM/sj
o-1/29/15
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEARS, DEREK
Employee/Petitioner

Case# **11WC041070**

15IWCC0134

SOUTHWEST AIRLINES INC
Employer/Respondent

On 9/3/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0365 BRIAN J McMANUS & ASSOC LTD
30 N LASALLE ST
SUITE 2126
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
THOMAS P CRONIN
140 S DEARBORN 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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0134

Derek Mears
Employee/Petitioner

v.

Southwest Airlines, Inc.
Employer/Respondent

Case # **11** WC **041070**

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 **May 22, 2014**. By stipulation, the parties agree:

On the date of accident, **June 8, 2011**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**39,170.04**, and the average weekly wage was $**753.27**.

At the time of injury, Petitioner was **27** years of age, *married* with **no** dependent children.

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

Respondent shall be given a credit of $**45,051.11** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,807.68 for a permanent partial disabilityadvance** for other benefits, for a total credit of $**46,858.79**.

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.

Petitioner works on baggage ramps. On June 8, 2011, he was pulling a partially broken cart of bags. The brakes did not work properly, so he bent over very low to pull the cart. Petitioner then felt a pop in his back and a lot of pain. Petitioner went to Concentra Medical Center for conservative treatment. Thereafter, he saw an orthopedic surgeon, Dr. Stamelos, who ordered a lumbar MRI, performed an epidural injection, and prescribed low back surgery. Petitioner obtained a second opinion from Dr. Zelby, who then performed an L4-L5 microdisectomy. Petitioner was subsequently seen by Dr. Frank, a physiatrist, who performed an epidural injection. Petitioner then underwent physical therapy at Physiotherapy Associates in Elmhurst. Petitioner returned back to work on February 26, 2013 in a light duty capacity, began working full duty on or about March 11, 2013, and has not returned for any more medical treatment. Petitioner experiences ongoing low back and radiating pain.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of **$451.96**/week for **125** weeks, because the injuries sustained caused the **25%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **June 9, 2011** through **February 25, 2013**, 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.

Milton Black

Signature of Arbitrator

September 3, 2014
Date

SEP 3 - 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kimberly Schweda,

Petitioner,

vs. No. 13 WC 32288

Walgreen's,

15IWCC0135

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of accident and being advised of the facts and law, expands, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's questioning Petitioner's credibility and denying the claim. However, the Commission's analysis of accident is somewhat different.

Petitioner testified her job duties on August 6, 2013, involved picking makeup products from shelves, including items located slightly overhead, and putting them into totes to ship to customers. The job was very fast paced, requiring 485 "picks" per hour. Petitioner described the alleged accident: "I was picking like I usually do, and I went to use my right arm, which I'm right-handed, to pick product from the top shelf. And as I was picking up sticking my hand in to grab, I felt a sharp burning pain by my shoulder blade." Petitioner explained she was in the process of reaching into a box of product, which was a little higher than her eye level. The Arbitrator found Petitioner failed to prove a compensable accident because she was simply reaching and not lifting anything at the time she felt the pain. The Arbitrator noted that reaching is a normal activity of life, and Petitioner described no awkward positioning.

The Commission finds that, even assuming Petitioner truthfully testified regarding the events on August 6, 2013, she failed to prove a compensable accident. The Commission relies on the testimony of Respondent's section 12 examiner, Dr. Kevin Rutz. Dr. Rutz credibly testified in his evidence deposition that Petitioner's preexisting cervical spine condition had deteriorated to the point she was going to sustain a disc herniation no matter what. It was just happenstance the disc herniation occurred at work. Dr. Rutz maintained Petitioner's reaching for product did not cause the disc herniation. The Commission therefore finds Petitioner's preexisting condition alone is the cause of her symptoms and need for surgery. See Sisbro. Inc. v. Industrial Comm'n, 207 Ill. 2d 193, 215 (2003) ("When an employee with a preexisting 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 preexisting condition or whether the preexisting condition alone was the cause of the injury").

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 12, 2014, is hereby expanded, 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.

DATED: FEB 1 1 2015
SM/sk
o-1/29/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

SCHWEDA, KIMBERLY Case# **13WC032288**
Employee/Petitioner

WALGREEN'S
Employer/Respondent

15IWCC0135

On 5/12/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.45% 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:

0781 KEEFE & GRIFFITHS PC
DANIEL KEEFE
10 S BROADWAY SUITE 500
ST LOUIS, MO 63102

0180 EVANS & DIXON LLC
KIM M PARKS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

15IWCC0135

STATE OF ILLINOIS)

)SS.

COUNTY OF **JEFFERSON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

KIMBERLY SCHWEDA
Employee/Petitioner

v.

WALGREEN'S
Employer/Respondent

Case # **13** WC **032288**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **March 13, 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] 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, **August 6, 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 $**31,408.58**; the average weekly wage was $**604.01**.

On the date of accident, Petitioner was **40** years of age, **single** with **0** dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**8,950.50** for other benefits, for a total credit of $**8,950.50**.

Respondent is entitled to a credit of $**0** for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident arising out of her employment or that her current condition of ill-being is causally related to her alleged accident. Petitioner's claim is denied and no benefits 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.

[signature]
Signature of Arbitrator

5.6.14
Date

ICArbDec19(b)

MAY 12 2014

Findings of Fact and Conclusions of Law

At the time of arbitration the disputed issues were: accident; causal connection, medical expenses, prospective medical care, and temporary total disability benefits. The parties agreed that Respondent should get a credit under Section 8(j) of the Act for non-occupational indemnity disability benefits paid to Petitioner; however, Respondent did not know the exact amount to claim. By agreement, that information was to be furnished to the Arbitrator via e-mail and a copy printed, marked as an exhibit, and made a part of the record. Consistent with that agreement, an e-mail was sent to the Arbitrator on March 27, 2014, has been printed and marked as "AX 5" and included with the record. Two witnesses testified at the hearing: Petitioner and Matthew Shook, Respondent's representative at the hearing.

The Arbitrator finds:

Petitioner worked for Respondent as a picker and had been so employed for approximately 13 years. Petitioner worked on August 6, 2013 and claims she was involved in a work accident that day. She did not report it that day but finished her shift and went home.

On August 7, 2013 Petitioner and Matthew Shook completed and signed a "Work Injury Solutions Request for Athletic Trainer Consultation." (RX 2) In response to the question, "Do you believe the condition for which you are seeking care is work related?" Petitioner circled "No." In the highlighted section in the middle of the form which was to only be completed if the condition was work-related, Petitioner wrote "shoulder blade/right side." Immediately below that was a bold-typed question for the "Function Manager" to complete asking "Was an Accident/Incident Report Completed? (Work related only)." Neither "Yes" nor "No" was circled. Petitioner was given an appointment on Friday, August 9, 2014 at 2:00 p.m. (RX 1)

Petitioner presented to Work Injury Solutions on August 9, 2013. Petitioner completed a pain drawing circling her right shoulder blade area on the anatomy drawing but circled "left" vs. "right" above the drawing. She complained of a dull ache, stiffness, and stabbing pain ranging from a 3/10 to an 8/10. (RX 3) Petitioner also completed a questionnaire that same date in which she denied any visits to a hospital emergency room for neck or arm pain, and acknowledged having difficulty sleeping because of her neck or arm pain, stating "Last couple of nights due to shoulder blade." (RX 4, p. 1) In response to the question, "What was the date you noticed these symptoms?" Petitioner wrote "8/6/13." In response to the questions, Where were you when these symptoms started?", she wrote "in bed @ home." (RX 4, p. 2) Petitioner denied any prior surgeries or significant pain in that area, indicated she was taking ibuprofen and noticed her symptoms increased when "reaching over head and throwing boxes in the trash bin." (RX 4, p. 2)

On August 13, 2013 an Accident Investigation report was completed. The date and time of the accident was given as "8/6 about 9 p.m." The accident explanation read as follows:

> Kim was reaching up to grab product out of the 2nd level from the top with her right arm. She felt a pulling/burning pain in her shoulder blade. She had not grabbed anything. When she went home she felt achy. The next day she came in and reported it to me. Reaching up is causing her pain. This was originally reported as non work related." (RX 5)

On August 21, 2013 Petitioner was examined by Dr. George Paletta (Orthopedic Center of St. Louis). In conjunction with the examination Petitioner completed a Questionnaire in which she indicated she had been referred by Dr. Lindsay Sledge for shoulder pain/shoulder blade problems. Petitioner stated the problem began two weeks earlier and in response to the question "How did the problem begin?" Petitioner wrote "work related." Petitioner noted she had undergone no testing but had seen Dr. Sledge. According to Dr. Paletta's office dictation of the same visit, Petitioner's claim adjuster was Mary Kopuster at Sedgwick and Petitioner's case managers was Lindsey Sledge. Petitioner gave a history of right upper extremity and neck pain dating back a couple of weeks earlier when she was working for Respondent and "picking" in her usual capacity when she reached up with her right arm above shoulder level to pick some makeup of very light weight. As she did so Petitioner felt "burning, pulling and sharp pain in the right shoulder and under the scapula." Petitioner was evaluated by the athletic trainer and given some exercises which seemed to make her shoulder worse. (PX 3)

Petitioner's current complaints were basicervical pain, periscapular pain, shoulder pain and pain down the arm. While Petitioner acknowledged a history of bilateral carpal and cubital tunnel releases she denied any prior history of "significant" shoulder or neck problems. Petitioner was working without any restrictions but experiencing significant difficulty with her "left" arm. On examination Dr. Paletta noted limited cervical spine motion especially with extension, right lateral bend, and right rotation. Spurling's sign was positive on the right causing pain down her arm to elbow level. Examination of the right shoulder was very limited as all motion and tests caused complaints of pain and some guarding. Every provocative test caused her pain. Right shoulder x-rays were taken and reportedly normal. (PX 3)

Dr. Paletta believed Petitioner's symptoms were "atypical of primary shoulder pathology" and he noted she had a "lot of neck findings" leading him to believe her problem might be of cervical origin and he recommended a cervical MRI. If it came back clear he would turn to her shoulder and order additional imaging. In the interim he recommended a Medrol dose pack and a ten pound lifting restriction from floor to chest, no lifting above chest level, and no repetitive over head activities or pushing/pulling more than ten pounds. "Based upon the history provided to [him by Petitioner] and the relationship of onset of symptoms to her work activities it [was the doctor's opinion] that her work activities are the contributing factor in her current shoulder complaints." (PX 3)

Dr. Paletta subsequently reviewed Petitioner's MRI that was completed on August 21, 2013. He felt it confirmed his clinical suspicion of a cervical disc as there was a central and right-sided disc herniation at C5-6 compressing the right C6 nerve root and a bi-lobe disc herniation at C6-7 involving both sides. He also noted other mild disc bulges but no frank disc herniations. He recommended evaluation by a spine specialis, Dr. Gornet, and would "withhold opinion with regard to causation." (PX 3)

On September 19, 2013 Petitioner was examined by Dr. Kevin Rutz at the request of Respondent. Dr. Rutz issued a written report thereafter. According to it Petitioner gave a history of having been at work on August 6, 2013 when she was raising her right arm above her head using her right hand to grasp an item which was not very heavy. Petitioner said she was working at a fast pace and throwing the item into a tote when she felt a burning, stringing pain in her shoulder blade and up into her shoulder. Petitioner told the doctor this was not an unusual activity for her as she performed it routinely. Dr. Rutz wrote, "There was no unique traumatic event related to this activity compared to her normal daily activities of the job." (RX 1 - dep. ex. 2) Dr. Rutz went on to note that Petitioner was seen by the "Athletic Trainer" on August 9, 2013 at which time it was noted that Petitioner felt her problem was work-related because she felt it happened when she reached up. Thereafter, Petitioner was seen by Dr. Paletta who believed her problem was most likely cervical in nature and ordered an MRI of Petitioner's cervical spine and imposed a 10 pound lifting restriction. After reviewing the MRI Dr. Paletta noted a central C6 disc herniation to the right and a "bi-lobed" disc herniation at C6-7. On the day of her

exam with Dr. Rutz Petitioner reported no improvement in her condition with pain in her neck radiating down her right arm all the way to her thumb. A Medrol Dosepak had been of limited improvement. (RX 1 - dep. ex. 2)

On physical examination Dr. Rutz noted positive impingement signs in Petitioner's right shoulder, decreased cervical flexion and extension, tenderness to palpation in the right-sided cervical and thoracic paraspinal muscles, 4/5 strength in the right triceps, "which is either secondary to true weakness or pain, it was difficult to tell." Rotator cuff strength was difficult to determine due to discomfort. (RX 1 - dep. ex. 2) Dr. Rutz did not have the cervical spine MRI available to review but he looked over the report. His diagnosis was cervical disc herniation, cervical stenosis, and cervical radiculopathy. He did not believe they were related to her work for Respondent as her mechanism of injury was "simply reaching up to pick up something that did not weigh very much and she started having burning in her shoulder." Dr. Rutz felt Petitioner just happened to be at work when she started to become symptomatic. He did not believe she was engaged in an activity that would cause a herniation in her neck He did not believe she had an overuse type injury either and noted the "imaging" clearly demonstrated a pre-existing disc degeneration. He did believe she was "fairly uncomfortable." (RX 1 - dep. ex. 2)

On September 23, 2013 Petitioner was examined by Dr. Matthew Gornet, also of the Orthopedic Center of St. Louis. Dr. Gornet reviewed various medical records, including those of Dr. Paletta and the actual MRI scan. Dr. Gornet found that the MRI films clearly revealed a disc herniation on the right side with what appeared to be a free fragment that was fairly significant. Foraminal views on the right showed fairly massive herniation at C5-6 and C6-7, both having an acute component. The acute component is significant, and suggested to Dr. Gornet that Petitioner's overhead activity at work was what caused the pathology revealed in the MRI films. His findings based on the MRI films differ substantively from the printed radiology report. Dr. Gornet consistently stressed that the injury was causally related to work, and that effective treatment would consist of surgery, preferably by a disc replacement procedure. He even wrote to the insurance adjuster on Ms. Schweda's behalf requesting authorization for surgery and asking that Ms. Schweda be paid temporary benefits, as she was temporarily totally disabled, and would not be able to work until after surgery. (PX 1,2)

Petitioner signed her Application for Adjustment of Claim on September 24, 2013, claiming an injury to her right shoulder, arm, neck, and "body as a whole" when she was reaching above her head on August 6, 2013 picking product. (AX 2)

Dr. Gornet attempted to treat Petitioner non-operatively, seeing her three more times, the last appointment on 1/16/14. (PX 1, 2)

Dr. Gornet's deposition was taken on January 30, 2014. (PX 1) He testified in accord with his records.

At arbitration Petitioner testified she is 41 years old and was employed by Respondent as a product picker on August 6, 2013. Petitioner testified that she had worked for Respondent thirteen years as of February 2014. For the six months prior to her alleged accident of August 6, 2013 she had worked as a "picker" picking product from a rack. Petitioner described the rack as having multiple shelves and she would be signaled by a light as to how much product to pull from a shelf to put in a tote which would later be shipped out. Petitioner is required to perform 485 picks per hour. The racks are placed on pods by robots. A pod is approximately 2 1/2 feet off the floor and the rack sits on the pod. According to Petitioner the top of the rack was a little higher than her eye level. Petitioner, who is 5'11"[1] thought the top of the rack was higher than six feet.

---

[1] See questionnaires in PX 2, 3.

Petitioner testified that on August 6, 2013 she was picking make-up products weighing just a few ounces from a rack. At approximately 9:00 p.m. she was picking from the top shelf of the rack with her right hand when she felt a sharp burning pain in her right shoulder blade while reaching into the shelf. Petitioner testified she was not lifting anything at the time nor were there any unusual movements being performed. According to her, she was performing her normal job duties. Petitioner continued working until 9:30 p.m. when it was time to clean up. Petitioner clocked out at 9:45 p.m. and went home.

Petitioner acknowledged that she did not report anything before she left work, explaining that one has aches and pains now and then and one thinks they will go away. It was also late.

Petitioner testified that her shift began the next day at 1:45 p.m. Petitioner testified that she reported to work a little early and reported what had occurred before her shift began. Petitioner testified that since the accident had occurred her condition had worsened. Petitioner noted that while she slept she experienced an achy pain and restlessness. She took some Ibuprofen but the pain kept her awake.

Petitioner testified that she reported the accident to her supervisor of four months, Matt Shook. She testified that she told him she was picking and reaching above her head and felt a sharp burning pain in her shoulder blade. According to Petitioner, Mr. Shook asked if it was work-related and she said "Yes."

Petitioner was shown RX 2 and agreed she filled out the Request For Athletic Trainer Consultation and circled no in response to the question "Do you believe the condition for which you are seeking care is work-related?". According to Petitioner, Mr. Shook told her there was a lot of paperwork to fill out if it was work-related so he suggested they just say "no" and see how things went with therapy.

Petitioner testified that Mr. Shook arranged for her see the therapist at the Wellness Center and a couple of days later she went there. She recalled two visits. On the second visit the therapist asked her if the exercise s were helping at all and she denied any benefit, indicating she felt worse. At some point the therapist took his forearm and pushed down on her shoulder at which point Petitioner experienced pain that took her breath away and she had tears in her eyes.

Petitioner testified that she was eventually referred to Dr. Paletta through "Lindsey" a nurse at the Wellness Center. She went there for her shoulder and was examined by two therapists. Dr. Paletta ordered a cervical MRI and subsequently referred her to Dr. Gornet who has recommended cervical spine surgery. Petitioner has not yet undergone the surgery but would like to.

Petitioner acknowledged being examined at Respondent's request by Dr. Rutz. Petitioner testified she has been off work since August 23, 2013 and hasn't received any temporary total disability benefits. Petitioner did acknowledge receiving short-term disability benefits.

Petitioner testified that her symptoms have worsened since August 23, 2013. Petitioner claims her entire arm hurts and her neck burns. It hurts to turn her neck to the right. Petitioner testified she cannot rake in her yard and her daughter does any mopping and vacuuming. According to Petitioner her daughter and son also help with grocery shopping and carrying groceries to the house. She notices a sharp, sharp pain when washing her hair. Petitioner denied the ability to raise her arm above shoulder level. Petitioner explained that she could not completely raise her right arm to take to be sworn in as a witness because it burns. She sleeps straight on her back and tucks a pillow behind her neck when sitting in a chair to take some of the pressure off her neck. Petitioner takes pain pills to help her sleep. Petitioner is right handed. Petitioner is able to drive but uses her left hand.

Petitioner denied any right pain in her shoulder or shoulder injuries before August 6, 2013. She denied any neck complaints or pain before August 6, 2013. Petitioner acknowledged undergoing bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome surgeries in 2012. She had a fractured sternum in 2011.

On cross-examination Petitioner acknowledged she has four grandchildren. One grandson is two years old and she cannot lift him. Her most recent grandchild was born in December of 2013. Petitioner denied being able to use her right arm to hold a baby; rather she uses her left arm. When shown a photograph of herself holding her new granddaughter, Petitioner acknowledged she was using her right arm but not up too high. Petitioner hasn't ridden a motorcycle in quite a while.

On redirect examination Petitioner expounded on the photograph of she and her granddaughter, adding that she can use her right arm if she has something to prop it on and she gets relief by handing her right arm down. If she does put her right arm up, she can't do it for very long.

Matthew Shook also testified. Mr. Shook was Petitioner's direct supervisor on August 6, 2013. According to Mr. Shook employees are to report any injury to the supervisor or function manager when it occurs. A determination is then made as to whether the accident is work related or not. If it is work-related, the supervisor takes a report and a safety evaluation follows. Mr. Shook believed that the top of the rack was 6'2" tall and , typically, no product is on top of the rack.

Mr. Shook testified that Petitioner approached him on August 7, 2013 and reported she was having shoulder pain. He asked her if it was work-related and she said it had hurt at home a couple of nights before. Together, they filled out RX 2 which is the form to be filled out if an employee seeks care from Respondent's on-site athletic trainer. The care is available regardless of whether the employee has work-related or non-work- related issues. Mr. Shook testified that Petitioner filled out RX 2 and he signed it. Mr. Shook denied that Petitioner ever said she hurt herself at work. He testified that they discussed the difference between work-related and now-work-related injuries and he never discouraged her from claiming it was work-related. Mr. Shook testified that Petitioner circled "No" on RX 2.

According to Mr. Shook, he and Petitioner again spoke on August 13, 2013. RX 5 are his notes from when Petitioner and he spoke that day. At that time Petitioner reported her injury was work-related. According to Mr. Shook Petitioner provided no explanation as to why she changed her mind.

On cross-examination Mr. Shook testified that he feels an injury is work-related if it happens at work during work hours; it is non-work-related if it happens at home or on an employee's own time. If a work injury report is made to him he is required to fill out an accident investigation report. If Petitioner had marked "Yes" on RX 2 Mr. Shook would have completed the additional paperwork.

The Request for Athletic Trainer Consultation was submitted as Respondent's Exhibit 2. Petitioner admitted she completed the form and signed it as well. Mr. Shook also testified on behalf of Respondent and he confirmed the form was completed by Petitioner and signed by her; however, Mr. Shook testified he specifically asked Petitioner if it was a work-related injury and she answered no. He also testified she told him she hurt herself a couple of nights before at home.

The Arbitrator concludes:

1. Petitioner's credibility.

Petitioner's credibility in this case is concerning. When asked to raise her right hand to be sworn in, Petitioner indicated she was unable to raise it to the normal position. When asked on cross-examination how long she had been unable to raise her arm, she indicated since the alleged accident. She then testified she has a new granddaughter who was born in December. When asked if she was able to hold her granddaughter, she indicated only with her left arm without using the right arm at all. When presented with Respondent's Exhibit 6, which clearly shows her using both hands to hold the baby, she immediately responded by indicating she was not lifting her arm above her head. Additionally, Petitioner was somewhat evasive during cross-examination when counsel was asking her about her activities and ability to use her arm.

2. Accident.

Petitioner failed to prove she sustained an accident on August 6, 2013 that arose out of her employment with Respondent. Petitioner admitted she was not lifting anything at the time she felt the pain, she was simply reaching. That history is consistently reported in the exhibits and the medical records, although there is some discussion as to whether the reaching was actually above her head, but there is no evidence indicating there was any unusual movement at the time Petitioner felt her pain. Reaching is a normal activity of life. Petitioner was tall. She described no awkward positioning. She was not holding anything in her right hand while reaching.

3. Causal Connection.

Even assuming Petitioner's accident is compensable, she failed to prove a causal connection between her accident and her current condition of ill-being in her cervical spine. Petitioner testified to experiencing a pain in her shoulder blade at the time of her alleged accident. She mentioned no neck pain. An early pain drawing clearly focuses on shoulder blade pain and nothing more. No neck complaints or arm complaints were noted.

When presenting to Dr. Paletta, her only complaints was shoulder pain/shoulder blade. While he noted some shoulder complaints he felt her problem more likely stemmed from her cervical spine. Dr. Paletta rendered no opinion regarding Petitioner's cervical condition. Dr. Gornet is of the opinion Petitioner has two herniated cervical discs which are causing Petitioner's shoulder pathology. He goes on to state she was lifting overhead and "Regardless of the weight that she was lifting her arm extended out from her body. Lifting anything would be the type that could cause a disc herniation." (PX 1, p. 11) Petitioner never said she was lifting anything nor is the evidence clear that she was having to reach with her arm overhead. Additionally, Dr. Gornet never examined Petitioner's early pain drawing or any records from the Wellness Center.[2] Had Dr. Gornet examined Petitioner's early pain drawing with the one she completed in September of 2013 he would have noticed very different complaints which might have undermined his causation opinion. Dr.Gornet acknowledged that if he didn't have a correct understanding of Petitioner's history he would have to reconsider his opinion. In this instance, he did not.

The Arbitrator further notes that it appears Petitioner continued working full duty for Respondent after her alleged accident as she did not begin losing time from work until August 24, 2013. She further

[2] While the Wellness Center's records were not admitted into evidence, their absence is not troubling since Dr. Gornet is basing his causation opinion on the exact mechanism of injury (allegedly overhead reaching) and nothing more.

testified that her symptoms have worsened since being off work. Her ability to continue working for several weeks and the worsening of her condition since being off work were not considered by Dr. Gornet nor adequately explained by Petitioner.

Petitioner's claim for compensation is denied. No benefits are awarded. All other issues are moot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Armstrong,

Petitioner,

vs. NO: 12 WC 15358

15IWCC0136

Con-Way Freight, Inc.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the sole issue of the nature and extent of Petitioner's permanent disability, 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.

In awarding permanent disability benefits to Petitioner, the Arbitrator awarded 30% loss of use of the right foot and 8% loss of use of the left foot under Section 8(e)(11) of the Act. A 30% loss of use of the right foot equals 50.10 weeks and an 8% loss of use of the left foot is equal to 13.36 weeks of permanent partial disability benefits. When added together, Petitioner is entitled to a total of 63.46 weeks of permanent partial disability benefits, not the 66.80 weeks awarded by the Arbitrator. Therefore, the Commission hereby corrects the Arbitrator's Decision to reflect that Respondent shall pay Petitioner permanent partial disability benefits for a further period of 63.46 weeks under Section 8(e)(11) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Decision of the Arbitrator filed April 17, 2014, is hereby corrected as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

$577.25 per week for a further period of 63.46 weeks, as provided in Section 8(e)11 of the Act, because the injuries sustained caused Petitioner to sustain a 30% loss of use of the right foot and an 8% loss of use of the left foot.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,700.00. 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: FEB 1 7 2015
MJB/ell
o-12/16/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARMSTRONG, ROBERT
Employee/Petitioner

Case# **12WC015358**

15IWCC0136

CON-WAY FREIGHT
Employer/Respondent

On 4/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
CHARLIE GIVEN
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
MARK P RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Robert Armstrong
Employee/Petitioner

v.

Con-Way Freight
Employer/Respondent

Case # **12** WC **15358**

Consolidated cases: ____

15IWCC0136

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **March 13, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other ____

FINDINGS

On **December 8, 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 $**50,028.68**; the average weekly wage was $**962.09**.

On the date of accident, Petitioner was **42** 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 $**11,636.04** for TTD, $**388.97** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**12,025.01**. The TTD and TPD benefits were paid for the correct periods at the correct rates.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $577.25/week for a total of 66.80 weeks, because the injuries sustained caused 30% loss of the right foot (50.10 weeks) and 8% loss of the left foot (13.36 weeks), as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner compensation that has accrued from December 8, 2011 through March 13, 2014, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

04-17-14
Date

APR 17 2014

FINDINGS OF FACT

Petitioner's Testimony at Hearing

Robert Armstrong ("Petitioner") is claiming accidental right foot and left foot injuries on December 8, 2011, while employed with Con-Way Freight ("Respondent") as a Truck Driver Sales Representative. At the time of the accident, Petitioner was 42 years old and had worked for the Respondent since February, 2008.

Petitioner testified that on the day of his accident, his bilateral feet were run over by a dolly pulled by a co-worker. The dolly weighed a few thousand pounds. Petitioner felt immediate pain in his bilateral feet and was taken to the Emergency Room at St Catherine's Hospital where he underwent surgery to his right foot on the day of the accident.

Petitioner is a 1987 graduate of De La Salle High School in Chicago. Petitioner attended Progressive Truck Driving School and obtained his CDL in December, 2007. As of the hearing date, Petitioner works his regular duties as a Truck Driver Sales Representative with Respondent. In his normal shift he works around 12 hours per day and he is required to line haul drive on a daily basis from his terminal in Bridgeview, Illinois, to the terminal in Tomah, Wisconsin, a round trip of 482 miles. Petitioner testified that his job requires driving and loading and unloading freight by hand and by forklift.

Petitioner testified that since his return to work full duty he has noticed an increase in pain and symptoms in his right foot. His right foot is always in pain and he has a constant throbbing

sensation. The pain is worse with cold weather, when driving long distances and when pressing his foot on the pedal of the truck. For pain relief he removes his boot while driving his truck and takes over the counter medication, like Aleve, on a daily basis. Petitioner testified that he walks his dog on a daily basis and is unable to walk as far as he did before the accident because of pain in his right foot. His right foot swells with overuse and his work shoes feel tighter. Petitioner can jog without pain but is unable to run like he used to. Hopping on his right foot causes pain. In the left foot, Petitioner has a constant tingling sensation from the top of the foot, near the fifth toe, to the middle, arch area of the foot. Petitioner notices a loss in the range of motion in the fifth toe and the left side at the top of the foot feels numb. Petitioner testified that his right foot pain is worse than his left foot pain.

The Arbitrator had the opportunity to listen to and observe Petitioner and finds him to be credible.

Medical Records

Petitioner's initial medical treatment was on December 8, 2011 at St Catherine Hospital. X-rays of the right foot revealed acute dislocation of the fifth metatarsal phalangeal joint with several small avulsion fracture fragments. There was an acute minimally displaced fracture in the proximal shaft of the fifth metatarsal and an acute spiral fracture with minimal displacement of the midshaft of the fourth metatarsal. X-rays of the left foot revealed evidence of a cuboid fracture and a minimally displaced corner fracture on the fibular side of the fifth proximal phalanx at the fifth PIP joint. Petitioner was referred to Dr Surender Paul Dhiman, an orthopedic

15IWCC0136

surgeon within St Catherine Hospital. Dr Dhiman placed a cast on Petitioner's left foot and prescribed surgery on his right foot. (PX2, p. 8-11)

Petitioner underwent right foot surgery performed by Dr Dhiman on December 8, 2011. The procedures performed included right foot closed manipulation and percutaneous screw fixation of the fifth metatarsal and closed manipulation of the dislocation of the metatarsophalangeal joint. During surgery it was revealed that Petitioner had suffered a fracture of the right fourth and fifth metatarsals and a dislocation of the proximal interphalangeal joint of the fifth toe on the right side. (PX2, p. 12-14)

On December 21, 2011, Dr Dhiman removed the cast on the right foot and prescribed a Cam walker. On the left side Petitioner remained in a Reese shoe. Petitioner was allowed to wear a regular shoe on the left side starting on January 11, 2012. (PX2, p.15-18)

On February 15, 2012, Dr Dhiman prescribed a course of physical therapy for the bilateral feet. (PX2, p. 21-22). Petitioner completed 12 sessions of therapy at St Catherine's Hospital between February 28, 2012 and March 26, 2012. (PX2, p. 37-43)

Petitioner returned to work in a light duty capacity on March 27, 2012.

On April 4, 2012, Dr Dhiman allowed Petitioner to return to work in a full duty capacity. (PX2, p. 27). Petitioner returned to work in a full duty capacity effective April 5, 2012.

Petitioner was re-examined by Dr Dhiman on December 3, 2012. X-rays of the right foot showed healing of the fractures but the two cabbulated screws and the washer were causing the Petitioner discomfort. Dr Dhiman prescribed surgery to remove the screws and the washer. (PX2, p. 30)

On December 27, 2012, Petitioner underwent surgery performed by Dr Dhiman at St Catherine Hospital. The procedures performed included 12/27/12 removal of one screw from the base of the fifth metatarsal on the right foot. The doctor did not remove the second screw or the washer and the hardware remained in placed through the date of the surgery. (PX2, p. 31)

Petitioner returned to work in a full duty capacity effective January 14, 2013.

On March 4, 2013, Dr Dhiman discharged the Petitioner at maximum medical improvement with no work restrictions. (PX2, p. 35)

AMA Impairment Rating

On June 24, 2013, Petitioner was examined by Dr Mark Levin, a Section 12 Independent Medical Examiner hired by the Respondent to perform an AMA impairment rating. Dr Levin found that Petitioner suffered 4% impairment to the right lower extremity. Dr Levin found that Petitioner suffered no impairment to the left lower extremity. (RX3)

CONCLUSIONS OF LAW

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

The causal connection between Petitioner's work accident and his present condition of ill-being is not stipulated to between the parties and is in dispute. Petitioner testified that before this accident he never had problems with his right foot or left foot. Immediately after the accident on December 8, 2011, he had pain in the right foot and left foot. Petitioner obtained medical treatment on the date of the accident at St Catherine Hospital. X-rays of the right foot revealed acute dislocation of the fifth metatarsal phalangeal joint with several small avulsion fracture fragments. There was an acute minimally displaced fracture in the proximal shaft of the fifth metatarsal and an acute spiral fracture with minimal displacement of the midshaft of the fourth metatarsal. X-rays of left foot revealed evidence of a cuboid fracture and a minimally displaced corner fracture on the fibular side of the fifth proximal phalanx at the fifth PIP joint. Petitioner underwent surgery to his right foot on the day of the accident. (PX2, p. 8-14)

On June 24, 2013, Petitioner was examined by Dr Mark Levin, a Section 12 Independent Medical Examiner hired by the Respondent to perform an AMA impairment rating. Dr Levin found that Petitioner suffered 4% impairment to the right lower extremity. Dr Levin found that Petitioner suffered no impairment to the left lower extremity. Dr Levin found that Petitioner's current right lower extremity, right fifth metatarsal, right fourth metatarsal and left lower extremity conditions are related to the work accident of December 8, 2011. (RX3, p. 4-5)

15IWCC0136

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the Petitioner and finds a causal connection between Petitioner's present condition of ill-being and the work accident of December 8, 2011.

L. What is the nature and extent of Petitioner's injury?

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

- (i) The reported level of impairment;
- (ii) The occupation of the injured employee;
- (iii) The age of the employee at the time of injury;
- (iv) The employee's future earning capacity; and
- (v) Evidence of disability corroborated by medical records.

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

i. Dr Levin's AMA impairment rating report was admitted into evidence as Respondent's Exhibit 3. Dr Levin concluded that Petitioner's impairment as a result of the work accident is 4% of the right lower extremity. Dr Levin found that Petitioner suffered no permanent partial impairment of the left lower extremity.

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

ii. Petitioner continues to be employed in his pre-injury employment as a Truck Driver Sales Representative with Respondent. The Arbitrator has reviewed the job description entered as Petitioner's Exhibit 4 and finds that this position involves heavy work. The Arbitrator concludes the Petitioner's permanent partial disability ("PPD") may be larger than an individual who performs lighter work.

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

iii. Petitioner is 44-years old. The Arbitrator considers the Petitioner to be approaching middle-age and concludes that Petitioner while he may have to live and work with the disability for a longer period of time than an older individual with the same injuries, he may just as likely recover from his injury more quickly than an older worker.

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

iv. At the present time, there is no evidence that Petitioner's future earning capacity has diminished as a result of this injury. Petitioner continues to work with Respondent driving a truck. Petitioner has remained in a full duty capacity with Respondent. The Petitioner testified that he received a raise since the accident. Petitioner testified that this raise was provided to all employees, not just Petitioner.

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

v. Evidence of disability in the medical records finds that x-rays of the left foot performed on December 8, 2011, revealed cuboid and fifth proximal phalanx fractures. Surgery on the right foot performed on December 8, 2011 revealed fractures of the right fourth and fifth metatarsals and dislocation of the proximal interphalangeal joint of the fifth toe. The procedures performed included closed manipulation and percutaneous screw fixation of the fifth metatarsal and closed manipulation of the dislocation of the metatarsophalangeal joint. (PX2, p. 8-14) Post surgery, Petitioner completed 12 physical therapy sessions to the bilateral feet between February 28, 2012 and March 26, 2012. (PX2, p. 37-43)

Petitioner was allowed to return to work on a full duty basis on April 5, 2012. He continued experiencing pain in his right foot and was re-examined by Dr Dhiman on December 3, 2012. Dr Dhiman prescribed surgery to remove the screws and washer. (PX2, p. 30). Petitioner

15IWCC0136

underwent surgery on December 27, 2012 but only one screw was removed. (PX2, p. 31). One screw and the washer remain in place as of the date of the hearing. Petitioner was discharged by Dr Dhiman on March 4, 2013. (PX2, p. 34-35)

At the time of the examination with Dr Levin, Petitioner had a scar over the right fifth proximal metacarpal area with some tenderness over the base of the right fourth and fifth metatarsals. He had slightly reduced pinprick sensation over the dorsal and lateral aspect of the right foot. Petitioner made subjective complaints of increased pain that interferes with normal work activities both inside and outside of the home, increased pain that interferes with personal care and increased pain that interferes with recreation hobbies and activities that are important to him. (RX3 and PX3)

The determination of PPD is not simply a calculation, but an evaluation of all five factors as stated in the Act. In making this evaluation of PPD, consideration is not given to any single enumerated factor as the sole determinant. Therefore, after applying Section 8.1b of the Act, 820 ILCS 305/8.1b and considering the relevance and weight of all these factors, including Dr Levin's AMA impairment rating, the Arbitrator concludes that Petitioner has sustained a 30% permanent loss of the right foot and an 8% permanent loss of the left foot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ken Lary,

Petitioner,

15IWCC0137

vs.

NO: 09 WC 38740

IST America Corporation,

Respondent,

DECISION AND OPINION ON REVIEW

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

The Commission agrees with the Arbitrator's factual summary, assessment of Petitioner's credibility, and ultimate findings in this case; however, the Commission supplements the Decision in order to address certain specific aspects of the case.

The Commission notes that the parties stipulated that Petitioner's medical expenses were paid by group insurance. (AX1) The Commission further notes that the parties also stipulated that, if Petitioner's claim was found to be compensable, then Respondent agreed to hold Petitioner harmless for unpaid medical bills. Respondent's witness, William Bonallo, Respondent's vice-president and Petitioner's supervisor, testified that Respondent received Petitioner's Application for Adjustment of Claim indicating that he has suffered a work injury on October 20, 2008 on September 11, 2009 (T.29,132), at which time Petitioner was still undergoing treatment for the injuries Petitioner claimed were a result of the October 20, 2008 accident.

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

> "In the event the injured employee receives benefits, including medical, surgical or hospital benefits under **any group plan covering non-occupational disabilities contributed to wholly or partially by the employer**, which benefits should not have been payable if any rights of recovery existed under this Act, then such amounts so paid to the employee from any such group plan as shall be consistent with, and limited to, the provisions of paragraph 2 hereof, shall be credited to or against any compensation payment for temporary total incapacity for work or any medical, surgical or hospital benefits made or to be made under this Act. **In such event, the period of time for giving notice of accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments.** This paragraph does not apply to payments made under any group plan which would have been payable irrespective of an accidental injury under this Act. Any employer receiving such credit shall keep such employee safe and harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit." (emphasis added) 820 ILCS 305/8(j) (2007)

The Commission finds that Respondent was notified of Petitioner's accident while still undergoing treatment for his injuries and while Petitioner's medical expenses were being paid by group insurance. As previously stated, the parties stipulated that group insurance had paid Petitioner's medical expenses. Additionally, the record indicates that group insurance had paid for Petitioner's November 30, 2009 lumbar MRI, which was performed over two months after Respondent had received Petitioner's Application for Adjustment of Claim.

However, the record fails to disclose if Respondent contributed wholly or partially towards the payment of Petitioner's group insurance. In fact, the record is silent on who actually paid for Petitioner's group insurance coverage.

Therefore, after considering the record in its entirety, including all of the testimony, exhibits, pleadings and arguments submitted by the parties, and reviewing the facts of the matter from both a legal and a medical/legal perspective, the Commission finds that Petitioner failed to meet the requirement under Section 8(j) of the Act which would have allowed the 45 day notice requirement under Section 6(c) to commence after the last medical bill had been paid by group insurance. Therefore, as previously stated, the Commission agrees with the Arbitrator's finding

15IWCC0137

that Petitioner failed to provide proper and timely notice as required under Section 6(c) of the Act and affirms the Arbitrator's denial of Petitioner's claim for benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 8, 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.

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: FEB 1 7 2015
MJB/ell
O-12/16/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LARY, KEN
Employee/Petitioner

Case# **09WC038740**

IST AMERICA CORPORATION
Employer/Respondent

15IWCC0137

On 4/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1869 PRESBREY & ASSOC PC
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

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

Ken Lary
Employee/Petitioner

v.

1 st America Corporation
Employer/Respondent

Case # 09 WC 38740

Consolidated cases: ______

15IWCC0137

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **January 23, 2014 and February 27, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0137

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 not*** given to Respondent.

In the year preceding the injury, Petitioner earned $**90,000.04**; the average weekly wage was $**1,730.77**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **0** dependent children.

ORDER

The Petitioner failed to provide timely notice of the accident within the time limits proscribed by Section 6(c) of the Act, therefore depriving the Illinois Worker's Compensation Commission of jurisdiction over this case. Benefits requested pursuant to Section 8 are therefore denied.

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

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

Deborah L. Simpson
Signature of Arbitrator

April 8, 2014
Date

APR 8 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Lary,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 09 WC 38740
	)	
1 st America Corp.,	)	
	)	
Respondent.	)	15IWCC0137
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on October 20, 2008, 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 was 52 years of age, single, with no dependent children at the time of the accident that is the subject matter of the dispute. They further agree that in the year preceding the injuries, the Petitioner earned $90,000.00, and that his average weekly wage was $1,730.77.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of her employment; (2) Did the Petitioner give the Respondent timely notice of the accident; (3) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Were the medical services provided to the Petitioner reasonable and necessary and has the employer paid for all reasonable and necessary medical services; (5) Is the Petitioner entitled to temporary total disability payments; (6) Is the Respondent liable for additional medical treatment; and (7) What is the nature and extent of the injury.

STATEMENT OF FACTS

Petitioner testified that he was employed by the respondent as a sales manager. He was working out of Kansas City at the time. He was contacted by Bill Bonallo, because Joe Osten, a co-worker of Petitioner, forgot to have a major display prepared for an upcoming trade show. He was asked to travel to Chicago, Illinois, to disassemble a display prepared for previous show, and take it to a contractor so that it could be modified for the trade show in October of 2008.

15IWCC0137

The Petitioner testified that on October 20, 2008, he travelled to the Bollingbrook office and that he rented a Dodge Caravan to transport the display pieces from the office to Exhibit Link where they were to be modified. He stated that when he got to Bollingbrook he took the display, which consisted of three pieces apart. He testified that each side was seven feet high and each side weighed about sixty pounds. One of the pieces was about three feet by three feet. He carried each piece separately and laid the pieces in the van. He was careful not to scratch them. He drove to Exhibit Link, which was located in Romeoville, Illinois. He drove to the address he was given, which turned out to be the owners' home. He received additional directions and drove to the shop.

As Petitioner was pulling and lifting one of the larger Plexiglas pieces out of the van, the panel was lodged in the van and he had to pull hard to release the piece. The piece started sliding and the van was parked on a downward incline. While pulling on the piece of Plexiglas he hurt himself. Petitioner testified that he experienced extreme pain in his back from his shoulders to his waist. Petitioner nevertheless held tightly onto the panel to prevent it from being dropped and scratched. He testified that once he stood up and got his balance he carried the first piece of Plexiglas piece twenty-five feet into the repair shop. He then told the worker, Ed Berzinski, about the injury. He asked Mr. Berzinski to help him remove the remaining pieces for the display out of the van which Mr. Berzinski did.

Petitioner testified that he may have had a phone conversation with Mr. Bonello regarding the injury that day. He went to his car and got some ibuprofen. He did not seek treatment right away for his back. He stated that he thought he just pulled a muscle. Petitioner also testified that he had no complaints of neck or back pain before the accident for eighteen to twenty years before that day.

Petitioner testified that he had a previously scheduled appointment to see Dr. Nouhan for a trigger finger at the time he suffered the injury.

Petitioner testified that he was present at the trade show for the entire show. He stated that his back was hurting. He stated that Mr. Bonallo was also present at the trade show, and they discussed the injury while they were there. He stated that Mr. Bonallo complimented Petitioner and Ed on how nice the display came out. Petitioner claimed he told Mr. Bonallo that "it came with pain and suffering," that he "had really wrenched his back." The Petitioner testified that this discussion was in the presence of Mr. Berzinski. According to the Petitioner he was repeatedly complaining about the pain in his back, so much so, that Mr. Bonallo, who had back problems himself and was on pain medications for the back problems and was awaiting surgery for them, repeatedly offered Petitioner some of his prescription pain medications which Petitioner declined. Mr. Bonallo also suggested Aleve gel caps, an over the counter medication, claiming the medication would get in his system faster.

Petitioner never testified that he made a formal report of the injury, or that he filled out any documentation at work regarding the injury. He also testified that group health insurance paid for the surgery and medical treatment that he had regarding his neck and his back. He testified further that he was only off of work for two or three days when he had the surgery.

Petitioner testified that he received some emails from Mr. Bonallo, Denise and Mr. Oaten (spelling?), challenging him for the time he took off for his surgery recovery. In his opinion the

e-mails were "inflammatory" and "challenging" so when he was in Chicago, on one of his trips, he took his lunch hour and went to see Mr. Berzinski. They took a picture of the last remaining big piece of Plexiglas that had not been cut down (PX 6, 7) and he wrote a statement regarding the day of the delivery and the injury for Mr. Berzinski to sign. (PX 10) He testified that he gave a copy of the document to Mr. Bonallo at a later date but did not recall the date.

On cross examination the Petitioner admitted that he had a prior injury to his neck, arm and back from a fall on ice in Chicago. He had ulnar nerve surgery and a neck fusion at C5-6 as result of the injury. This occurred around 1990.

He admitted that he started working for Respondent in July of 2007, and in January of 2008, he was given a copy of the employee handbook which said that all injuries must be reported immediately to a supervisor. Petitioner identified a series of emails and reports sent by Petitioner to Mr. Bonallo from October 21, 2008 through November 12, 2008, (RX 15, 16). None of the emails mentions the accidental injury that Petitioner claims he suffered on October 20, 2008.

Petitioner testified that he and another employee were terminated from the company, and that they currently have a lawsuit alleging discrimination pending against the Respondent.

Petitioner was shown Respondent's exhibit number 7 and identified the document as having been made by him. On February 11, 2009, the Petitioner filled out a health questionnaire describing his chief complaint as: "severe pain and electrical like shocks to back left shoulder blade, upper arm, lower arm and left hand-some around left ear." He lists the date symptoms started as: "immediately after trigger release." He listed as how injury occurred as: "positioned wrong for surgery." (RX 7) Petitioner does not mention anywhere in this complaint his October 2008 injury to his neck, arms and back.

On cross examination, Petitioner also identified Respondent's exhibit #6, a letter he wrote to Dr. Paul L. O'Boynick, MD in Shawnee Mission, Kansas dated February 14, 2009. In the letter he describes having complaints that began after his recent trigger finger surgery including:

> various types of escalating and severe pain and extreme electrical like shocks in my back left shoulder and shoulder blade to my spine, up my left neck and around my left ear, along the front of my left shoulder, my upper arm, fore arm and left hand, as well as being unable to sense hot and cold water in my left hand or function well with that hand, I understand that after reviewing the disc my recent MRI, that you believe that I have a ruptured disc adjacent to a former fusion in my neck (circa about 1990). The pain emitting from the neck area coincides with what my physical therapist, hand surgeon and family physician suspected that my neck somehow got hyper extended during the trigger release and was placing pressure on a nerve. (RX 6)

Respondent's exhibit #8 is a typewritten medical report from Dr. O'Boynick wherein Dr. O'Boynick gives Petitioner's present illness as left arm pain, woke up after a procedure in November with the pain. He advised Dr. O'Boynick he had suffered an injury 20 years ago and had anterior cervical microdiskectomy infusion, but does not mention any injury in October of 2008. The doctor noted that he has had no problems since the surgery 20 years ago.

William "Bill" Bonallo is the Vice President of 1st America Corp. He was first called as a witness by the Petitioner and he testified before the Petitioner did. Mr. Bonallo testified that the display was made of Plexiglas, about five feet by three feet, weighing about forty or fifty pounds. He believed the Plexiglas was one inch thick. There were two upright sections that they were going to have modified for the trade show in October of 2008. There were two stainless steel support devices with flanges on the outside and bolted to the Plexiglas. The display was in Bollingbrook at the office and needed to be transported to Exhibit Link to be modified. They were taking a floor display and turning it into a table display. He asked Petitioner to pick up the display and take it to Exhibit Link so that the work could be done.

Mr. Bonallo identified Petitioner's Exhibits #6 and #7 as being the two pieces that were the display. He believed the male in the pictures was Ed Berzinski. He believed that the photos actually came from Exhibit Link. He stated that Petitioner's #8 was not the final display, he believed that #9 was the final display. He stated that per the Trade Show rules someone from a display company had to bring the display into the trade show venue.

Mr. Bonallo denied discussing the back injury Petitioner claimed to have suffered with him, he stated the only notice he had that Petitioner was injured was when they received notice of the law suit. He also denied receiving a copy of the note signed by Mr. Berzinski.

Mr. Bonallo was also called to testify as a witness on behalf of the Respondent. Mr. Bonallo testified that he began working for the company on January 1, 2008, as the Vice President of Business Development. When he started at the company he was not aware of an official procedure for reporting injuries. He does know that the company rules required reporting an accidental injury immediately to the supervisor, and is not sure when the rule was put in place exactly but it could have been in January of 2008.

According to Mr. Bonallo he spoke to Petitioner approximately five times a day and exchanged numerous e-mails with him. Petitioner sent Mr. Bonallo an e-mail on October 21, 2008 (RX 15) referencing the job with Exhibit Link but making no reference of having sustained an accidental injury. Petitioner sent e-mails on October 24, 2008, and a summary of the exhibition dated November 3, 2008, again with no reference to having sustained any accidental injury. (RX 16).

Mr. Bonallo denied that he had any discussion with the Petitioner over the phone regarding an injury to his back delivering the display to Exhibit Link. He also denied speaking with Petitioner about the injury to his back at the trade show in October of 2008. He also denied offering Petitioner any prescription medication for pain. Mr. Bonallo denied having a discussion with the Petitioner and Ed Berzinski at the trade show about the purported back injury. Mr. Bonallo also denied that he had accused the Petitioner of not having a back injury.

Mr. Bonallo testified that Ken Lary and David Bohn were each let go due to lack of business effective July 16, 2009. He stated that Mr. Lary filed an EEOC complaint and discrimination suit against the company, which is still pending. Mr. Bonallo testified that the company's first knowledge from any source of an alleged work related incident regarding Mr. Lary was upon receipt of the application for adjustment of claim forwarded by his counsel and received on September 11, 2009. (RX 20). He stated that both he and Denise Woods researched where Petitioner was and what he was doing at the time upon receipt of the notice.

According to Mr. Bonallo there was no way to guess or estimate how many times he and Petitioner had discussed Mr. Bonallo's back problems. He stated they talked about them significantly.

Mr. Bonallo stated that he was with the Petitioner the entire four days of the show plus the day before and the day after. The Petitioner never told him that he had hurt his back or had been injured moving the Plexiglas display. Petitioner did not make a reference to any injury to himself the entire six days. During the six days he did not notice anything different about the Petitioner's appearance or his demeanor. Mr. Bonallo was aware of the fact that the Petitioner had sustained a previous injury to his back.

On cross examination, Mr. Bonallo testified that his best guess regarding the handbook was that it came out in January or February of 2008. He testified that the policy requires that injuries be reported to the supervisor or office manager immediately. When an injury is reported to a supervisor or the office manager an accident report is generated and given to the office manager for further action. They go to Denise Woods, because she does the HR which includes insurance and workers compensation.

Mr. Bonallo testified that he did not make an accident report for the Petitioner regarding the accident of October 2008, because he was not advised by the Petitioner that he had been injured accidentally.

David Bohn, was a co-worker of Petitioner, he was called as a witness by the Respondent. Mr. Bohn testified that in January of 2008, he worked for the Respondent as a sales manager for the Midwest. He stated that there was a meeting in January of 2008, he does not recall the exact date, which Mr. Lary attended wherein the company handbook was provided to individuals and all employees were instructed to report all injuries on the job immediately to their supervisor. If the supervisor was not available then they were to be reported to the office manager.

Mr. Bohn identified himself as being one of the individuals in the photo which is Respondent's exhibit #19. The photo was taken at the trade show. Mr. Bohn testified that he was there for the entire show and the Petitioner never mentioned his back hurting or a work injury that he had sustained in October of 2008. He testified further that he and the Petitioner had contact typically one time per month when they were in the office for meetings. The Petitioner never mentioned neck or back pain or an injury to his neck or back. The first time he heard about the October 2008, accident, was two weeks ago when he was contacted to testify.

Mr. Bohn was also let go on July 16, 2009, the same day that the Petitioner was.

Respondent offered RX 20, which is an affidavit of Ed Berzinski. In the affidavit, Mr. Berzinski indicates that he examined a copy of PX 10, which is attached to the affidavit. He states that Petitioner brought him the paper, the typed portions were not typed by Mr. Berzinski. Mr. Lary brought the document to him typed in that fashion and asked him to sign it. He did sign the document on April 22, 2009. He agrees that the first paragraph is correct. The second sentence of the second paragraph is incorrect. The sole complaint Mr. Berzinski recalls Petitioner voicing at the time was relative to the low back. Mr. Berzinski did help Petitioner

unload and carry the remaining sheets up the ramp and into the shop, and Petitioner assisted him with the same.

Mr. Berzinski maintains that he was present for the show only the morning of October 25, 2008, and he did not witness any conversation on that date or any subsequent date wherein Petitioner allegedly told Mr. Bonallo that he was hurt while delivering Plexiglas to Exhibit Link. (RX 20)

On cross examination, Mr. Bonallo testified that the first time he heard about the Petitioner's claimed injury was in September of 2009, when they received the notice that the Petitioner had filed an application for adjustment of claim.

The medical records show that Petitioner complained to Dr. Nouhan of both right and left upper extremity symptoms before the trigger finger release. (PX3) Dr. Nouhan's October 23, 2008 *Health History* note reports that Petitioner cannot close his left hand, it is painful and locks up. Dr. Nouhan further documents right hand numbness for the past few days. For the "date of onset" question, the left hand is given as 12 months and the right hand problem is identified as starting "this week". (PX3) Back pain is also identified as having started "this week". Dr. Nouhan's typewritten note from October 23, 2008, tells us that Petitioner is presenting with bilateral hand complaints. Petitioner "has had a newer onset (last couple of days) of right hand numbness in the median nerve distribution. This seems to have occurred after he was moving some heavy displays and pulled a neck and back muscle, by his report. He has also been getting a little proximal radiation of his symptoms on the right side" (PX3) Dr. Nouhan recommended an EMG/NCV test to see whether the symptoms were acute CTS or something from the neck. However, Petitioner wanted to undergo the trigger finger release before Dr. Nouhan could fully work up the neck issue.

Notes from Dr. Nouhan on December 30, 2008, indicate that the Petitioner was seeking treatment from Dr. Nouhan for the neck and shoulder problems, had also consulted Dr. Erickson and gotten a referral to a Dr. Ryan, a neurologist in addition to having the EMG done, and he did not tell Dr. Nouhan about this.

The left trigger finger release was performed on November 12, 2008. The surgical report reveals absolutely no evidence of hyperextension of the neck during the procedure and it documents the procedure was completed "without complication". (RX2; PX1 p.65, 67) The contemporaneous medical records also reveal no injury at the time of the trigger finger release. Petitioner returned to Dr. Nouhan on November 13, 2008, complaining of neck, shoulder and arm pain.

On November 25, 2008, Petitioner complained of significant right forearm, upper arm, neck and shoulder pain which was radiating and limiting Petitioner's function. On November 25, 2008, Dr. Nouhan documented that "he is still having significant pain in the forearm, upper arm, neck and shoulder that seems to be radiating and is functionally limiting for him". (PX3) Dr. Nouhan recommended a course of therapy and possible workup with an EMG/NCV. Dr. Nouhan also reported that the first EMG/NCV revealed moderate carpal tunnel syndrome on the right side and that Petitioner was considering surgery for the right hand.

The right carpal tunnel release was done on December 16, 2008.

Petitioner returned to Dr. Nouhan on December 30, 2008. At this point he was 2 weeks out from his right carpal tunnel release and 1 ½ months out from the trigger finger release. Dr. Nouhan noted that Petitioner continued complaining of the severe neck and shoulder problems and electrical shocks that go down the arm and up to his ear.

On January 9, 2009, Petitioner had a physical therapy evaluation at SERC Physical and Hand Therapy where the therapist documented resolution of right hand numbness following the carpal tunnel release and resolution of triggering on the left side with that surgery. (PX3) On the right side, Petitioner did report occasional volar right wrist pain at a level up to 6/10 and decreased strength and grip strengths on the right. Strength and grip strengths were also at a deficit on the left side, although Petitioner was able to complete his activities of daily living. He also reported continuing dorsal pain in the forearm and elbow radiating proximally to the shoulder and upper trapezius. (PX3)

The February 23, 2009, therapy progress report noted gains in strength on both sides and an improvement in grip strength on the right side, but a decrease in pinch strength on in the left hand and continuing pain in the left upper extremity. The note further reflects the upcoming February 26, 2009 cervical surgery.

Dr. O'Boynick , at the Olathe Medical Center in Kansas, noted in his History & Physical notes (PX 4) that the Petitioner woke up with the left arm pain after a procedure in November of 2008. The pain went down his arm to his forearm extending from the shoulder down. He also complained of electrical shocks in his fingers. His right arm was free of symptoms. Dr. O'Boynick read the radiographs as showing a solid prior fusion at C5-6 and a large disk herniation to the left at C6-7. Dr. O'Boynick performed the cervical fusion on February 26, 2009.

The left arm symptoms resolved with the surgery, but Dr. O'Boynick's records show continuing problems with midthoracic spine pain with radiation to the right parascapular region. (PX4 March 9, 2009 letter) Dr. O'Boynick offered various medications without success.

On the March 25, 2009 return visit with Dr. O'Boynick, Petitioner was still reporting spasming and cramping pain between his shoulder blades and across his shoulders. (PX4- March 25, 2009 letter) Dr. O'Boynick sent Petitioner out for a follow up MRI with contrast at St Josephs to assess the continuing problem.

Petitioner was also seen by Dr. Jay Dunfield on May 7, 2009 at ENT Associates of GKC-Overland Park. Dr. Dunfield documented Petitioner's gradual increasing harshness to his voice, increasing dysphasia, globus sensation and a feeling of pressure in the lower anterior neck. (PX4) The dysphasia was worse with eating and swallowing his pills. Dr. Dunfield performed an esophaogram which he reported as being normal.

Petitioner also saw a neurosurgeon on August 2, 2010, reporting continuing problems with swallowing and hoarseness following the cervical surgery. (PX5) He also reported occasional continuing discomfort in the left arm. He further noted that his back pain had become more of an issue and he had difficulty standing for very long which increased his back pain.

CONCLUSIONS OF LAW

Section 6(c) of the Illinois Workers' Compensation Act states that notice of the accident shall be given to the employer as soon as practicable, but not later than 45 days after the accident. Section 6(c) (2) states that "[n]o defect or inaccuracy of such notice shall be a bar to the maintenance of proceedings on arbitration or otherwise by the employee unless the employer proves that he is unduly prejudiced in such proceedings by such defect or inaccuracy." *820 ILCS 305/6(c)* (West 2004)

The purpose of the notice provisions is to enable the employer to investigate promptly and to ascertain the facts of the alleged accident. *City of Rockford v. Industrial Commission,* 214 N.E.2d 763 (1966)

The giving of notice under the Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. However, the legislature has mandated a liberal construction on the issue of notice. *S&H Floor Covering v. The Workers Compensation Commission,* 870 N.E.2d 821 (2007)

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).

Did Petitioner sustain accidental injuries that arose out of and in the course and scope of his employment with Respondent?

Petitioner testified that on October 20, 2008, he transported a large Plexiglas panel to Exhibit Link for modifications and while getting it out of the van it became stuck. He pulled on the Plexiglas to dislodge it and experienced pain in his back and neck. Mr. Bohn, a co-worker of Petitioner testified that Petitioner was at a meeting in January of 2008, wherein company policy manuals which contained among other things the policy regarding workplace injuries were discussed and a copy given to each employee. Petitioner testified that he had received a copy of the manual. Mr. Bonallo, Petitioner's supervisor, testified that Petitioner was aware of the rule to report all accidental injuries on the job immediately to the supervisor. Mr. Bonallo indicated that despite being in contact with Petitioner up to five times per day, exchanging e-mails with Petitioner surrounding the time period of the incident and seeing Petitioner at the exhibit conference that weekend, he had no knowledge from any source of Petitioner sustaining an accidental injury on October 20, 2008. (RX 15 and 16).

Petitioner procured a statement from an Ed Berzinski of Exhibit Link on April 22, 2009, some six months after the occurrence. Ed Berzinski executed an affidavit on February 6, 2014, and stated that Petitioner's Exhibit No. 10 was presented to him already typed by Mr. Lary. He indicates the sole complaint Mr. Lary voiced to him at the time of moving the object was to the low back. Petitioner testified that he gave a copy of the statement Mr. Berzinski identified some time after it was executed, to Mr. Bonallo, however he does not recall the date he gave it to Bonallo. Mr. Bonallo denied receiving a copy of the statement.

The Arbitrator also notes that Petitioner saw Dr. Nouhan on October 23, 2008 for an appointment that was previously scheduled. It was noted Petitioner had a long history of left ring finger and left small finger triggering. Petitioner had a newer onset the last couple days of right hand numbness. There was a reference that he was moving some heavy displays pulling a neck and back muscle by his report. He complained of some proximal radiation of symptoms on the right side.

Based upon Ed Berzinski's affidavit and the testimony of Petitioner and Dr. Nouhan's note, the Arbitrator finds that Petitioner sustained an accidental injury on October 20, 2008.

Did the Petitioner give the Respondent timely notice of the accident?

Bill Bonallo testified that the company rules required reporting an accidental injury immediately to the supervisor. David Bohn, a co-worker, testified that in January of 2008, there was a meeting which Mr. Lary attended wherein the company handbook was provided to individuals and all employees were instructed to report all injuries on the job immediately to their supervisor. This requirement is reportedly in the handbook and was discussed specifically at the meeting. Petitioner agreed he was at the meeting and that he did receive a copy of the handbook.

Mr. Bonallo spoke to Petitioner approximately five times a day and exchanged numerous e-mails with him. Petitioner sent Mr. Bonallo an e-mail of October 21, 2008 (RX 15) referencing the job with Exhibit Link but making no reference of having sustained an accidental injury. Petitioner sent e-mails October 24, 2008, and a summary of the exhibition dated November 3, 2008, again with no reference to having sustained any accidental injury. (RX 16).

Petitioner testified that he may have told Mr. Bonallo, by phone the day of the accident that he had injured himself. Petitioner provided no details as to time, where he was when he made the call or anything to substantiate the call. Mr. Bonallo denies having had a telephone conversation regarding an injury to Petitioner on that day.

Petitioner claims that as result of the injury he has "severe pain and electrical like shocks to the back left shoulder blade, upper arm, lower arm and left hand, with some of it extending up his neck around his left ear." The problem with that testimony is that he accused the anesthesiologist from his trigger finger surgery of having caused these symptoms in writing, as well as telling another doctor that the symptoms started immediately after his trigger finger surgery which was in November, after the trade show. He indicated he woke up from surgery experiencing this pain.

Petitioner and David Bohn were each let go due to lack of business effective July 16, 2009. Petitioner filed an EEOC and discrimination suit, which is still pending. Mr. Bonallo testified that the company's first knowledge from any source of an alleged work related incident regarding Petitioner was upon receipt of the application for adjustment of claim forwarded by his attorney to the Respondent and received on September 11, 2009. (RX 20).

Mr. Bohn testified that he was in contact with Petitioner and saw him one time a month and had no knowledge that Petitioner was alleging a work related condition until two weeks before the hearing.

Petitioner testified while attending the conference on October 5, 2008 he advised Mr. Bonallo in Mr. Berzinski's presence of the work injury. Mr. Bonallo denies any such conversation taking place. Ed Berzinski in his affidavit stated he did not witness any conversation on that date or any subsequent date wherein Petitioner allegedly told Mr. Bonallo that he had been hurt delivering Plexiglas to Exhibit Link. (RX 20).

The Arbitrator also notes that Petitioner in e-mails contemporaneously sent surrounding the occurrence made no reference of the incident.

The Arbitrator finds that the Petitioner is not credible.

The Arbitrator finds that Petitioner failed to prove timely notice as required under Section 6(c) within 45 days of the accidental injury of October 20, 2008. Respondent's first notice was upon receipt of the application for adjustment of claim September 11, 2009, some 11 months later.

Section 6(c) provides that notice is to be given within 45 days of the accident. The notice required by Section 6(c) is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. *Ristow v. Industrial Commission*, 39 Ill. 2d 410, 413 235 N.E.2d 617 (1968). In *Fenix & Scisson v. Industrial Commission*, 27 Ill. 2d 354, 357, 189 N.E.2d 268 (1963), a heavy board fell a distance of 7 feet onto the claimant's great toe on November 9, 1959. The toe became sore the following Saturday and Sunday. On Monday, November 16 he told his foreman at the plant that his toe was sore, and he was going to see his family doctor. He said nothing about an accident. He was examined by his doctor the same day who told him the injury was a result of the November 9 accident. His toe later became black and was amputated on November 25. He was in the hospital through December 11. His employer was notified of the accident on December 28, 1959, or 49 days after the accident. Compensation was denied as there was no disclosure at any time of the fact that an accident had occurred and the employer had no actual knowledge of the accident until after the 45 day period had expired.

Wherefore, the Arbitrator finds that petitioner's claim for compensation is barred pursuant to Section 6(c) for failure to give timely notice as required.

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure? Were the medical services provided to the Petitioner reasonable and necessary? Has the employer paid for all reasonable and necessary medical services? Is the Petitioner entitled to temporary total disability payments? Is the Respondent liable for additional medical treatment? What is the nature and extent of the injury?

In light of the determination Petitioner failed to failed to give timely notice of the accident as provided in the Act to the Respondent, the Commission does not have jurisdiction over the subject matter, the remaining issues of Respondent's liability for Section 8 medical

benefits and the nature and extent of the injury are moot, and not reached by this Arbitrator. Accordingly, benefits are denied.

ORDER OF THE ARBITRATOR

The Petitioner failed to provide timely notice of the accident within the time limits proscribed by the Act, therefore depriving the Illinois Worker's Compensation Commission of jurisdiction over this case. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson — April 8, 2014

Signature of Arbitrator — 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

Guillermo Arroyo,

Petitioner,

15IWCC0138

vs.

NO: 11 WC 46053

Bretford Manufacturing, Inc.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, and temporary total disability benefits, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

So that the record is clear, and there is no mistake as to the intentions or actions of 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 and find that the medical treatment provided by Dr. Ma of the New Life Medical Center from March 26, 2012 on was not reasonable, necessary or causally related pursuant to Section 8.2(e) of the Act.

The Commission agrees with the Arbitrator's factual summary, application of the law, and ultimate findings in this case; however, the Commission supplements the Arbitrator's Decision in order to address the treatment provided by Dr. Ma.

Section 8.2(e) of the Act states, in pertinent part:

> "Except as provided under subsections (e-5), (e-10), (e-15), and (e-20), a provider shall not bill or otherwise attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or the insurer on a compensable injury, or for medical services or treatment determined by the Commission to be excessive or unnecessary." 820 ILCS 305/8.2(e) (2007)

Petitioner underwent physical therapy treatment with Dr. Ma from March 26, 2012 through February 11, 2014. (PX8) The records indicate that Petitioner continued to have pain, tenderness, and muscle spasms in the lumbar region throughout his treatment. On February 11, 2014, Dr. Ma noted no substantial improvement in Petitioner's condition when compared to prior treatments. (PX8) Furthermore, as noted by the Arbitrator in her decision, Dr. Ma's treatments were neither necessary nor reasonable "given the failure of multiple rounds of prior physical therapy and chiro treatment." (Arb.Dec.7) In light of this, the Commission finds that Dr. Ma's treatment was excessive, unnecessary and unreasonable. Therefore, based on the totality of the evidence and based upon Section 8.2(e) of the Act, the Commission finds that Dr. Ma's treatment was excessive and unnecessary and finds that neither Respondent nor Petitioner is liable for the treatment provided by Dr. Ma.

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 Arbitrator's Decision filed on April 17, 2014, is affirmed and adopted.

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

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

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

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

the sum of $36,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 1 7 2015
MJB/tdm/ell
o-12/16/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

ARROYO, GUILLERMO
Employee/Petitioner

Case# **11WC046053**

BRETFORD MANUFACTURING INC
Employer/Respondent

15IWCC0138

On 4/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1427 BERG & BERG
STEPHEN M WAUCK
2100 W 35TH ST
CHICAGO, IL 60609

1109 GAROFALO SCHREIBER HART ET AL
JAMES R CLUNE
55 W WACKER DR 10TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Guillermo Arroyo
Employee/Petitioner

v.

Bretford Manufacturing, Inc.
Employer/Respondent

Case # **11** WC **46053**

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 **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **March 13, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On the date of accident, **July 13, 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 $**35,767.68**; the average weekly wage was $**687.84**.

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

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**2,934.81** for other benefits, for a total credit of $**2,934.81**.

Respondent is entitled to a cfedit under Section 8(j) of the Act. ARB EX 1.

ORDER

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits representing 72 -1/7 weeks commencing 10/25/12 through 3/13/14 at a weekly rate of $458.56, as provided in Section 8(b) of the Act.

Medical Benefits
Respondent shall pay the medical expenses in accordance with the Decision. See Decision. Respondent shall receive credit for amounts paid. See Decision

Prospective Medical Care
Respondent shall authorize and pay for the transforaminal lumbar interbody fusion and associated aftercare recommended by Dr. Salehi, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

[signature]
Signature of Arbitrator

4/10/14
Date

ICArbDec19(b)

APR 17 2014

FINDINGS OF FACT

The parties stipulated to the issue of accident at trial. Petitioner testified via interpreter at trial. Petitioner testified that he has worked 15 years for Respondent Bretford Manufacturing. On 7/13/11, Petitioner was lifting and carrying sheet metal when he twisted and felt a sharp pain in his low back. He reported the pain to a supervisor and was sent to Advanced Occupational Medicine Specialists. He took a taxi from the work site to the clinic on the day of the accident.

The records from Advanced Occupational on 7/13/11 indicate a history of back pain over the last several months that occurs each day at work but "goes away without treatment while at home." PX 1. Petitioner further reported severe pain on July 6, 2011 which went away at home. Petitioner further reported that while lifting sheet metal at work on 7/13/11 he experienced back pain again which worsened throughout the day and at the clinic he reported low back pain at 9/10. Petitioner denied a history of previous back pain or injury in these records. Following exam, Petitioner was given ibuprofen and was instructed to perform exercises and use ice and heat. The diagnosis was lumbosacral strain and lumbago. He was returned to regular duty work. PX 1. The diagnosis was continued at the follow up visit of 7/20/11 as were the care instructions and the return to full duty work. PX 1. It was noted that no follow up was needed.

Petitioner testified that he returned to work regular duty as of 7/20/11 and that he did not have any additional treatment until he reported to the La Sagrada clinic on 9/28/11 and saw Dr. Avalos. PX 2. Petitioner reported the July work injury and that he experienced constant low back pain since that time. Petitioner was noted as holding his right side and reported pain of 9/10. Petitioner was diagnosed with bilateral sciatica and low back pain. Petitioner was prescribed medication for pain. PX 2. Dr. Avalos' notes of 9/28/11 indicate "He has been seeing Dr. Weiss (chiropractor) with very little improvement." PX 2. DR. Avalos prescribed a physical therapy consult and treatment for Petitioner at MacNeal. Dr. Avalos also took Petitioner off work through 10/2/11. At the visit of 10/2/11, Dr. Avalos noted that Petitioner's pain continued and that he "...did not take medication previously because chiropractor told him not to." PX 2. Dr. Avalos prescribed medication and told Petitioner to follow up with an orthopedic for evaluation and treatment. PX 2. He continued Petitioner off work. At the visit of 10/24/11, continued pain complaints were noted and the records again reference treatment by a chiropractor without improvement. PX 2.

The first record of chiropractic treatment by Dr. Weiss in the record is dated 10/6/11. There are no records or bills for treatment submitted at trial that pre-date 10/6/11. The record is devoid of any medical records supporting chiropractic treatment by Dr. Weiss between July 20 and October 6, 2011. PX 3.

Dr. Weiss treated Petitioner from 10/6/11 through 10/24/11. The first X-ray taken on October 12, 2011, showed an "elongated pars interarticularis at the L5 level...with spondylolisthesis, most likely an upper pars type." PX3. As of 10/24/11, Dr. Weiss noted that Petitioner reached maximum improvement from chiro care and had continued complaints of pain. He discharged Petitioner to the care of Dr. Avalos. PX 3.

Petitioner's last visit to Dr. Avalos for this condition was on 11/8/11. At that time Dr. Avalos noted that Petitioner had been seen by the orthopedic Dr. Iftikar for objective testing and that Petitioner was to follow up with the orthopedic. PX 2.

Petitioner saw Dr. Iftikhar for one visit on 11/7/11. At that visit Dr. Iftikhar noted Petitioner's accident on 7/13/11 at work while lifting sheet metal and that he continued to complain of "…some discomfort in the lower back. There was radiation to the posterior aspect of the gluteal region. He was seen by a chiropractor for all this time, and was given multiple muscle relaxants and anti-inflammatory medication but did not get any better. The patient still has the discomfort and abnormal feeling on the gluteal aspect of both buttocks. The pain does not radiate distal to that. There is no history of any bladder or bowel disturbances of recent origin." PX 4. The physical exam revealed no difficulties with ambulating. The back examination "… seemed to have mild discomfort in the lumbosacral area and it is also present a little more distal to that. Mobility of the lumbosacral spine is within normal limits. Straight leg raising shows some hamstring tightness on both sides, but is negative for any reproduction of pain. Sensory and motor examination of the legs is essentially unremarkable, but the patient does seem to have some mild paresthesias over the gluteal region on both sides. Hip range of motion is good. Alignment is satisfactory in the lower extremities. There is no shortening present. The patient has no significant changes in the reflex, motor, and sensory examination of the lower extremities." Dr. Iftikhar's impressions were "low back strain with the possibility of radiculopathy and isolated case of stretching of the spinal nerves like the L1 dermatome, which could not be ruled out because of the radiation of pain in the gluteal region. The twisting injury could be associated with that." PX 4. Dr. Iftikhar wrote, "due to the very long duration of symptoms, we must do an MRI of the lumbosacral spine. I have also ordered an EMG and NCV study to rule out the possibility of any neuropathy in the lumbosacral spine area. In the meantime, he should stay with the conservative treatment. Further treatment plans will depend on the results of the MRI and EMG studies." PX 4.

Petitioner did not return to Dr. Iftikhar.

On 11/22/11, Petitioner began treating at Alivio Physical Therapy and Chiropractic with various doctors including Drs. Barnabas and Hassan. PX 5. Dr. Barnabas ordered an MRI which Petitioner had on 11/23/11. The radiologist noted, "… showed a mild broad based disc bulge at the L5-S1 level which slightly effaces the ventral aspect of the thecal sac but does not cause significant central canal stenosis at this level. There is mild bilateral neural foraminal stenosis appreciated and bulging disc material is noted to abut the exiting left L5 nerve root without associated nerve root effacement. No additional levels of focal disc pathology, central canal stenosis or neural foraminal stenosis are appreciated on this exam." The impression was "there is a broad based disc bulge indentified at the L5-S1 level which minimally effaces the ventral aspect of the thecal sac but does not cause significant central canal stenosis. Mild bilateral neural foraminal stenosis is identified and bulging disc material is noted to abut the exiting L5 nerve root. Clinical correlation is recommenced to exclude radicular symptoms within this dermatome." PX 5. On 12/6/11, an EMG/NCV was read as "consistent with right L5-S1 lumbosacral radiculopathy." PX 6. On 12/13/11, Dr. Barnabas MD noted positive straight leg raise and positive Patrick/FABERE test on the left. Petitioner underwent EMS and hot and cold packs and a series and variety of injections and pain management from Dr. Hassan at Proclinics through February 2012. PX 6.

In the interim, Dr. Hassan sent Petitioner to work conditioning at Elite Physical Therapy on 12/28/11, 1/20/12 and 2/3/12. Petitioner attended 20 sessions of work conditioning. As of the last visit on 2/3/12, it was noted that Petitioner could lift and carry 35 pounds on an occasional

basis, lift 20 pounds overhead on a frequent basis and push and pull 20 pounds on an occasional basis. It was recommended on that date that Petitioner continue work conditioning for 2 more weeks. He did not continue. PX 7.

On 2/14/12, Respondent sent Petitioner to an IME with Dr. Gleason. Petitioner reported a consistent history of accident on 7/13/11. As of 2/14/12, Petitioner had undergone the 11/23/11 MRI, and three injections from Dr. Hassan which provided little relief. Dr. Gleason also noted that Petitioner started work conditioning 5 weeks earlier, that Petitioner had returned to light duty work 2 weeks earlier and that he reported that he was slowly improving. PX 10. Petitioner complained of lower mid back and buttock pain which is increased with prolonged standing, sitting or with heavy lifting. X-rays taken at the exam of the lumbar spine showed minimal grade 1 spondylolisthesis L5-S1 with possible lysis. Dr. Gleason reviewed the 11/23/11 MRI scan and noted that it demonstrated mild degenerative disc disease with mild diffuse bulging on the left greater than right. Dr. Gleason noted no positive objective findings on physical examination relative to the lumbar spine and lower extremities. Prior to his exam, Dr. Gleason reviewed all of Petitioner's medical records cited above.

Dr. Gleason concluded that Petitioner was able to return to full duty work without restrictions with a home exercise program and over the counter medication for the diagnosis of mild degenerative disc disease with mild diffuse bulging on the left greater than right. He further determined that the accident was not the cause of Petitioner's "…current condition, in as much as the employee currently has no positive objective findings on physical examination and finding as reflected in the imaging studies are long standing, dating back to adolescence." He further concluded that Petitioner was at MMI "from any injury which he may have sustained on July 13, 2011." PX 10.

On 2/21/12, Dr. Hassan noted "patient has low back pain no radiating anywhere pain is only concentrated across low back standing is better but still painful patient is working with restriction but when at work he rather stand because sitting he feels buttocks swollen…" Dr. Hassan ordered a discogram and CT scan based on "lumbar radiculopathy". On 2/27/12, Petitioner underwent a CT of the lumbar spine at Proclinics which was read to show a mild posterior disk protrusion/herniation at L4-5 slightly elevating the posterior longitudinal ligament and indenting the ventral surface of the thecal sac without spinal stenosis and an L5-S1 3-4 mm subligamentous posterior disk herniation slightly elevating the posterior longitudinal ligament and indenting the ventral and slightly left side of the thecal sac without significant spinal stenosis. Mild left lateral recess narrowing is seen. PX 6. A lumbar discogram dated 2/27/12 confirmed concordant pain with L4-5, L5-S1 levels and a percutaneous disc decompression procedure was recommended at these levels. Petitioner underwent a percutaneous discectomy at L4-S1 on 3/12/12 performed by Dr. Hassan. PX 6.

On 3/20/12, Petitioner saw Dr. Hassan at Proclinics and reported feeling 30% better after the disc decompression. PX 6. However, as of 4/17/12, Petitioner reported low back pain radiating to bilateral legs causing tingling and numbness. Dr. Hassan ordered another MRI/CT and a surgical consult along with an EMG of the lower extremities. The MRI and CT of 4/20/12 was compared to the post diskogram CT of 2/27/12 and the MRI of 11/23/11. The MRI was read to show the 3-4mm posterior and left-sided disk protrusion/herniation indenting the ventral and left side of the thecal sac without significant spinal stenosis. Mild left lateral recess narrowing was seen.

Thereafter in May 2012, Petitioner reported some improvement with minimal radiating pain to the bilateral legs. He was ordered to continued PT and medication.

In the interim, on 3/26/12, Petitioner was seen at the New Life Medical Center by Dr. Ma, a chiropractor. PX 8. It appears this physician was Petitioner's choice. Petitioner received conservative chiropractic care through 12/4/12. PX 8.

On 8/9/12, Petitioner returned complaining of low back radiating pain to buttocks causing tingling and numbness and limited range of motion and a burning sensation on his buttocks occasionally going down bilateral legs. Petitioner was sent for a surgical consult. The consult was recommended again at his last visit to Proclinics on 10/16/12 when Dr. Hassan noted he had reached maximum improvement from his care. PX 6.

Respondent submitted a utilization review report dated 12/26/12. Dr. Smith performed the review and determined that none of the care and specifically the series of multiple injections administered by Alivio was not necessary given Dr. Iftikhar's findings of an L5-S1 radiculopathy with a broad based disc bulge at that level. Dr. Smith concluded that based on this diagnosis only the first lumbar epidural injection was reasonable using the ODG low back treatment guidelines. He noted that the percutaneous diskectomy and the discography were not recommended or medically necessary based on the guidelines and the lack of any strong clinical indication for these procedures. Finally, he determined that since Petitioner had already failed physical therapy by the time he started the series of injections, no additional physical therapy after Dr. Iftikar's exam of 11/7/11 was necessary under the guidelines. RX 1.

On 2/5/13, Petitioner was seen by Dr. Salehi per referral from Dr. Hassan. Dr. Salehi reviewed the 11/23/11 MRI, the 4/20/12 MRI and the 2/27/12 CT scan. He concluded that Petitioner has lumbar degenerative disc disease and acquired spondylolisthesis. Dr. Salehi writes Petitioner's "...back pain is consistent with instability at L5-S1 as a result of bilateral pars defects at L5 and this level's subluxation over S1. For further evaluation I would like Mr. Guillermo to obtain flexion/extension x-rays of the lumbar spine and to return with them for my personal review at which point we may discuss surgery in the form of a lumbar fusion." PX 9.

On 3/14/13, Petitioner returned to Dr. Salehi for follow up. Petitioner again reported constant pain 5/10 which gets worse with prolonged sitting or walking and is better if he is able to switch between positions. He states that the pain still radiates from mid back to the gluteal region bilaterally. He denies any numbness/tingling or shooting pains down the legs." Dr. Salehi noted that the MRI he ordered and taken on 2/8/13 showed central disc bulge without neural compression at L5-S1 and the x-ray of 2/12/13 showed low grade spondylolisthesis at L5-S1 which does not change on dynamic views and evidence of bilateral pars defect at L5. Dr. Salehi concluded Petitioner "continues with back pain which is consistent with instability at L5-S1 as a result of bilateral pars defects at L5 and this level's subluxation over S1. Since he continues to be symptomatic and his pain is not tolerable I am recommending surgical intervention in the form of a left L5-S1 transforaminal lumbar interbody fusion."

Petitioner continued to attend physical therapy at New Life through 2/11/14. PX 8.

Respondent called Mr. Churchwell to testify at trial in his capacity as Respondent's safety manager. He consults with Respondent's HR department on Everify requirements. He testified

that Petitioner's restrictions were accommodated during periods of light duty through October 2012. However, in October 2012 he had to terminate Petitioner's employment with Respondent due to E-verify requirements. He testified that if Petitioner could have stayed employed Respondent would have continued to accommodate the restrictions.

CONCLUSIONS OF LAW

F. Is Petitioner's current condition of ill-being causally related to the injury? K. Is Petitioner entitled to any prospective medical care?

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the injury.

Before the July 13, 2011, accident, Petitioner had worked full duty for Respondent for approximately fifteen years with no history of back pain or other work injuries. Petitioner's work required him to do frequent lifting. After the accident, Petitioner reported the immediate onset of sharp back pain to his supervisor and then promptly sought medical treatment at Advanced Occupational Medicine Specialists. Petitioner's complaints have been constant and consistent. As he told Dr. Salehi, he often feels "an intense burning pain in his mid back" which radiates "from mid back to the gluteal region bilaterally" (PX9, p. 248).

The Arbitrator notes that the objective testing also supports a finding of causal connection for Petitioner's current condition of ill-being in his lumbar spine. The first X-ray taken on October 12, 2011, showed an "elongated pars interarticularis at the L5 level...with spondylolisthesis, most likely an upper pars type" (PX3, p. 36). The MRI carried out on November 23, 2011, showed "T2 signal loss of L5-S1 disc without height loss" with "a slight subluxation of L5 over S1" (PX9, p. 250). The EMG/NCV study carried out on December 6, 2011, came back as "consistent with right L5-S1 lumbosacral radiculopathy" (PX6, p. 90). Dr. Salehi read the CT scan from February 27, 2012, as showing "bilateral pars defect of L5 with a grade one spondylolisthesis" (PX9, p. 250). Finally, Dr. Salehi ordered flexion/extension X-rays, which showed "low grade spondylolisthesis at L5-S1 which does not change on dynamic views" with "evidence of bilateral pars defect at L5" (PX9, p. 253). The diagnostic testing from the beginning of the case through Dr. Salehi's surgery recommendation has shown that Petitioner has an injury at the L5-S1 level of his spine.

Dr. Salehi diagnosed Petitioner with acquired spondylolisthesis and explained that his "back pain is consistent with instability at L5-S1 as a result of bilateral pars defects at L5 and this level's subluxation over S1" (PX9, p. 250). Dr. Salehi also obtained additional diagnostic testing (flexion/extension X-rays) before confirming his diagnosis and recommending surgery.

Finally, the Arbitrator notes that Section 12 examiner, Dr. Gleason notes that Petitioner has the same condition which Dr. Salehi intends to treat with his proposed surgery: spondylolisthesis at L5-S1 (PX10, p. 257). Based on the foregoing, the chain of events, and placing greater weight on the opinion of Petitioner's treating physicians, specifically Dr. Saleghi, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to Petitioner's work accident of July 13, 2011.

Based on the finding of causal connection for Petitioner's current condition of ill-being, the Arbitrator further finds that Petitioner is entitled to the prospective medical treatment recommended by Dr. Salehi. Petitioner has gone through extensive conservative treatment for his back injury, including physical therapy, epidural steroid injections, trigger point injections, and a percutaneous discectomy, none of which has provided him with significant relief from his back pain. Petitioner testified that his pain was a 9 out of 10, and that he now had difficulty doing basic household tasks, such as clearing snow or doing yard work.

Dr. Salehi diagnosed Petitioner with acquired spondylolisthesis and explained that his "back pain is consistent with instability at L5-S1 as a result of bilateral pars defects at L5 and this level's subluxation over S1" (PX9, p. 250). Dr. Salehi also obtained additional diagnostic testing (flexion/extension X-rays) before confirming his diagnosis and recommending surgery. When he recommended surgery, Dr. Salehi explained that Petitioner "continues to be symptomatic and his pain is not tolerable" (PX9, p. 253). Specifically, Dr. Salehi has recommended a "left Transforaminal Lumbar Interbody Fusion (TLIF)" (PX9, p. 253). After surgery, Petitioner would require some time off work and physical therapy before returning to light duty work (PX9, p. 253). Petitioner would then complete a work conditioning program and an FCE before being released (PX9, pp. 253-254).

Petitioner testified that he would like to undergo the surgery recommended by Dr. Salehi so that he can return to his previous level of activity and work. The Arbitrator finds that the surgery recommended by Dr. Salehi offers Petitioner the best chance of returning to his previous level of activity and return him to his regular work in a timely fashion. Accordingly, the Arbitrator finds that Petitioner is entitled to the surgery recommended by Dr. Saleghi and that Respondent shall pay for the prospective surgery and attendant care pursuant to Sections 8 and 8.2 of the Act.

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

The petitioner argues that all services for which bills were submitted at trial were necessary and related to a condition of ill-being causally related to the accident of July 13, 2011. Respondent denies causal relationship and further denies that the medical services were either related to the condition associated with the accident at issue or were necessary to address the condition. ARB EX 1. The respondent further argues that the treatment addressed by Dr. Gregory Smith was unnecessary treatment no matter the condition of ill-being and its cause.

Based in part on the opinions of Dr. Smith, the Arbitrator finds that the only reasonable and necessary treatment Petitioner received at Alivio was through 12/6/11, which includes the MRI of 11/23/11, the injections received on 11/30/11 and the EMG/NCV of 12/6/11. The Arbitrator notes the MRI and EMG/NCV were previously ordered as well by Dr. Iftakhar. The Arbitrator further finds that the work conditioning Petitioner attended at Elite Physical Therapy on 12/28/11, 1/20/12 and 2/3/12 was also reasonable, necessary and causally related. Respondent shall pay Petitioner these stated reasonable, necessary and causally related medical expenses as well as the medical expenses incurred from the other treaters prior to initiating treatment at Alivio pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive a credit for amounts paid pursuant to Sections 8(a) and 8(j) of the Act to the extent those sections apply. ARB EX 1.

Pursuant to the Arbitrator's findings on the issue of causal connection for Petitioner's current condition of ill-being and the foregoing findings on the issue of medical expenses, the Arbitrator further finds Respondent shall pay the reasonable, necessary and causally related medical expenses incurred by Petitioner subsequent to 8/9/12 when he returned to Alivio and Dr. Hassan sent him to Dr. Salehi for a surgical consult. The bills incurred by Petitioner from the Alivio visits of 8/9/12 and 10/16/12 are included in this award as are the bills incurred in connection with Petitioner's visits to Dr. Saleghi. Respondent shall pay these expenses pursuant to Sections 8 and 8.2 of the Act with credit to Respondent under Sections 8(a) and 8(j) of the Act to the extent those sections apply. ARB EX 1.

Finally, the Arbitrator finds that the chiropractic treatment Petitioner received from Dr. Ma at the New Life Medical Center starting 3/26/12 and continuing thereafter was not reasonable or necessary or causally related given the failure of multiple rounds of prior physical therapy and chiro treatment. Those bills are not awarded.

L. What temporary benefits are in dispute? TTD

Section 8(b) of the Act provides that the employer shall pay weekly compensation to an injured worker during the period of temporary total disability; if "the temporary total incapacity for work continues for a period of 14 days or more from the day of the accident compensation shall commence on the day after the accident." 820 ILCS 305/8(b). "[T]he employer's obligation to pay TTD workers' compensation benefits continues until the employee's medical condition has stabilized and he has reached maximum medical improvement." Interstate Scaffolding, Inc. v. Workers' Compensation Comm'n., 236 Ill.2d 132, 135 (2010). Furthermore, a worker's immigration status is irrelevant to the question of whether he is eligible for workers' compensation benefits; undocumented workers "are considered 'employees' within the meaning of the Act and, under Illinois law, are entitled to receive workers' compensation benefits, …." Econ. Packing Co. v. Workers' Comp. Comm'n., 387 Ill.App.3d 283, 289 (1st Dist. 2009). "[N]othing in the [Immigration Reform and Control Act of 1986] or its accompanying regulations indicates that Congress sought to supersede state laws providing workers' compensation benefits to injured employees, whether undocumented or otherwise." Id. at 290.

In the present case, the parties agree that Petitioner worked light duty for Respondent until October 24, 2012, when Respondent terminated his position pursuant to federal immigration laws implemented through the E-Verify program. The evidence shows that Respondent did accommodate Petitioner's restriction by assigning him to desk work, which did not involve significant lifting. Mr. Churchwell testified that the accommodation would have continued had Petitioner's employment continued. Based on the foregoing, and pursuant to the Court's holding in Economy Packing, the Arbitrator finds Petitioner is entitled to TTD during the contested period of 72-1/7 weeks commencing 10/25/12 through 3/13/14. Respondent shall receive credit for amounts paid, if any.

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

Bill Reynolds,
Petitioner,

vs. NO: 04 WC 41351

15IWCC0139

Otto Baum Co. Inc.,
Respondent.

DECISION AND OPINION ON REMAND

This claim had been previously been appealed to the Appellate Court. The Appellate Court affirmed an earlier Circuit Court Order and remanded the claim to the Commission. As a result of the remand, the Commission, on August 7, 2012, issued a decision. In its decision, the Commission found in addition to a cervical injury Petitioner proved he sustained bilateral shoulder injuries which arose out of and in the course of his employment on July 13, 2004. As a result Petitioner was temporarily totally disabled from July 24, 2004 through March 27, 2007 for 139-2/7 weeks under Section 8(b) of the Illinois Workers' Compensation Act, was entitled to $235.00 for out of pocket medical expenses and a $120,612.67 balance in medical expenses subject to the fee schedule under Section 8(a) and 8.2 of the Act. In addition to the previously awarded 50% man as a whole under Section 8(d)2 of the Act, the Commission found Petitioner was entitled to a 25% loss of the use of his dominant right arm and 22.5% loss of the use of his left arm under Section 8(e) of the Act. Petitioner was not entitled to any additional compensation or attorneys' fees.

The Commission's August 7, 2012 decision was appealed to the Circuit Court for the second time. The Circuit Court of LaSalle County, with the exception of reversing the Commission's decision awarding the shoulder injuries as a percentage of an arm, affirmed the Commission's August 7, 2012 decision. As part of the reversal, the Circuit Court is remanding this case to the Commission with a directive to further determine the permanency on the shoulder injuries based on a person-as a whole award pursuant to Section 8(d)2 of the Act and the Appellate Court's holding in *Will County Forest Preserve District v. Illinois Workers'*

15IWCC0139

Compensation Commission, 970 N.E.2d 16 (2012). Pursuant to the Circuit Court's directive, the Commission finds that Petitioner is entitled to an award of 24% person as a whole for the shoulders injuries in addition to the previously determined 50% person as a whole for a total of 74% person as a whole pursuant to Section 8(d)2 of the Act and the Appellate Court's holding in *Will County Forest Preserve District v. Illinois Workers' Compensation Commission,* 970 N.E.2d 16 (2012).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $584.87 per week for a period of 139-2/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $235.00 for out of pocket medical expenses and a $120,612.67 balance in medical expenses subject to the fee schedule under Section 8(a) and 8.2 of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $526.38 per week for a period of 370 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 74% loss of a person as a whole.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00.

DATED: FEB 1 7 2015

MB/jm

O: 1/29/15

43

Mario Basurto

David L. Gore

Stephen Mathis

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

Dewayne Willhoite,
Petitioner,

vs.

NO: 07WC 46055

SV Concrete Construction,
Respondent,

15IWCC0140

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 July 17, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,418.00. 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: FEB 1 9 2015
MJB/bm
o-02/17/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WILLHOITE, DEWAYNE
Employee/Petitioner

Case# **07WC046055**

15IWCC0140

SV CONCRETE CONSTRUCTION
Employer/Respondent

On 7/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0564 WILLIAMS & SWEE LTD
DIRK MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0980 HASSELBERG GREBE SNODGRASS ET AL
JOHN DUNDAS
124 S W ADAMS ST SUITE 360
PEORIA, IL 61602

STATE OF ILLINOIS)

)SS.

COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DEWAYNE WILLHOITE
Employee/Petitioner

Case # **07 WC 46055**

v.

Consolidated cases: ____

SV CONCRETE CONSTRUCTION
Employer/Respondent

15IWCC0149

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois**, on **May 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On **April 3, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**3,076.50**; the average weekly wage was $$**439.50**.

On the date of accident, Petitioner was **47** years of age, *married* with **0** dependent children.

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

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

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $263.70/week for 5 weeks, because the injuries sustained caused the 1% 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   7/6/14
Date

JUL 1 7 2014

FINDINGS OF FACT:

Petitioner was working for Respondent as a foreman on April 3, 2006. Petitioner testified that at that time he was struck in the head by two concrete panels. Petitioner provided that as a result of this occurrence, he had "blood gushing from [his] head and he lost consciousness.

Following the incident on April 3, 2006, Petitioner was transported to the Emergency Room at Memorial Medical Center. Petitioner testified that this occurred three hours after the incident indicating that he had to wait until a supervisor arrived at the job site. Nursing notes indicate "[Petitioner] was struck in the head by a heavy piece of wood, he states that the wood knocked him to his knees and he states he had a LOC (loss of consciousness). He states that the LOC was brief." The Emergency Room's Final Report states "[Petitioner] present[ed] with a Minor head injury. The occurrence was 30 minutes prior to arrival…Degree of bleeding minimal. The degree of pain is minimal…" An examination revealed a 27 cm. linear laceration of the superior occipital region. Petitioner was given staples for a laceration and released with instructions to follow-up with his primary physician. (PX 2)

Petitioner testified that he returned to work the following day. Petitioner provided that as he continued performing his normal duties, he experienced headaches and dizziness.

On April 12, 2006, Petitioner reported to Dr. Jyotir Jani. The doctor's notes provide that Petitioner presented to have his staples removed. Dr. Jani noted the wound appeared well healed and he removed the staples without difficulty. (PX 5)

Petitioner testified that he continued working. He stated that while doing so, he experienced headaches at least twice a week. He couldn't "stand light or eat." He provided that his headaches got worse in the Fall of 2006. Petitioner indicated that he attempted to get an appointment to see a neurologist, but it took some months to get an appointment.

On cross-examination, Petitioner testified that in May 2006, he experienced a second incident of being hit in the head by a concrete form. Petitioner stated the incident didn't "break my head open." He denied that he ever reported to medical personnel that the second incident was more severe than the first. Petitioner also testified that he did not seek treatment for the second incident.

On November 14, 2006, Petitioner saw Dr. John Tran with complaints of left side tingling which was worse when he extended his neck. The doctor noted, "[h]e states he's been in one car accident when he hurt his neck…and two injuries at work where he hit his head. Since that time he's had headaches occurring about once a week which is associated with nausea and vomiting. Petitioner was assessed with left sided paresthesias and headaches. The doctor ordered CT head and carotid Doppler studies. (PX 5, RX 4)

On November 16, 2006, Dr. Naveed Yousuf performed a CT scan of the brain. Prior to undergoing the study, Petitioner conveyed a history of experiencing left sided numbness and paresthesias and migraines, with a history of a head injury six weeks prior. Dr. Yousuf noted an essentially unremarkable CT scan of the brain. The doctor noted that given Petitioner's history of carotid stenosis, a MRI of the brain may be helpful. (PX 5, RX 5)

Petitioner saw Dr. Jani on December 4, 2006. Dr. Jani noted Petitioner was "…complaining of symptoms of left sided paresthesias that he has had for over a year now but worse in last 3-4 months. He has had 2 head injuries this year where he lost consciousness, both within a month of each other. One episode was for 30 seconds. Another was for a minute and a half. Since then, patient has noted that he has been having worse headaches that he describes as frontal occipital, throbbing in nature, associated with nausea and vomiting, photophobia and phonophobia…" Dr. Jani assessed left-side paresthesias, ASCVD (arteriosclerotic cardiovascular disease), hyperlipidemia and referred Petitioner to Dr. Dick. (PX 5, RX 7)

Records submitted show Dr. Jani also referred Petitioner to Dr. Jesse VanLe for a consultation regarding a TIA and carotoid stenosis. Petitioner saw the doctor on November 21, 2006. As part of the work-up, the doctor noted "[Petitioner] also stated that approximately a few months ago that he [had] two accidents which he was hit in the head and lost consciousness. He also developed significant migraine headache occasionally after the accident. Dr. VanLe assessed Petitioner with significant symptoms with TIA or post concussion syndrome. The doctor felt Petitioner's migraine headaches as well as memory and confusion might be related to concussion. (PX 5)

Pursuant to Dr. Jani's referral, Petitioner saw Dr. Herman Dick on January 16, 2007. Petitioner presented with complaints of numbness of the left arm and leg as well as headaches. Petitioner provided that he had been struck in the head by panels in July and September 2006. He also provided a family history of stroke and diabetes. Dr. Dick assessed left sided parasthesias and ordered MRI, CT and EEG scans. Both the CT of the brain and EEG scans were performed on January 16th was deemed essentially unremarkable. (PX 3)

Petitioner testified that he lost consciousness while driving a crew to Springfield, Illinois on March 6, 2007. Petitioner received emergent care at St. John's Hospital. Records submitted show Petitioner presented with the chief complaint of numbness in his arms and legs that began while on his way to work. Petitioner reported that the numbness lasted a few minutes and then improved. Petitioner denied any headache, neck or back pain. A CT scan of the head was taken and read as negative. Petitioner was discharged and diagnosed with paresthesia. The Arbitrator notes the records makes no mention of a history given of a loss of consciousness. There is also no finding of Petitioner having sustained as seizure. The only mention of a seizure in the records is noting that Petitioner reported a history of mini seizures. (PX 4, RX 9)

Petitioner was also seen by Dr. Dick on March 6, 2007. Dr. Dick noted in his records that Petitioner was driving to work when he suddenly got a headache on the right side of his head which then spread down into the right cheek area. Petitioner reported that he went unconscious for a few moments. The doctor stated, "he said that the person sitting next to him was a paramedic, and placed the vehicle that he was driving into neutral and guided the car over to the side of the interstate…As he came to, he noted that his left leg would not move properly, it felt weak…The patients symptoms began after two closed head injuries last year. He notes that one was in July and the other was in August, and occurred while he was on the job. He was struck in the head with objects that were 300 pounds and 120 pounds on these two occasions. The first he was stunned. The second time he was "laid out." He developed a laceration requiring staples to suture it because of excessive bleeding with the first head injury. The second one caused a large goose egg to form, which prevented him from wearing a hat for a while. This later resolved." Dr. Dick's clinical impression was that Petitioner had a brief episode of loss of consciousness associated with some right-sided headache and had symptoms of parathesias, primarily in the left leg and distal right lower extremity. The doctor was uncertain as to what the symptoms may represent. He included the possibilities of a seizure or transient ischemic attack. Petitioner was placed on seizure precaution. Petitioner was taken off work and a MRI of the brain was ordered. The MRI when performed was within normal limits. (PX 3)

At the request of Dr. Dick, Petitioner saw Dr. John Pula at the Illinois Neurological Institute on March 22, 2007. Dr. Pula noted Petitioner was referred for consultation for headache and parasthesias over the last year. Petitioner provided a history of two closed head injuries over the past year. After performing an examination and reviewing diagnostic studies, Dr. Pula's impression was subjective symptoms of paresthesias and headache with a relatively normal neurolgic exam and multiple diagnostic studies not showing significant pathology to explain his symptoms. The doctor did not recommend further diagnostic studies at that time. Indicating Petitioner should be observed with repeat neurologic examination and further studies based on objective findings on examination. (PX 3)

On May 9, 2007, Dr. Dick referred Petitioner to the Neurology Department at Northwestern University Hospital for an opinion as to whether Petitioner's head injuries were related to his left lower extremity symptoms or whether there was any other underlying neurological etiology.

Pursuant to Dr. Dick's referral, Petitioner was seen by Dr. Alan Shepard at Northwestern University Medical School on May 11, 2007. The doctor noted that Petitioner's problem seemed to have arisen after two closed injuries in the past year. Petitioner described intermittent headaches that could be triggered by anything. Dr. Shepard found normal sensation but an antalgic gait. Because of Petitioner's complaint of persistent left-sided paresthesias, the doctor ordered an EMG which was normal. Dr. Shepard assessed muscle contraction type headaches and recommended physical therapy. The doctor noted that he did not see any evidence for progressive or significant neurological process at that time. He felt Petitioner should experience improvement over the next few weeks. (PX 3)

On August 1, 2007, Dr. Dick returned to Petitioner to light duty work with restrictions of no climbing and no lifting over ten (10) pounds. Dr. Dick also referred Petitioner to the Rehabilitation Institute of Chicago. Records show Petitioner presented on October 10, 2008 and was seen by Drs. Petra Joseph and Lynn Rader with a chief complaint of "Head pain daily since I was hit on the head on 4/7/06 and on 5/26/06, and intermittent numbness and tingling in left arm and both legs." In the history portion of the records it's recorded that "…on 4/7/06 he was hit in the head with a concrete form weighing 90 pounds…after which he lost consciousness for a few seconds...He returned to work soon after and approximately one week later after the injury, he was driving a truck when several days later he experienced a "light seizure" when he blacked out. One month later, again while at work, he was hit by two forms weighing approximately 120 pounds each on the right side of the head and again resulting in loss of consciousness lasting for a few seconds…He has experienced severe daily headaches since that time…" Petitioner underwent an examination and his prior treatments and diagnostic test were reviewed. At the conclusion of the examination, it was noted Petitioner became extremely curt and stated, "I am leaving, that's it. I have several hours to drive. I am done."It was noted Petitioner appeared very angry and not open to any further considerations for treatment. Petitioner was assessed with chronic headaches post closed head injury times two; probable tension type headaches; anger; postural abnormalities; recent mild injury to the left posterior rotator cuff and sleep disturbance. (PX 3)

Petitioner continued treating with Dr. Dick. On January 21, 2009, the doctor noted Petitioner had been diagnosed with post traumatic migraine headaches and had been responding to medication. Petitioner reported three to four headaches per month. Petitioner also reported that he had been quite active and like doing manual work. Dr. Dick's clinical impression remained posttraumatic migraine headaches. (PX 3)

On July 15, 2009,Petitioner underwent another MRI of the brain. Same was read to show no significant intracranial abnormalities. (PX 3)

On December 11, 2009, Dr. Dick authored correspondence indicating, "…[Petitioner] developed problems with severe recurrent headaches after having two closed head injuries which occurred in 2006…He

also had developed recurrent episodes of left arm and leg numbness and tingling. The above symptoms all occurred since his two head injuries in 2006...I did not obtain any history that these symptoms were present before the two head injuries...I also did not obtain any history of seizure episodes occurring before his closed head injuries...He has continued to have headaches described as posttraumatic migraine headaches, which are a chronic problem and for which he continues to receive medication..." Dr. Dick opined that Petitioner's headache and left-sided sensory symptoms all relate back to the head injuries incurred in 2006 while on the job. (PX 3)

Petitioner testified that he last treated with Dr. Dick in September 2010. He had an appointment scheduled in October 2010, but cancelled same. Petitioner also testified that when he was placed on work restrictions by Dr. Dick, he spoke with Respondent and was told they had no work available for him. He has not return to work with the Respondent. Petitioner testified that he was able to find work doing maintenance at a grain elevator in September of 2007. He works at heights close to 200 feet. He works sixteen hour days, seven days a week for months on end, and for at least the first two years at his job he only missed one day of work.

Dr. Dick testified via deposition in this matter. Dr. Dick testified that he initially saw Petitioner for complaints of left arm and leg numbness and clumsiness. Petitioner also complained of headaches. Petitioner provided a history that he sustained two closed head injuries, the first in April 2006 and the second in May 2006. An examination showed no abnormal findings on neurological examination. The doctor stated that the symptoms described were not associated with any fixed or permanent neurological deficits. He did not find any permanent weakness, loss of feeling or clumsiness. Dr. Dick testified that he ordered testing including a CT scan and additional testing. None of the testing showed significant abnormalities to explain Petitioner's symptoms. As a result he diagnosed postconcussive migraine headaches with associated left-sided symptoms from complicated migraine. The doctor treated same with medications. Dr. Dick stated that the medication regiment helped in that there was an improvement in the frequency of the headaches and left-sided symptoms. When asked to explain postconcussive syndrome and what is going on in the brain, Dr. Dick explained, "...this is something that can't be visualized on his MRI scans, but what is happening is that the right side of the brain, which is the area that was struck I believe by history, his nerve cells that are basically more irritable, that are more likely to cause migraine-like attacks, complicated migraine attacks. The other possibility that I considered but did not prove was post-concussive seizures..." Dr. Dick stated that he believed that the combination of both concussions that Petitioner experienced led to his diagnosis. (PX 1)

Dr. Dick testified that he last saw Petitioner on September 1, 2010. At that time, Petitioner described recurrent neurological symptoms including sudden numbness of the left side with tingling and right leg numbness and tingling. Petitioner was instructed to return is one month but he cancelled the appointment. Dr. Dick testified that Petitioner's prognosis was uncertain as there were symptoms in September 2010 approximately four years after the original concussions. Dr. Dick stated same was unusual as "...symptoms like this usually go away over, in my opinion, a couple of years. (PX 1)

On cross-examination, Dr. Dick testified that it's very rare for a diagnosis of postconcussion syndrome to last more than two years. He stated that it's widely accepted that that same cannot go beyond two years. Dr. Dick testified that other than Petitioner's history, there was no objective findings based on neurological examination or imaging studies to support his conclusion of postconcussion syndrome. The doctor stated, "the diagnosis was based on the significance of the head injuries and that these were heavy objects and that the history seemed to be consistent after that." (PX 1)

Dr. Dick testified that his causal relationship opinion was based on Petitioner's history of not having any prior symptoms before the head injuries. He indicated that he was not aware that Petitioner had been complained of experiencing left-side paresthesias before the accident in question. The doctor also reiterated that

it was unusual that Petitioner continued to complain of postconcussion symptoms two years post accident. He testified that it was possible that Petitioner's symptoms could be due to something else. As of September 2010, the doctor was attempting to look for additional causes of Petitioner's symptoms.

Dr. Dick testified that he was unable to discern which incident at work caused Petitioner's symptoms. He stated, "I would say it's a combination of both." Dr. Dick followed that if the evidence shows that one injury was more severe than the other, that injury was more likely to be the cause of Petitioner's symptoms. (PX 1)

On re-direct examination, Dr. Dick testified that if he had been provided with a history that Petitioner sustained only one head injury, his opinion would "probably" be the same in that the one head injury would be causally related to Petitioner's symptoms. (PX 1)

At Respondent's request, Dr. Norman Kohn, a neuropsychiatrist, prepared a medical records review pursuant to Section 12 of the Act. Dr. Kohn noted several unusual characteristics of Petitioner's treatment. This included Dr. Dick referring Petitioner for two neurological consultations in a short period of time, which "... infers either an unusual or thorny clinical problem (not the case here) or a demanding, implacable patient." Dr. Kohn also noted the absence of any counseling by Petitioner's neurologists against driving, which the doctor indicated implies either an uncooperative patient or that the doctors doubted Petitioner's complaints about seizure symptoms. (RX 1)

Dr. Kohn also noted that the injury from the April 3, 2006 accident was minor from a neurologic standpoint. Dr. Kohn noted that the histories given by Petitioner changed as to the chronology and severity of his injuries, and that Petitioner "...appears to have tailored what he told his neurologists, in a manner that encouraged the diagnosis of persistent unusual symptoms after minor head injury." Dr. Kohn further noted that important history was not given by Petitioner to certain doctors, including Dr. Dick. Dr. Kohn also found that multiple other causes for Petitioner's symptoms were reflected in the medical records. (RX 1)

Dr. Kohn opined that he saw "... no medical basis for concluding that the reported head injuries sustained in mid-2006, including specifically the injury that led to emergency care on 04/03/06, caused any of the symptoms of headache or numbness or tingling reported to physicians on and after November 2006." Dr. Kohn further stated that his opinions were "... held to a reasonable degree of medical and neurologic certainty. (RX 1)

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

Petitioner's support for his claim of a causal connection between his alleged continuing symptoms and the April 3, 2006 accident date is the testimony of Dr. Herman Dick, who opined that Petitioner's symptoms were caused by post-concussion syndrome. Dr. Dick's medical records state that Petitioner was being treated for incidents incurring in July, September, and August of 2006. Dr. Dick testified that he found no objective evidence relating to Petitioner's alleged condition, and only came to his opinion because of the history given by Petitioner of the symptoms arising after being hit in the head twice at work.

The histories given by Petitioner to his physicians, when looked at as a whole, does not support Dr. Dick's opinion. In December of 2006, Petitioner reported to Dr. Jani that he had been having symptoms for over a year, well before the accident date of April 3, 2006. Dr. Dick admitted that this would go against the Petitioner's symptoms being caused by the accident on April 3, 2006. Dr. Dick also testified that symptoms from post-concussion syndrome would be expected to arise soon after an accident, and that the longer it took for symptoms to arise the more likely it would be that something else was the cause. Nine days after the accident

Petitioner was seen by Dr. Jani to have his staples removed, at which time it was noted that the wound had healed well and no mention of any headaches or other symptoms are mentioned. Petitioner sought no other treatment and made no complaints of symptoms until November 14, 2006, seven months after the accident date. Petitioner also reported on December 4, 2006 that his symptoms had gotten worse three to four months prior, which would have been four to five months after the accident date.

Dr. Dick admitted that a minor injury is less likely to cause post-concussion syndrome. The evidence shows that Petitioner's April 3, 2006 injury was minor, with minimal pain and bleeding. Although Petitioner's testimony implies that the second incident was of no consequence, the records submitted suggest otherwise. Dr. Jani's record from December 4, 2006 show Petitioner was "…complaining of symptoms of left sided paresthesias that he has had for over a year now but worse in last 3-4 months. He has had 2 head injuries this year where he lost consciousness, both within a month of each other. One episode was for 30 seconds. Another was for a minute and a half…" Dr. Jesse VanLe note from November 21, 2006 show, "[Petitioner] also stated that approximately a few months ago that he [had] two accidents which he was hit in the head and lost consciousness…" Dr. Dick's record from March 7, 2007 show Petitioner provided that "…The first he was stunned. The second time he was "laid out." Finally, the Rehabilitation Institute of Chicago records on October 10, 2008 indicate Petitioner provided that "…on 4/7/06 he was hit in the head with a concrete form weighing 90 pounds…after which he lost consciousness for a few seconds...He returned to work soon after…One month later, again while at work, he was hit by two forms weighing approximately 120 pounds each on the right side of the head and again resulting in loss of consciousness lasting for a few seconds…" Petitioner testified the April 3, 2006 incident was the first incident. This is the only date for which any notice was provided to any employer, and the only date for which an Application for Adjustment of Claim has been filed.

Dr. Dick also admitted that he was not able to state within a reasonable degree of medical certainty that the April 3, 2006 accident was a cause of the Petitioner's alleged symptoms. Dr. Dick testified that he gave the opinion that Petitioner's symptoms were caused by two incidents in which Petitioner was hit in the head because he was given a history of two such incidents. However, Dr. Dick admitted that if one injury was more severe than the other it would be more likely that that injury was the causative factor, and that he could not say within a reasonable degree of medical certainty which incident caused the alleged symptoms. As noted above, the medical records suggest the second alleged incident was just as or more severe than the April 3, 2006 accident.

Dr. Dick testified that if a patient was suffering from post-concussion syndrome, the symptoms would be expected to arise fairly soon after the accident, and, if they did not, other causes should be considered. Also, Dr. Dick testified that it would be unusual for someone to continue to suffer from post-concussion syndrome for as long as Petitioner has been alleging symptoms, and that it is a mostly accepted opinion in the medical field that post-concussion syndrome symptoms should not last more than two years. The fact that Petitioner continued to report to Dr. Dick that he was suffering from symptoms in September of 2010, and testified at trial that he continued to suffer from migraines in 2014, goes against Dr. Dick's opinion that Petitioner's current condition is the result of post-concussion syndrome from the April 3, 2006 accident.

Lastly, although Dr. Dick testified that his opinion was based upon Petitioner's reported history and not finding any neurologic deficits for Petitioner's symptoms, the medical records show that a multitude of other potential causes were identified by Petitioner's physicians. Other potential causes of Petitioner's alleged symptoms identified by Petitioner's physicians include, but are not limited to, other trauma such as car accidents, tension type headaches, carotid stenosis, muscle contraction type headaches, and psychological and psychosocial issues. Dr. Dick himself was continuing to search for other causes of Petitioner's alleged symptoms up until Petitioner stopped treating with him in September of 2010, including ordering tests such as a carotid ultrasound. The only reason Dr. Dick stopped looking for other causes was because Petitioner canceled

an appointment and of his own volition stopped treating with Dr. Dick. The doctor's continued pursuit of the cause of Petitioner's symptoms goes against his opinion that the symptoms were caused by the April 3, 2006 accident.

Respondent, relying on Dr. Norman Kohn, disputes that Petitioner's present condition of ill-being is causally related to the April 3, 2006 accident. Dr. Kohn, a neuropsychiatrist, preformed a medical record review and issued a report dated October 29, 2012. A review of the report show Dr. Kohn was able to review records which included information and history that appears to not have been seen by the physicians treating Petitioner. Dr. Kohn noted several unusual characteristics of Petitioner's treatment. This included Dr. Dick referring Petitioner for two neurological consultations in a short period of time, which "… infers either an unusual or thorny clinical problem (not the case here) or a demanding, implacable patient." Dr. Kohn also noted the absence of any counseling by Petitioner's neurologists against driving, which the doctor felt implies either an uncooperative patient or that the doctors doubted Petitioner's complaints about seizure symptoms. Dr. Kohn also noted that the injury from the April 3, 2006 accident was minor from a neurologic standpoint. Dr. Kohn also noted that the histories given by Petitioner changed as to the chronology and severity of his injuries, and that Petitioner "…appears to have tailored what he told his neurologists, in a manner that encouraged the diagnosis of persistent unusual symptoms after minor head injury." Dr. Kohn further noted that important history was not given by Petitioner to certain doctors, including Dr. Dick. Dr. Kohn also found that multiple other causes for Petitioner's symptoms were reflected in the medical records. Dr. Kohn concluded that he saw "… no medical basis for concluding that the reported head injuries sustained in mid-2006, including specifically the injury that led to emergency care on 04/03/06, caused any of the symptoms of headache or numbness or tingling reported to physicians on and after November 2006." Dr. Kohn further stated that his opinions were "… held to a reasonable degree of medical and neurologic certainty.

The Arbitrator finds the opinions of Dr. Kohn persuasive.

Based upon the foregoing, the Arbitrator finds that Petitioner sustained a minor head injury on April 3, 2006 which resulted in minimal pain and minimal bleeding. The staples Petitioner received at that time were removed on April 12, 2006, at which time the wound had healed well and no other symptoms were reported. Petitioner has not proved that any symptoms or treatment after this date were causally connected to the April 3, 2006 injury.

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

The Arbitrator adopts and incorporates herein the findings set forth in Section (F) above. None of the allegedly unpaid medical bills put forth by Petitioner are from prior to that date. Therefore, Petitioner has not proved that any reasonable and necessary medical bills have not been paid, and no award is granted.

With regard to (K) What temporary benefits are in dispute, the Arbitrator finds as follows:

Having found that Petitioner failed to prove that a causal relationship existed between his condition of ill-being subsequent to April 12, 2006 and the accident sustained on April 3, 2006, the Arbitrator finds that all claimed temporary total disability benefits are denied.

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

Petitioner sustained a minor head injury on April 3, 2006 with minimal pain and minimal bleeding. He returned to work the next day without restrictions. The only treatment Petitioner received causally connected to this accident was being seen in the Emergency Room thirty minutes following the accident where he received staples, and having the staples removed nine days later on April 12, 2006. When Petitioner's staples were removed on April 12, 2006 it was reported that the wound had healed well. There were no report of headaches or dizziness.

Based on the above, the Arbitrator finds that as a result of the accident sustained on April 3, 2006, Petitioner is permanently disabled to the extent of 1% under Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Victor Fernandez,

Petitioner,

vs.

NO: 13WC 16854

15IWCC0141

Packers Sanitation Services,

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, 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, 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.

15IWCC0141

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: FEB 1 9 2015
MJB/bm
o-02/17/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

FERNANDEZ, VICTOR
Employee/Petitioner

Case# **13WC016854**

PACKERS SANITATION SERVICES
Employer/Respondent

15IWCC0141

On 3/18/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

5038 WILLIAM J BRIBRIESCO & ASSOC
ANDREW W BRIBRIESCO
2407 18TH ST SUITE 200
BETTENDORF, IA 52722

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

15IWCC0141

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)
- [x] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Victor Fernandez
Employee/Petitioner

Case # 13 WC 16854

v.

Consolidated cases: ______

Packers Sanitation Services
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **February 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **October 12, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**22,620.00**; the average weekly wage was $**435.00**.

On the date of accident, Petitioner was **40** years of age, *married* with **2** dependent children.

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

Respondent shall be given a credit of $ 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

- The respondent shall pay the petitioner temporary total disability benefits of $ /week for ___ weeks, from ___ through ___, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner, the disabling condition is temporary and has not yet reached a permanent condition, pursuant to Section 19(b) of the Act.

- The respondent shall pay for medical services provided by ORA Orthopedics for treatment on May 6, 2013, as provided in Section 8(a) of the Act, subject to the Fee Schedule, and also prospective medical causally related to the Petitioner's accidental injuries of October 12, 2012, pursuant to qualifications set forth in Sections 8 (a) and 8.2 of the Act.

  - As the findings and conclusions attached state, the conditions which have been causally related to the accident are the right carpal tunnel syndrome and the right extensor carpi ulnaris tenosynovitis.

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

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

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

D. Dylan McCarty
Signature of Arbitrator

March 4, 2014
Date

MAR 18 2014

FINDINGS OF FACT

Petitioner began working for the Respondent in May of 2003. Petitioner had also worked at Respondent's predecessor beginning in approximately 1996. Respondent's business involves cleaning machines, floors, and surfaces at the Tyson meat packing plant in Joslin, Illinois. He testified through the use of an interpreter.

Petitioner testified that his job with Respondent was that of a "power-hoser." His job was characterized as that of a laborer in his initial incident report. (RX 1) A more detailed description of his job can be found at Deposition Exhibit 2 ("Job Description") of Petitioner's Exhibit 8. Petitioner testified that Deposition Exhibit 2 was an accurate description of his job as a power-hoser.

Petitioner testified at hearing that his job involved repetitive use of his right hand and right upper extremity. He demonstrated how he performed the power-hosing job, which required constant squeezing of the hose, flexing of his wrist and hand to maneuver the hose, rotation of his hand and wrist to wash all areas and surfaces, and involved lifting and maneuvering the hose above shoulder-level. Petitioner would regularly perform the power-hosing job for two consecutive hours and for a total of three-to-four hours in a day. (*Pet. Ex. 8*)

The Petitioner testified that on October 12th of 2012, he was working for Packers Sanitation Services, Inc., and in that capacity was responsible for doing clean up following the slaughter of cattle at the Tyson plant. In conjunction with this work, he would use a high powered hose to clean the slaughter area. While using the hose, he felt a twist in his wrist followed by a burning sensation and pain. When he took off his glove, he had a ball sized lump on his wrist. He was taken to the cafeteria and ultimately was directed to Genesis Healthcare, where he underwent initial treatment.

The first treatment at Genesis Healthcare was on October 24th of 2012. At that time, a strain of the right wrist was diagnosed. X-rays were taken on that date, which were normal. The petitioner returned to treatment at Genesis Healthcare on October 31st of 2012, and at that time, the diagnosis changed to right forearm extensor tendonitis and right wrist strain. Treatment continued with Genesis Healthcare through January 31st of 2013 and the diagnosis at all times was some form of right wrist tendonitis. (Petitioner's Exhibit #2).

His symptoms on his initial visit involved pain from the fifth finger of the right hand into the forearm. Swelling was noted along the dorsal ulnar aspect of the hand, and the area was tender to palpation. At his next two visits, the Petitioner's symptoms remained along the ulnar aspect of the hand. When he returned for treatment on November 9, 2012, after he had returned to his normal job using the hose, his symptoms had increased. However, they remained along the ulnar side of the wrist and forearm.

At his next two treatment visits on November 15 and 29th, the Petitioner began to complain about pain in the right shoulder. He also reported pain at not only the lateral aspect of the wrist, but the medial aspect as well. On December 13, his wrist pain was gone and he was released to full duty work. He returned one week later reporting increased symptoms using the hose. His pain was again on the dorsal ulnar side of the wrist and lateral epicondyle at the elbow. Following that visit, PA Benson placed him on a restriction of no use of the right hand.

He returned to the clinic on January 17, 2013, and complained of a worsening of symptoms. Now he had tenderness over the anterior shoulder, the extensor forearm and dorsum of the wrist. He also had a complaint of numbness in the fingertips, and showed a mildly positive Tinel's sign. His history concerning work

was significant. While he had been told not to use his right hand, he reported that he had been performing shoveling and scooping, as well as repetitive cleaning using the right hand. Ms. Benson's commented as follows: "My impression is that he has continued to use the upper extremity too much, this (sp) contributing to his problems." (PX 2 1/17/2013) Nerve studies were performed on January 29, 2013, and they revealed moderate right carpal tunnel syndrome. (PX 5)

On January 31st of 2013, a therapist at Genesis made a diagnosis of right carpel tunnel syndrome and referral was made to Dr. Hussain for an orthopedic opinion. (Petitioner's Exhibit #2). Dr. Hussain first saw the Petitioner on February 11th of 2013 and made an initial diagnosis of extensor carpi ulnaris tendon synovitis. This diagnosis was based in part upon an MRI which had been completed and demonstrated extensor carpi ulnaris tenosynovitis. Dr. Hussain treated the condition with an injection to the ECU sheeth. There is no indication that the doctor reviewed the nerve studies during that visit. (Petitioner's Exhibit #6 and Respondent's Exhibit #7).

The Petitioner again treated with Dr. Hussain on March 25th of 2013. At that time, Dr. Hussain reviewed the aforementioned electrical studies, and added carpel tunnel syndrome to his prior diagnosis of right extensor carpi ulnaris tenosynovitis. The doctor again suggested ongoing therapy and stated he was hesitant to provide multiple injections in the future. The doctor noted that with regard to the carpel tunnel syndrome, he was going to proceed forward with a corticosteroid injection. The doctor did mention that the patient could be a candidate for a carpel tunnel release. (Petitioner's Exhibit #6 and Respondent's Exhibit #7).

The Petitioner's third and final treatment with Dr. Hussain was on May 6th of 2013. He complained that he still had persistent numbness and tingling in the hand, and also persistent problems in the wrist. His examination produced pain and restricted wrist motion. Dr. Hussain felt that he had symptoms related to both carpal tunnel syndrome and his synovitis of the tendon. He told the Petitioner that carpal tunnel surgery might help with some of his hand numbness and tingling, but not his persistent wrist pain. At that time, he continued his diagnosis of right carpal tunnel syndrome and extensor carpi ulnaris tenosynovitis. He wanted the Petitioner to consider his options and return to him if needed.

Following his final visit with Dr. Hussain, the Petitioner testified that the Respondent forced him to perform his regular job. He said that his job duties had changed, however, and he was no longer using the power hose. He did say that he was doing more scrubbing which was heavier work with respect to his hands. He further testified that the Respondent advised him not to return to Dr. Hussain. He testified that he still has all of his symptoms, including wrist pain, tingling of the fingers and pain in the right shoulder and neck.

The Petitioner was next seen for an evaluation and possible treatment by Dr. Richard Kreiter, an orthopedic surgeon. The visit was at the request of his attorney. Dr. Kreiter saw the Petitioner on October 2nd of 2013. The doctor diagnosed carpel tunnel syndrome, extensor tenosynovitis of the right wrist, and for the first time, interjected the diagnoses of lateral epicondylitis and AC joint rotator cuff impingement. The doctor rendered the opinion that all of these conditions were causally related to the Petitioner's many years of strenuous work for Packers Sanitation. The doctor recommended open carpel tunnel release on the right side for the carpel tunnel condition. (Petitioner's Exhibit #8).

The Petitioner was also seen for evaluation purposes at respondent's request by Dr. Stephen Weiss on April 22nd of 2013. Dr. Weiss, after performing an examination and doing an extensive medical records review, arrived at the conclusion that the Petitioner did suffer from extensor carpi ulnaris tenosynovitis. Dr. Weiss

further came to the conclusion that the condition would have been causally related to the injury described by the Petitioner. The doctor noted that at the time of his exam, there was no objective evidence of ongoing problems with the extensor carpi ulnaris tenosynovitis and he believed that the work injury of October 12th of 2012 had been resolved. (Respondent's Exhibit #6). Dr. Weiss also made a diagnosis of an idiopathic carpel tunnel syndrome. He came to the conclusion that the condition had nothing to do with the accident of October 12th of 2012, since the symptomatology relating to the described accident was to the distal radial joint, which has nothing to do with the carpel tunnel. Instead, Dr. Weiss related the Petitioner's carpel tunnel condition to his obesity. (Respondent's Exhibit #6).

The Petitioner is now requesting that the Respondent authorize a right carpal tunnel release.

Conclusions Of Law

The main issue in this 19(b) proceeding is whether there is a causal relationship between the Petitioner's work and carpal tunnel syndrome. If a relationship exists, then the Respondent would be responsible for the treatment requested, which is a carpal tunnel release.

One medical bill for the Petitioner's final office visit with Dr. Hussain is also at issue. The Arbitrator believes the bill is the Respondent's responsibility. The office notes clearly show that the Petitioner was seen on May 6, 2013 for both his carpal tunnel and tendon synovitis. As the Respondent concedes that the synovitis is causally related to the Petitioner's accident, it is ordered to pay the bill, subject to the Fee Schedule.

On his Application, the Petitioner is alleging an accident due to repetitive trauma. (Arb. 2) Respondent takes the position that the claim only involves a specific trauma on October 12, 2012, because that is what the Petitioner described in his initial report to his employer. (RX 1,2) While that appears to be true, there is no requirement under our Act that a Petitioner make an election as to which theory he is claiming when he first reports an injury. When the Petitioner first went for medical treatment on referral from the Respondent on October 24, 2012, he gave a history of a more gradual onset, repetitive type accident. The note from Genesis At Work clearly states that the Petitioner was doing repetitive hosing by moving his wrist back and forth in a rotation type involvement. He denied a direct trauma.(PX 2 at 5) Whether the evidence shows a specific accident or an accident as the result of repetitive trauma, the question remains whether the accident is related to the condition of ill being, in this case carpal tunnel syndrome.

The evidence also supports the conclusion that the Petitioner's job as a laborer on the Kill Floor involved the repetitive use of his hands and wrists, primarily his dominant right hand. He testified to all of his duties, including the use of a power hose. He operated the hose with his right hand at least two hours per shift without taking a break. His testimony is corroborated by the histories he gave to his treating providers. He explained to the PA at Genesis on October 31, 2012 that he used the hose for overhead cleaning and in so doing, had his wrist in a bent position. When he was seen on November 9, 2012 with increasing symptoms, he related that he had been using the hose above his shoulder with his wrist bent for three to four hours a shift.(PX 2)

He also testified that he regularly shoveled, scooped and scrubbed the walls as a regular part of his job, and he gave similar histories to his doctors on several occasions. (PX 2 at 12/20/2012, 1/17/2013; PX 3) The Respondent did not dispute the Petitioner's accounts of his job duties.

Finally, the Arbitrator gives weight to Dr. Kreiter's opinion that the job was repetitive. He showed in his testimony a good understanding of the job duties thorough communication with the Petitioner and also visiting the Kill Floor on occasion. (PX 8 at 12,13,22)

The more difficult question is whether the repetitive activity was causally related to the Petitioner's carpal tunnel. The early treatment notes reflect tenderness and swelling of the wrist, but most of the symptoms were towards the Petitioner's ulnar hand and wrist. He also did not report the classic carpal tunnel symptoms of numbness and tingling until his visit to Genesis on January 17, 2013.

He did however, have ongoing wrist symptoms of pain and swelling throughout his course of treatment. Also, he did periodically try to resume his hand intensive work while still experiencing some of those symptoms which resulted in an increase of his symptoms. After initially working light duty, he resumed his hosing activities on November 8, 2012. The next day he was back at the doctor's with increased wrist pain. Again he was returned to his regular job on December 13, only to return for treatment one week later with increased wrist pain which he attributed to his hosing.

On January 17, 2013 he was again examined at Genesis. He said that he had been shoveling and scooping at work though he was to have been on a no use of the hand restriction. He was found to have pain in the wrist, numbness of the fingertips and showed a mildly positive Tinel's sign. The PA ordered nerve conduction studies, and opined that his overuse of his right arm at work was contributing to his symptoms. (PX 2) The studies, done on January 29, 2013, confirmed a condition of moderate right carpal tunnel syndrome. (PX 5)

The Petitioner had no carpal tunnel symptoms prior to October 12, 2012. On that date, while doing his regular job, he began having pain and swelling in his wrist. While the subsequent treatment resulted in some improvement, the improvement was short lived because he repeatedly returned to his repetitive job. There was no period of a prolonged absence of symptoms nor any history of an independent intervening accident which could breal the causal chain between October 12 and the date of diagnosis. Based upon the above facts, the Arbitrator finds a causal relationship between the Petitioner's accident and his carpal tunnel syndrome.

The fact that he was involved in fence building activities at his home on May 5,2013 is ofno significance. He'd already been diagnosed, and Dr, Hussain on the day following suggested that carpal tunnel surgery might help some of his symptoms. (PX 6)

In addition, the Petitioner also has tenosynovitis of the wrist which the Respondent concedes is causally related to his accident. As for the other two diagnoses of Dr. Kreiter, epicondylitis and impingement of the shoulder, the Arbitrator does not believe the evidence shows a causal relationship to the events of October 12, 2013. While he may well have those conditions, the Petitioner injured his wrist on the accident date. Any treatment requested for those conditions is denied.

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

Barbara Leo,

Petitioner,

vs. Nos. 05 WC 00630
05 WC 27977

DuPage School District #88,

Respondent.

15IWCC0142

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the circuit court. The circuit court reversed the Commission's finding of causal connection and awards of medical benefits and permanent total disability, and remanded the matter to the Commission "for a recalculation of benefits consistent with this Order *** for soft tissue lumbar strain arising out of the accidents of September 23, 2004 and May 18, 2005."[1] The Commission hereby complies with the order of the circuit court.

The following evidence is pertinent on remand. Petitioner, a teacher's aide to special needs children, denied having low back problems before September 23, 2004. Petitioner testified that on September 23, 2004, she felt a sharp pain in her low back and left hip while she was helping another individual transfer a "heavy" 16 or 17 year old student from a bathroom commode to a wheelchair. The following day, Petitioner began treating for the injury at DuPage Medical Group. Petitioner continued to work until October 22, 2004. She stopped working when her treating physician took her off work because of worsening pain. Petitioner received conservative treatment until May of 2005 consisting of muscle relaxants and pain medication. On or about May 2, 2005, Petitioner returned to work on restricted duty.

[1] The appellate court dismissed the ensuing appeal because the circuit court's order was interlocutory and not immediately appealable.

Petitioner further testified that on May 18, 2005, she sustained another work accident. She was walking with a blind student when she tripped over his cane and fell on the sidewalk. Petitioner received emergency treatment at Elmhurst Hospital and followed up with Dr. Steven Mather, an orthopedic surgeon.

Kevin Green, a private investigator, testified that he performed video surveillance of Petitioner on June 5 and June 6, 2005. Paul Rybicki, another private investigator, testified he performed video surveillance of Petitioner on October 15, 2005. The surveillance videos were admitted into evidence.

Audrey Dickerson, Petitioner's neighbor and friend who is a registered nurse, testified that she observed Petitioner doing yardwork on June 5, 2005. Ms. Dickerson stated Petitioner was in pain. On cross-examination, Ms. Dickerson admitted that on June 5, 2005, she saw Petitioner do lawn spreading on and off for approximately 20 minutes. During that time, Petitioner bent down several times to fix the lawn spreader.

Regarding the events on June 5, 2005, Petitioner testified she "was out there just to get some exercise because [she] had been laying [*sic*] around for two weeks." She wanted to move around and walked back and forth with the lawn spreader. There was a "handful of seed" in the spreader, "but it never worked." At the time, Petitioner was taking Vicodin and Skelaxin, which helped dull the pain. Petitioner admitted going grocery shopping the following day, stating she bought only a few light items. Petitioner also admitted clipping rose bushes in October of 2005. Petitioner maintained she suffered from persistent low back pain between May 18, 2005 and October 15, 2005, and thereafter.

Petitioner further testified that she stopped treating with Dr. Mather after he testified via evidence deposition in this matter in 2006. Ultimately, Petitioner came under the care of Dr. Stavros Maltezos, a neurosurgeon. On September 11, 2007, Dr. Maltezos performed the first low back surgery, followed by six more surgeries—for infection, internal bleeding, "to stabilize the spine" and to remove hardware. The last surgery was on June 18, 2008. In September of 2009, Petitioner began receiving Social Security disability benefits. At the time of the arbitration hearing, Petitioner was still under the care of Dr. Maltezos and receiving Social Security disability benefits. Petitioner testified she continued to suffer from constant, debilitating low back pain.

In a narrative report dated January 19, 2006, Dr. Mather stated that he began treating Petitioner on February 14, 2005, for complaints of pain in the low back and left leg since the work accident on September 23, 2004. Dr. Mather reviewed Petitioner's MRI and X-rays, and diagnosed grade II spondylolisthesis at L5-S1 and severe foraminal stenosis bilaterally. After Petitioner received three epidural steroid injections, Dr. Mather released her to return to work with a 10 pound lifting restriction on May 2, 2005. On June 13, 2005, Petitioner followed up, describing the work accident on May 18, 2005. Dr. Mather felt "the spondylolisthesis had not significantly changed from that recent injury." Thereafter, Petitioner followed up with Dr. Mather through October of 2005, reporting no improvement. Dr. Mather's opinion at the time

was the work accident on September 23, 2004, aggravated preexisting spondylolisthesis at L5-S1 and severe foraminal stenosis, and Petitioner would likely need surgery.

Dr. Mather testified via evidence deposition on June 16, 2006. During the deposition, Dr. Mather viewed the surveillance videos from June 5 and June 6, 2005, noting that Petitioner did not appear to be in any pain and she exhibited much greater physical abilities than during a physical therapy visit on June 15, 2005. Dr. Mather stated the range of motion Petitioner exhibited would typically not be seen in patients with chronic low back problems. The videos changed Dr. Mather's opinions. Dr. Mather now opined Petitioner sustained a back strain and was probably able to return to work as of June 5 or June 6, 2005. Dr. Mather further opined Petitioner did not require surgery.

Dr. Maltezos testified via evidence deposition on April 10, 2009, that he diagnosed spondylolisthesis at L5-S1, which was probably congenital. Dr. Maltezos opined the work accident on September 23, 2004, caused the spondylolisthesis to become symptomatic, and the work accident on May 18, 2005, aggravated the symptoms. Dr. Maltezos acknowledged that during the initial consultation he noted Petitioner "was focused on the adversarial issues of her worker's comp. situation" and he questioned whether she magnified her symptoms. He also noted Petitioner was obese. Ultimately, Dr. Maltezos decided Petitioner was not a malingerer because she had been compliant with all his treatment recommendations. On September 11, 2007, Dr. Maltezos performed instrumented fusion surgery, following which Petitioner developed a wound infection and required surgery to repair the skin and soft tissue. Dr. Maltezos also "removed the presumably infected hardware and replaced it and redid the fusion." At the time of the deposition, Petitioner was "doing better" and weaning off narcotic pain medication. On cross-examination, Dr. Maltezos testified that in April of 2008 Petitioner "was opened and closed and no anterior fusion was accomplished" because he could not safely perform it. Dr. Maltezos performed the revision fusion surgery in June of 2008 to remove presumably contaminated hardware. Post-deposition, Dr. Maltezos issued a report on January 19, 2010, opining that Petitioner was only capable of sedentary work.

Dr. David Spencer, an orthopedic surgeon and Respondent's section 12 examiner, testified via evidence deposition on May 19, 2009. Dr. Spencer examined Petitioner on June 28, 2005. During the examination, Petitioner did not appear to be in any discomfort. The range of motion in the lumbar spine was full and relatively painless. The neurologic exam was normal. During the deposition, Dr. Spencer viewed the surveillance videos from June 5 and June 6, 2005, noting the video from June 5, 2005, depicted Petitioner doing yardwork without any apparent physical impediment. Petitioner's motions were fluid, and she did not show any sign of back pain. In some instances, Petitioner bent 90 degrees or more, which a person with significant back pain would be unable to do without apparent discomfort. Dr. Spencer further noted the video from June 6, 2005, depicted Petitioner outside a grocery store. She did not appear to be in any pain. Dr. Spencer reiterated that Petitioner did not show a significant back impairment. Dr. Spencer therefore opined that Petitioner had recovered from her work injuries by June 5, 2005, without any residual impairment.

On March 16, 2010, Dr. David Trotter, an orthopedic surgeon, performed a records review, including the surveillance videos. Dr. Trotter found it implausible that Petitioner's low back was asymptomatic before September 23, 2004, given her longstanding degenerative condition. Dr. Trotter opined:

> "The injury on September 23, 2004 and the injury on May 18, 2005 appear to have been not dissimilar in that they both appear to have resulted at most in a sprain/strain injury of the lumbosacral spine superimposed upon pre-existent and ongoing degenerative abnormalities of the spine including spondylolysis, spondylolisthesis, stable and multiple other levels of degenerative abnormalities of the spine. The pre-existent degenerative abnormalities of the spine, however, do not appear to have at all been caused nor chronically aggravated whatsoever by the apparent soft tissue injuries sustained on the date of injury. *** Also, the injuries do not appear to have caused any significant aggravation of the subjective sciatica. * * * ¶ The injuries sustained on the date of injury of September 23, 2004 and May 18, 2005 *** appear to have resolved within approximately a six to eight week period post the date of injury. ¶ Any diagnostics and treatment rendered on behalf of the claimant post approximately eight weeks post date of injury of September 23, 2004 and May 18, 2005 would appear to have been medically unreasonable and/or unnecessary whatsoever for the apparent injuries sustained on the date of injury. * * * ¶ The claimant appears to have been at maximum medical improvement and a probable end treatment date *** on or prior to November 23, 2004 and July 18, 2005, respectively."

Dr. Trotter opined Petitioner could return to work full duty. On May 18, 2010, Dr. Trotter testified via evidence deposition consistently with his report.

The circuit court found against the manifest weight of the evidence the Commission's dismissing the surveillance videos as *de minimis* and non-dispositive and giving greater weight to the opinions of Dr. Maltezos over the opinions of Dr. Mather, Dr. Spencer and Dr. Trotter. The circuit court reversed the Commission's finding of causal connection and awards of medical benefits and permanent total disability, and remanded the matter to the Commission "for a recalculation of benefits consistent with this Order *** for soft tissue lumbar strain arising out of the accidents of September 23, 2004 and May 18, 2005."

The Commission notes that in case No. 05 WC 00630 it awarded only temporary total disability benefits from October 22, 2004, through May 2, 2005. This award comports with the circuit court's order. With respect to case No. 05 WC 27977, the Commission relies on the opinions of Dr. Mather and Dr. Spencer and finds that Petitioner was able to return to work by June 5, 2005. Further, the Commission relies on the opinion of Dr. Trotter and finds Petitioner reached maximum medical improvement by July 18, 2005. Accordingly, the Commission awards temporary total disability benefits from May 19, 2005, through June 5, 2005, and the medical bills (see Arbitrator's Exhibit 3) that Petitioner incurred through July 18, 2005. Respondent shall have credit for the medical bills Respondent or its group medical plan, Blue Cross Blue Shield, paid on Petitioner's behalf relative to the accidents on September 23, 2004

and May 18, 2005, provided Respondent holds Petitioner harmless from any claims and demands by Blue Cross Blue Shield. Turning to the nature and extent of Petitioner's disability, the Commission finds the injuries Petitioner sustained on September 23, 2004, caused permanent disability to the extent of 5 percent of the person as a whole. The injuries Petitioner sustained on May 18, 2005, caused no permanent disability.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $112.80 per week for a period of 27 4/7 weeks, from October 22, 2004, through May 2, 2005, and the sum of $141.27 per week for a period of 2 4/7 weeks, from May 19, 2005, through June 5, 2005, those being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the medical bills listed in Arbitrator's Exhibit 3 that Petitioner incurred through July 18, 2005, pursuant to §8(a) of the Act. Respondent is entitled to a credit for the medical bills Respondent or Blue Cross Blue Shield paid on Petitioner's behalf on account of said accidental injuries, provided that to the extent Respondent claims credit under §8(j) of the Act, Respondent shall hold Petitioner harmless from any claims and demands by Blue Cross Blue Shield.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $101.52 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 permanent disability to the extent of 5 percent of the person as a whole.

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

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

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: FEB 19 2015
SM/sk
o-02/05/2015
44

Stephen J. Mathis

Mario Basurto

David L. Gore

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose F. Gaytan,

Petitioner,

vs. NO. 13 WC 22971

Joyce Farms Recycling Inc.,

Respondent.

15IWCC0143

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary disability, causal connection, medical expenses, prospective medical care and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 29, 2014 is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $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: FEB 1 9 2015
SJM/sj
o-2/5/15
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

GAYTAN, JOSE F
Employee/Petitioner

Case# **13WC022971**

15IWCC0143

JOYCE FARMS RECYCLING INC
Employer/Respondent

On 5/29/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1427 BERG & BERG
STEPHEN M WAUCK
2100 W 35TH ST
CHICAGO, IL 60609

0766 HENNESSY & ROACH PC
SUSAN V BARRANCO
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

15IWCC0143

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

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

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

Jose F. Gaytan,
Employee/Petitioner

v.

Joyce Farms Recycling, Inc.,
Employer/Respondent

Case # **13** WC **22971**

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 **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **2/7/14**. 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. [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 ______

15IWCC0143

FINDINGS

On the date of accident, **10/1/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**[not stipulated]**; the average weekly wage was $**416.86**. (See Arb.Ex.#1).

On the date of accident, Petitioner was **66** years of age, *single* 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 $**6,612.24** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**6,612.24**. (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 $277.91 per week commencing 10/5/12 through 10/6/12 (2/7 weeks) and from 1/7/13 through 6/19/13 (23-2/7 weeks), for a period of 23-5/7 weeks, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 10/2/12 through 2/7/14, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $6,612.24 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $147.17, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be entitled to a credit for any and all benefits paid on account of the injury, 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 to Petitioner penalties of $**0.00**, as provided in Section 16 of the Act; $**0.00**, as provided in Section 19(k) of the Act; and $**0.00**, as provided in Section 19(l) of the Act.

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

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

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

Signature of Arbitrator

5/27/14
Date

ICArbDec19(b)

MAY 29 2014

15IWCC0143

STATEMENT OF FACTS:

Petitioner testified through an interpreter that on October 1, 2012, he was working at Respondent's recycling plant when he slipped on a sheet of water and fell to the ground hitting his right knee. Petitioner noted that he felt immediate pain in his right knee at the time of the incident. Accident is not in dispute. (Arb.Ex.#1). Petitioner testified that had never missed any time from work in the past because of his knee and that he had had "very little" pain in his knees prior to the accident in question. He noted that he did not have x-rays of his knees performed before the accident, but that Dr. Waheed had been prescribing pain medication during the year leading up to the incident in question.

Following the accident Petitioner visited the Riverside Medical Center emergency room on October 4, 2012. At that time Petitioner presented with complaints of pain and swelling in his right knee after tripping and falling at work the previous Monday. (PX1). X-rays of the right knee revealed no acute fractures or dislocations but did show degenerative changes as well as a moderate to large joint effusion in the suprapatellar region. (PX1). Petitioner was diagnosed with a contusion of the right knee. (PX1). He was prescribed Tramadol, given an Ace wrap and a cane and was restricted from work for two days. (PX1).

On October 8, 2012, Petitioner visited Dr. Harris Waheed, his primary care physician at First Care Family Clinic. On that date it was recorded that Petitioner "[f]ell and hit his right knee on 10/01/12 and went to the hospital on 10/4/12... Here with [complaints] of R[ight] knee pain not getting better with tramadol..." (PX2). Dr. Waheed diagnosed "PAIN IN JOINT LOWER LEG[,] Assessment; Worse." (PX2). Dr. Waheed prescribed hydrocodone-acetaminophen as needed for 15 days and told him to follow up in two weeks. (PX2).

Petitioner returned to Dr. Waheed on October 16, 2012 at which time it was noted that Mr. Gaytan "[c]ontinues with pain on his knee, states is less swollen but still hurts to walk and put pressure." (PX2). Once again, Petitioner was diagnosed with "PAIN IN JOINT LOWER LEG[,] Assessment; Worse." (PX2). He was instructed to continue with present management, call if he experienced worsening symptoms and follow up in 1 to 2 weeks. (PX2).

Petitioner returned to Dr. Waheed on October 19, 2012 at which time it was noted that "Pt is here for a FU in regrds [sic] to his R knee which is improcving [sic] and he needs a note to return on Monday 10/22/12. No other complaints." (PX2). Dr. Waheed's diagnosis was "PAIN IN JOINT LOWER LEG[,] Assessment; Better." (PX2).

Petitioner returned to Dr. Waheed on November 9, 2012 with continued complaints of right knee pain, although it was noted he was getting better and was requesting a refill of his medication. (PX2). Dr. Waheed's diagnosis was "PAIN IN JOINT LOWER LEG[,] Assessment; Better." (PX2). Petitioner was instructed to continue with present management and follow up after 3 to 4 weeks. (PX2).

Petitioner returned to Dr. Waheed on November 29, 2012 at which time it was noted that Mr. Gaytan was "... still having R knee pain and is not getting better especially with ambulation > he has also noticed some instability as well..." (PX2). Dr. Waheed diagnosed "PAIN IN JOINT LOWER LEG[,] Assessment; Worse" and recommended that Petitioner obtain an MRI and follow up with the specialist. (PX2).

On December 6, 2012 Petitioner underwent an MRI of the right knee which was interpreted as evidencing severe degenerative changes involving the medial compartment as well as a complex tear involving the body of the medial meniscus which appeared to extend into the inferior articular surface. (PX1; PX2).

On December 10, 2012, Petitioner followed up with Dr. Waheed regarding his MRI at which time he was referred to OAK Orthopedics for further specialized treatment. (PX2).

Petitioner began treating with Dr. Eddie Jones at OAK Orthopedics on December 18, 2012. Following his examination and review of the records, Dr. Jones noted that Petitioner presented with "DJD of the right knee and instability with mechanical symptoms. The patient had an MRI performed, which shows a complex tear of the medial meniscus. He also has severe degenerative changes in the medial compartment on the MRI. As such, we gave the patient a brochure for arthroscopic procedures and an injection to treat the DJD, which may be part of his symptoms. We will see him back in followup for reevaluation. If he is no better, we will proceed with an arthroscopy." (PX3). Petitioner testified that the injection did not help.

Petitioner returned to Dr. Jones on January 7, 2012 at which time it was noted that was still having debilitating knee pain and that the knee gives way and clicks. (PX3). Dr. Jones noted a painful range of motion and an equivocal McMurray upon examination, and indicated that "[t]his is Workmen Comp. We will go ahead and submit his information for surgery and await approval." (PX3). Dr. Jones also completed a "Work Status Report" taking Petitioner off work until further notice pending approval for right knee arthroscopic partial medial menisectomy. (PX3).

In a "Peer Reviewer Final Report" completed January 11, 2013, an unnamed orthopedic surgeon retained by the Respondent agreed that the recommended right knee arthroscopic medial meniscectomy was medically necessary. (RX3). This reviewer also agreed that the mechanism of injury would have likely caused the knee symptomatology and diagnosis noted. (RX3).

On January 24, 2013, Petitioner underwent a partial medial meniscectomy of the right knee and debridement at the hands of Dr. Jones. (PX3). Dr. Jones' post operative diagnosis was medial meniscal tear with significant medial-sided arthrosis. (PX3). As part of his observation at the time of surgery, Dr. Jones recorded that in addition to the complex tear of the posterior horn of the meniscus and "some moderate arthrosis on the femoral portion of the patellofemoral groove ... [as well as] some moderate synovitis in the patellofemoral joint ...", there was also "... severe DJD of the medial compartment with eburnated bone both on the tibia and femoral side." (PX3). Petitioner testified that the surgery did not resolve his knee pain.

Petitioner returned to Dr. Jones for a post-operative follow-up examination on February 7, 2013 at which time it was noted that "[t]he patient is still complaining of pain. We will put him in some therapy and see him back in three weeks afterwards for reevaluation." (PX3). Dr. Jones also issued a separate "Work Status Report" restricting Petitioner from work until further notice. (PX3). Thereafter, Petitioner began a post-surgery course of physical therapy at ATI Physical Therapy. (PX4).

In an office note dated March 11, 2013, Dr. Jones recorded that "[t]he patient still states he is not comfortable returning to full duty, so we will put him in work hardening over the next three weeks after which point the agreement is he will be returning to work." (PX3). In a "Work Status Report" on that date, Dr. Jones noted that Petitioner was off work until further notice and that the prognosis was "good." (PX3).

Petitioner underwent a Functional Capacity Evaluation at ATI Physical Therapy on April 8, 2013. (PX4). It was noted that the assessment was completed with the assistance of a translator. (PX4). Furthermore, the assessment was identified as "valid" and noted that Petitioner displayed functional capabilities at the "Heavy Physical Demand level (62-93 lbs. occasional lifting)." (PX4). It was also noted that Petitioner's job as a maintenance worker, as described in the Dictionary of Occupational Titles, was listed as a Medium Physical Demand Level occupation. (PX4). As a result, it was indicated that "... the client meets [his] job's physical demand level and

may attempt a return to work following the FCE activity recommendations and lifting tolerances listed on the Functional Assessment Overview – pending MD approval. Mr. Gaytan certainly may return to work within the guidelines outlined in the full FCA report, pending MD recommendations…" (PX4). This report went on to state that "[d]ue to demonstrated functional lifting deficits, pain reports and pain behaviors squatting, stair climbing and crouching are recommended on an Occasional basis … defined as 6-33% of the time (.5 – 2.5 hrs out of an 8 hr workday). Balancing activities, crawling and kneeling are recommended on a 'not at all' basis. Mr. Gaytan simply stated he could not perform these exercises…" (PX4).

Petitioner returned to Dr. Waheed on April 9, 2013 at which time it was noted that he "… still continues to have pain and instability of the knee…" (PX2). Dr. Waheed's diagnosis was "PAIN IN JOINT LOWER LEG[,] Assessment; Better." (PX2). Petitioner was instructed to continue with physical therapy for now and to follow up with Dr. Jones. (PX2).

In an office note dated April 15, 2013, Dr. Jones noted that "[i]t seems like he is not going to get better and still complains of significant pain particularly when he weight bears." (PX3). Dr. Jones went on to state that "[t]he operative note was reviewed as well as new x-rays today, which shows extensive tricompartmental DJD of the knee. It was noted in the operative note that he has eburnated bone and of course this does not bode well in terms of prognosis, which is poor at this juncture." (PX3). Dr. Jones then administered an injection and noted that "[i]f he is not significantly better [when he returns in two weeks], we will initiate a discussion on total knee arthroplasty." (PX3). In a separate "Work Status Report" on that date, Dr. Jones noted that Petitioner was off work until further notice and that the prognosis was "good." (PX3).

In an office note dated April 29, 2013, Dr. Jones indicated that Petitioner had reviewed "… the brochure on total knee arthroplasty, which is the only thing left, but the patient does have significant arthrosis as well. We will try placing him in work hardening and put in for the surgery through Workmens Comp. He understands that they may reject this; however, we will see him back at that point to make additional recommendations…" (PX3). In a separate "Work Status Report" on that date, Dr. Jones once more noted that Petitioner was off work until further notice and that the prognosis was "good." (PX3).

In an office note dated May 8, 2013, Dr. Jones' staff noted that Petitioner's niece "Lindsey" had called stating that Mr. Gaytan was in severe pain with physical therapy and asking if he needs to continue with same. (PX3).

Petitioner returned to Dr. Waheed on May 9, 2013 at which time he noted that physical therapy was worsening his right knee pain and that "[h]e was told that R[ight] TKA is the only option for his R[ight] knee as per Dr. Jones…" (PX2). Later that same day, another message was taken concerning a call from a "family member in Michigan saying [Petitioner] was having a lot more knee pain and did not want to return to work conditioning/work hardening program." (PX3).

In an office note dated May 14, 2013, Dr. Jones' office noted that they had spoken "… with Chad from ATI and he states that the patient refuses to participate in therapy so therefore patient will be discharged from physical therapy." (PX3).

In a "Peer Reviewer Final Report" completed May 15, 2013, an unnamed orthopedic surgeon retained by the Respondent opined that the recommended total knee arthroplasty was not causally related to the accident, noting that the previous procedure had revealed "… degenerative joint disease of the medial compartment with eburnated bone on the tibia and femoral side. This finding would be indicative of severe pre-existing disease that has not had reasonable documentation of either causation or chronic aggravation by the injury of 10/1/12." (RX4).

At the request of the Respondent, Petitioner visited Dr. Bradley Dworsky at Hinsdale Orthopaedics for purposes of a §12 evaluation. (RX5). In a report dated June 19, 2013, Dr. Dworsky noted that Petitioner presented with "... severe degenerative joint disease involving his right knee with an acute on chronic meniscal tear adequately treated with meniscectomy." (RX5). Dr. Dworsky was of the opinion that Petitioner's treatment to date had been reasonable and necessary and that "... the meniscal tear most likely had some chronic changes that were exacerbated by his injury, but that they had been adequately treated with a meniscectomy and that currently the patient's disability and restrictions are brought about due to his preexisting degenerative joint disease, as described at the time of his surgery." (RX5). Dr. Dworsky also felt, based on the FCE, that "... the patient is capable of returning to a full duty job. However, I do recommend that he be returned to work with the defined limitations his FCE points out, including occasional squatting, stair climbing, and crouching, and that he should not perform any crawling or kneeling activities. I do feel the patient should be given a trial of this, and based on his ability to progress, possibly have limitations removed after reassessment." (RX5). Dr. Dworsky went on to state that he felt "... the patient has maximized his recovery from a meniscectomy. I do, however, feel that he continues to suffer from severe degenerative joint disease symptomatology and that these will continue to be a source of problems given the severity of it and the advanced nature of it. I do feel, however, that the patient may still be benefited by medical treatments." (RX5). Dr. Dworsky indicated that he felt "... the patient may still benefit from further medical treatment, all geared toward decreasing the symptomatology of his degenerative joint disease ... [and that] an attempt at viscosupplementation with a medication such as Synvisc would be highly valuable and decrease the patient's symptomatology so that he can return to his occupation at a higher level more comfortably. I also feel that possible use of a stabilization brace, including a possible unloader brace if the lateral joint appears to be less affected, may be very useful in allowing the patient to be on his feet for prolonged periods of time back on a job site." (RX5). Finally, Dr. Dworsky opined that "... the need for the total knee arthroplasty is solely due to the patient's pre-existing severe degenerative joint disease, as demonstrated at the operative note of eburnated bone, which would have taken many years to establish and that the patient's current symptomatologies are very consistent with a severe form of degenerative joint disease. It is my opinion that the need for total knee arthroplasty is not causally related to an injury he sustained in the fall of 2012, rather that was limited to the meniscal pathology which was previously adequately addressed." (RX5).

In an addendum dated July 15, 2013, Dr. Dworsky opined that the restrictions set forth in the FCE "... are the result of his ongoing degenerative joint disease and not a direct manifestation of his meniscal tear which I do feel that he has reached his maximal medical improvement for this particular disorder." (RX5).

In an office note dated October 3, 2013, Dr. Jones noted that "[t]he second opinion stated that [Petitioner] had preexisting pathology that predisposed him to the need for total knee and as such this still needs to be worked out legally. The patient does have personal insurance and has to decide whether he would like to go ahead with the total knee arthroplasty based on that insurance or if he wants to work through the Workmen Comp process, which is what I think he wants to do. As such, we will be available for any correspondence with his attorney, but we will see him back on an as needed basis for this and as far as I am concerned at this juncture the patient can return to work." (PX3).

Petitioner testified that he has not attempted to return to work since.

Currently, Petitioner notices that his right knee is "not too well" and that it wakes him up at night. He also indicated that he has problems doing daily living activities and that he does not have strength in his right leg. He noted that as a result it finds it difficult to walk and climb stairs. Petitioner also testified that he wants to go ahead with the surgery recommended by Dr. Jones.

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

There would appear to be no question that Petitioner suffers from severe degenerative joint disease ("DJD") in his right knee, and that this condition pre-existed the undisputed accident on October 1, 2012. It seems equally clear that the initial surgery, consisting of a partial medial meniscectomy to address a complex tear of the medial meniscus of the right knee, was causally related to the accident, based not only on the peer review report dated January 11, 2013 (RX3) but also on the opinion of Respondent's §12 examining physician, Dr. Dworsky. (RX5). Indeed, Dr. Dworsky even agreed that Petitioner is in need of additional treatment relative to his DJD, and in fact does not seem to dispute the need for the total knee replacement ("TKR") recommended by Dr. Jones. Thus, the issue in dispute is simply whether Petitioner's current condition of ill-being relative to his right knee, including the need for a TKR, is causally related to the accident in question, or whether it is more reasonably related to Petitioner's underlying degenerative condition. More to the point, the issue is whether Petitioner sustained his burden of proving the former by a preponderance of the evidence.

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill. 2d 193, 204-206, 797 N.E.2d 665, 672, 278 Ill.Dec. 70, (2003); citing *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); *Azzarelli Construction Co. v. Industrial Comm'n*, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); *Fitrro v. Industrial Comm'n*, 377 Ill. 532, 537, 37 N.E.2d 161 (1941). 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. *Sisbro, Inc.*, 797 N.E.2d at 673; citing *Rock Road Construction Co. v. Industrial Comm'n*, 37 Ill. 2d 123, 127, 227 N.E.2d 65 (1967). Whether a claimant's disability is attributable solely to a degenerative process of the preexisting condition or to an aggravation or acceleration of a preexisting condition because of an accident is a factual determination to be decided by the Industrial Commission. *Id.*, at 673; citing *Roberts v. Industrial Commission*, 93 Ill.2d 532, 538 (1983); *Caterpillar Tractor Co. v. Industrial Commission*, 92 Ill. 2d at 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99.

In the present case, the Arbitrator is not convinced that Petitioner sustained his burden of proving that the accident was, at the very least, a causative factor in his current condition of ill-being and concomitant need for a total knee replacement. Along these lines, the record shows that Petitioner had complaints relative to his knees approximately a year before the accident in question, along with complaints involving his neck, low back and right hip, for which he was prescribed Tramadol and cyclobenzaprine. (RX9). However, there is no indication that Petitioner sought further treatment for these complaints, other than to refill his prescriptions, and there is no evidence to suggest that Petitioner lost time from work due to right knee complaints during the period leading up to the accident.

That being said, the medical evidence shows that Petitioner suffers from a severe underlying degenerative joint condition in his right knee, as evidenced by the MRI performed on December 6, 2012 and as noted by Dr. Jones at the time of the arthroscopic procedure he performed on January 24, 2013. (PX1-PX3). At that time Dr. Jones observed "... severe DJD of the medial compartment with eburnated bone on both the tibia and femoral side." (PX3). Both the peer review orthopedic surgeon and Dr. Dworsky, Respondent's §12 examining physician, commented on the significance of this finding, with the latter noting that an eburnated bone "would have taken many years to establish" and that the finding was "very consistent with a severe form of degenerative joint

disease." (RX5). Dr. Jones himself later touched upon the significance of this finding, noting that it "... does not bode well in terms of prognosis, which is poor at this juncture." (PX3).

More importantly, the record contains no medical opinion to the effect that the incident in question aggravated or accelerated the underlying DJD, much less that it was a causative factor in the ensuing need for a TKR. Indeed, treating orthopedic surgeon Dr. Jones offered no opinion whatsoever along these lines. Instead, he simply points out that "[t]he second opinion [doctor] stated that [Petitioner] had preexisting pathology that predisposed him to the need for total knee" and that the matter needs to be "worked out legally." (PX3).

On the other hand, Respondent submitted the opinions of two orthopedic surgeons – one in the form of a peer review report dated May 15, 2013 and the other in the form of Dr. Dworsky's §12 examination report dated June 19, 2013 – both of whom dispute the claim that a causal relationship exists between the accident and the current need for a TKR. (RX4, RX5). These opinions, in conjunction with the aforementioned MRI and operative findings, would seem to speak to the advanced nature of Petitioner's underlying, pre-existing condition, irrespective of the fact that Petitioner was not actively treating or losing time from work prior to the accident. More to the point, absent a medical opinion to the effect that the accident somehow aggravated or accelerated the condition, the Arbitrator is not willing to find causation based on a "chain of events" theory of recovery, particularly where the underlying condition is as severe as it is here.

Accordingly, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove by a preponderance of the credible evidence that his current condition of ill-being with respect to his right knee, and concomitant need for a total knee replacement, is causally related to the accident on October 1, 2012. In support of this finding, the Arbitrator relies on the opinions contained in the peer review report dated May 15, 2013 (RX4) as well as the report of Dr. Dworsky dated June 19, 2003 (RX5), and once again points out that no actual opinion on the question of whether or not the recommended TKR was related to the accident was offered by the treating orthopedic surgeon, Dr. Jones. Furthermore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's condition of ill-being, specifically with respect to the injury necessitating the partial medial meniscectomy, had reached maximum medical improvement as of July 15, 2013 or the date Dr. Dworsky opined that the restrictions set forth in the FCE "... are the result of his ongoing degenerative joint disease and not a direct manifestation of his meniscal tear which I do feel that he has reached his maximal medical improvement for this particular disorder." (RX5).

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 submitted into evidence two (2) outstanding medical bills, along with a breakdown of said bills pursuant to the fee schedule, at PX5. The first bill is from Riverside Medical Center for services rendered on October 4, 2012. This bill shows an amount charged of $390.00, or $147.17 pursuant to the fee schedule. (PX5). The second billing statement is from Orthopedic Associates of Kankakee and shows a balance of $104.00 ($59.85 per the fee schedule) for an office visit on October 3, 2013. (PX5).

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses in the amount of $147.17 pursuant to §8(a) and §8.2 of the Act, or those expenses incurred prior to July 15, 2013, the date Dr. Dworsky opined that Petitioner had reached MMI with respect to his torn medial meniscus.

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

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner failed to prove his entitlement to prospective medical care and treatment in the form of a right total knee replacement. As a result, Petitioner's claim for same is hereby denied.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, THE ARBITRATOR FINDS AS FOLLOWS:

Subsequent to the accident, Petitioner initially sought treatment at the Riverside Medical Center emergency room on October 4, 2012. At that time he was diagnosed with a right knee contusion and restricted from work for two days. (PX1).

Petitioner then visited his primary care physician, Dr. Waheed, on October 8, 2012. (PX2). Petitioner was diagnosed with "PAIN IN JOINT LOWER LEG", prescribed medication as needed for 15 days and told to follow up in two weeks. (PX2). There is no indication that Petitioner was taken off work at that time. (PX2). Petitioner subsequently followed up with Dr. Waheed on October 16, 2012, October 19, 2012, November 9, 2012, November 29, 2012, and December 10, 2012. (PX2). Petitioner was diagnosed with "PAIN IN JOINT LOWER LEG" and instructed to "continue with present management" at each of these visits. (PX2). Once again, there is no indication that Petitioner was restricted from work at the time of these visits. (PX2).

Petitioner eventually visited Dr. Jones on December 18, 2012. (PX3). There is no indication in Dr. Jones' records that Petitioner was taken off work at this time. (PX3). In fact, the record contains no documentation along these lines until a "Work Status Report" by Dr. Jones dated January 7, 2013 wherein he prescribed "[n]o work until further notice. Waiting for approval for right knee arthroscopic partial medial meniscectomy." (PX3).

Petitioner eventually underwent the above surgery January 24, 2013. (PX3). Petitioner returned to Dr. Jones for post-surgery follow up on February 7, 2013 at which time he issued another "Work Status Report" restricted the patient from work until further notice. (PX3). The same off work restriction was noted in a "Work Status Report" dated March 11, 2013. (PX3). In the interim, Petitioner began a program of post-surgery physical therapy at ATI. (PX3).

Petitioner subsequently underwent an FCE on April 8, 2013. (PX4). The assessment was determined to be "valid" and placed Petitioner at the Heavy Physical Demand level. (PX4). The FCE also noted that Petitioner's job as a maintenance worker was listed as Medium Physical Demand Level as described in the Dictionary of Occupational Titles. (PX4).

Petitioner returned to Dr. Waheed on April 9, 2013 with complaints of pain and instability in the right knee. (PX2). He was instructed to continue with physical therapy and to follow up with Dr. Jones. (PX2).

Petitioner visited Dr. Jones on April 15, 2013 at which time it was noted that "[i]t seems like he is not going to get better and still complains of significant pain particularly when he weight bears." (PX3). At that time Dr. Jones administered an injection and noted that "[i]f he is not significantly better [when he returns in two weeks],

we will initiate a discussion on total knee arthroplasty." (PX3). In a separate "Work Status Report" on that date, Dr. Jones noted that Petitioner was off work until further notice and that the prognosis was "good." (PX3).

In an office note dated April 29, 2013, Dr. Jones indicated that Petitioner had reviewed "... the brochure on total knee arthroplasty, which is the only thing left, but the patient does have significant arthrosis as well. We will try placing him in work hardening and put in for the surgery through Workmens Comp. He understands that they may reject this; however, we will see him back at that point to make additional recommendations..." (PX3). In a separate "Work Status Report" on that date, Dr. Jones once more noted that Petitioner was off work until further notice and that the prognosis was "good." (PX3).

In an office note dated May 8, 2013, Dr. Jones' staff noted that Petitioner's niece "Lindsey" had called stating that Mr. Gaytan was in severe pain with physical therapy and asking if he needs to continue with same. (PX3).

Petitioner returned to Dr. Waheed on May 9, 2013 at which time he noted that physical therapy was worsening his right knee pain and that "[h]e was told that R[ight] TKA is the only option for his R[ight] knee as per Dr. Jones..." (PX2). Later that same day, another message was taken concerning a call from a "family member in Michigan saying [Petitioner] was having a lot more knee pain and did not want to return to work conditioning/work hardening program." (PX3).

In an office note dated May 14, 2013, Dr. Jones' office noted that they had spoken "... with Chad from ATI and he states that the patient refuses to participate in therapy so therefore patient will be discharged from physical therapy." (PX3).

At the request of the Respondent, Petitioner visited Dr. Dworsky who opined that "... currently the patient's disability and restrictions are brought about due to his preexisting degenerative joint disease, as described at the time of his surgery." (RX5). Dr. Dworsky also felt, based on the FCE, that "... the patient is capable of returning to a full duty job. However, I do recommend that he be returned to work with the defined limitations his FCE points out, including occasional squatting, stair climbing, and crouching, and that he should not perform any crawling or kneeling activities. I do feel the patient should be given a trial of this, and based on his ability to progress, possibly have limitations removed after reassessment." (RX5). Dr. Dworsky went on to state that he felt "... the patient has maximized his recovery from a meniscectomy..." (RX5).

In an addendum dated July 15, 2013, Dr. Dworsky opined that the restrictions set forth in the FCE "... are the result of his ongoing degenerative joint disease and not a direct manifestation of his meniscal tear which I do feel that he has reached his maximal medical improvement for this particular disorder." (RX5).

In an office note dated October 3, 2013, Dr. Jones noted that "[t]he second opinion stated that [Petitioner] had preexisting pathology that predisposed him to the need for total knee and as such this still needs to be worked out legally. The patient does have personal insurance and has to decide whether he would like to go ahead with the total knee arthroplasty based on that insurance or if he wants to work through the Workmen Comp process, which is what I think he wants to do. As such, we will be available for any correspondence with his attorney, but we will see him back on an as needed basis for this and as far as I am concerned at this juncture the patient can return to work." (PX3).

Petitioner testified that he has not attempted to return to work since.

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination as to causation (issue "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from October 5, 2012 through October 6, 2012, based on the Riverside Medical Center October 4, 2012 order to remain off work for 2 days, and from January 7, 2012, the date Dr. Jones took Mr. Gaytan off work completely, through June 19, 2013, the date Dr. Dworsky opined that Mr. Gaytan had reached MMI with respect to the meniscectomy, for a period of 23-5/7 weeks. The Arbitrator notes that Petitioner offered no testimonial or documentary evidence to show that he was restricted from work, or even that he did not work, during the period leading up to the date that Dr. Jones ultimately took him off work on January 7, 2013.

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

The Arbitrator finds that Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious under the circumstances. More to the point, a legitimate question existed as to the need for the recommended total knee replacement and its relation to the accident. As a result, the Arbitrator finds that Petitioner's claim for additional compensation pursuant to §19(k) and §19(l) and/or attorneys' fees pursuant to §16 of the Act is hereby denied.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF PEORIA	)	☐ 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

Loren VanScyoc,

Petitioner,

vs. NO: 13 WC 17234

15IWCC0144

Morton Buildings,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, prospective medical expenses, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 1, 2014, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $7,800.00. 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: FEB 20 2015
TJT:yl
o 1/26/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

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

VanSCYOC, LOREN
Employee/Petitioner

Case# **13WC017234**

MORTON BUILDINGS
Employer/Respondent

15IWCC0144

On 7/1/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

4707 LAW OFFICE OF CHRIS DOSCOTCH LLC
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

1337 KNELL LAW LLC
CHARLES D KNELL
504 FAYETTE ST
PEORIA, IL 61603

15IWCC0144

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

- [ ] 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)

Loren VanScyoc
Employee/Petitioner

Case # **13** WC **17234**

v.

Morton Buildings
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 **Peoria**, on **May 19, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

K. ☒ Is Petitioner entitled to any prospective medical care?

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other

FINDINGS

On the date of accident, **January 22, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**34,695.96**; the average weekly wage was $**667.23**.

On the date of accident, Petitioner was **58** years of age, *married* with **0** dependent children.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $7,706.00, pursuant to the medical fee schedule, as provide in section 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary medical expenses associated with the arthroscopic left knee surgery prescribed by Dr. Below, pursuant to the medical fee schedule s provided in section 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for 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

June 27, 2014
Date

JUL 1 - 2014

15IWCC0144

FACTS:

On January 22, 2013, the Petitioner was employed by the Respondent, working on its shipping dock. The Petitioner testified that he had been so employed for 18 years and that his job consisted mostly of "pulling steel". The Petitioner explained that his job involved unloading sheets of steel measuring 2 feet wide by 25 feet long from a truck, one at a time, onto a pallet so that they could be moved. The Petitioner testified that when he was unloaded the steel, pulling it from his left side, across his body to his right side, he was required to twist and turn his body, his hips, and his legs. The Petitioner testified unloading the steel was a two man job and that he almost always worked with the same partner.

The Petitioner testified that on January 22, 20133, he was required to work with another employee of the Respondent who was not familiar with the job of pulling steel. The Petitioner testified that this caused the job to be more difficult than normal because the normal rhythm and pace of the movement required to do the job was not as smooth as usual. The Petitioner testified that while he was pulling steel on January 22, 2013, he began to notice soreness in his left knee. The Petitioner testified that he had no soreness or problem with his knee prior to January 22, 2013 and that he reported his onset of soreness to his supervisor that same day. The Petitioner testified that a written accident report was completed a couple days later.

The Petitioner testified that he continued to work his regular job with the Respondent but the soreness in his left knee continued to worsen and he developed swelling and stiffness in the knee. The Petitioner testified that he was also treating for prostate cancer at this time so he wasn't so concerned about his knee.

On February 22, 2013 the Petitioner sought medical treatment for his left knee with his regular physician, Dr. Henry Gross. The Petitioner testified that Dr. Gross was on vacation that day so he was seen by a physician's assistant, Cheryl Leneve. The note of that visit indicates that the Petitioner reported a one month history of left knee pain that "started when he twisted his knee at work on 1/22/13." The Petitioner also reported "no known injury other than he may have twisted his knee." The Petitioner denied any other injury and reported no prior history of knee problems in the past. There was noted to be tenderness with palpation to the medial aspect of the left knee but no obvious redness or swelling and full range of motion. The diagnosis was left knee pain.

On March 15, 2013 the Petitioner followed up with Dr. Gross. The Petitioner reported that he started having left knee pain at work on January 22, 2013 and it was noted that the Petitioner's left knee was puffy and there was swelling in the back of the knee. Dr. Gross' assessment included "Left knee pain", "Work related injury", and "Effusion of left knee joint", and Dr. Gross prescribed an MRI.

An MRI of the Petitioner's left knee was performed on March 16, 2013 and was reported to demonstrate a marked medial meniscus tear, a strained medial collateral ligament, osteoarthritis, and "Probable posttraumatic cartilage and bone marrow injury to the

15IWCC0144

medial patella."

On April 1, 2013, the Petitioner was seen by Dr. Steven Below, on referral from Dr. Gross. Dr. Below noted that the Petitioner reported that he started to have some pain in his left knee on January 22, 2013 and that he currently continued to have pain, catching, some swelling and tenderness mainly over the medial joint line and some over the anterior aspect of the knee. Dr. Below noted that the Petitioner's MRI showed a medial meniscus tear involving the anterior horn, posterior horn, and body, a strain of the MCL, some degenerative changes in the medial and anterior aspects of the knee in the medial and patellofemoral compartments, and some chondromalacia and degenerative changes in the medial patella. Dr. Below's assessment was left knee medial meniscus tear and some minimal tricompartmental degenerative changes mainly involving the medial and patellofemoral compartments. Dr. Below prescribed physical therapy and he injected the Petitioner's knee with Cortisone.

The Petitioner returned to Dr. Below on April 29, 2013 and the doctor's assessment was left knee symptomatic medial meniscus tear with chondromalacia of the patella and medial compartment and inflamed plica. Dr. Below prescribed an arthroscopic partial medial meniscectomy, chondroplasty, and plica excision.

On August 13, 2013, the Petitioner was examined by Dr. Richard Lehman at the request of the Respondent. Dr. Lehman diagnosed the Petitioner as having degenerative arthritis in his left knee and degenerative maceration of the medial meniscus. Dr. Lehman opined that the findings noted in the Petitioner's MRI predated January 22, 2013 and that the condition of ill-being in the Petitioner's left knee was not related to the Petitioner's work. Dr. Lehman noted that there was no specific trauma to the Petitioner's knee, that the tear noted on the MRI was consistent with the degenerative arthritis in the Petitioner's knee and that the Petitioner had a varus knee. Dr. Lehman opined that the Petitioner was in need of a partial knee replacement but not as a result of his work activities.

On September 20, 2013, the Petitioner was examined by Dr. Joseph Newcomer at the request of the Petitioner's attorney. Dr. Newcomer noted that the Petitioner described an injury to his left knee in January of 2013 and he diagnosed the Petitioner as having a medial meniscus tear. Dr. Newcomer noted that the Petitioner demonstrated the movement required when he was "pulling steel" for the Respondent and that he noticed achiness and pain when he pivoted on his left knee while pulling steel. Dr. Newcomer opined that it was possible that the twisting required to pull steel caused the Petitioner's meniscal tear based upon that mechanism alone. Dr. Newcomer opined that based upon the timing of the onset of the Petitioner's left knee pain and the specific mechanism that would have loaded the medial side of the Petitioner's left knee, the Petitioner's left knee condition was more likely than not caused by the event described by the Petitioner.

The Petitioner has continued to work since January 22, 2013 and is not currently under any work restrictions. The Petitioner testified that he continues to experience pain in his left knee, along with swelling and stiffness, and he wants to undergo the arthroscopic surgery

prescribed for him by Dr. Below.

On cross examination, the Petitioner acknowledged that he did not experience any specific trauma to his left knee on January 22, 2013 nor did he experience a specific "pop" in his left knee. The Petitioner also acknowledged that he has missed no time from work as a result of the condition of his left knee.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

While as a general rule, the mere onset of symptoms while working is not, in itself, sufficient to constitute an "accident" as contemplated by the Act, in the instant matter the Petitioner testified to an onset of symptoms while performing a specific task which required a specific movement of his body. Dr. Newcomer testified that the movement demonstrated to him by the Petitioner loaded the medial side of the Petitioner's left knee and was a competent cause of a meniscal tear.

The Petitioner consistently testified to an onset of pain while pulling steel on January 22, 2013. It is not disputed that the Petitioner reported that onset of pain to his supervisor the same day and that a written accident report was prepared thereafter. The Petitioner then sought medical treatment for his knee and provided a consistent history of injury to all of his medical providers. [The Arbitrator notes that it appears from the medical records that the Petitioner may have been required to seek medical care in order to get a release to return to work following the reporting of his injury.]

While the Petitioner did not report a specific trauma or a "pop" in his knee, he consistently testified, and the medical records demonstrate, that he had no left knee symptoms, problems, or complaints prior to pulling steel on January 22, 2013. The Petitioner's onset of left knee pain occurred at a specific time and place while the Petitioner was performing a specific activity which required him to twist his body and knees and which was required as a regular duty of his employment.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that on January 22, 2013 the Petitioner sustained an accidental injury that arose out of and in the course of his employment with the Respondent.

15IWCC0144

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, and (K.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

The Petitioner consistently testified to an onset of pain while pulling steel on January 22, 2013. It is not disputed that the Petitioner reported that onset of pain to his supervisor the same day and that a written accident report was prepared thereafter. The Petitioner then sought medical treatment for his knee and provided a consistent history of injury to all of his medical providers. The Petitioner testified, and the medical records demonstrate, he had no left knee symptoms, problems, or complaints prior to pulling steel on January 22, 2013. Dr. Gross, the Petitioner's treating physician assessed the Petitioner as having a "Work related injury", and an MRI of the Petitioner's left knee demonstrated a medial meniscus tear. Dr. Below, the Petitioner's treating surgeon, prescribed an arthroscopic partial medial meniscectomy, chondroplasty, and plica excision for the Petitioner.

Dr. Newcomer, the Petitioner's examining physician, observed the Petitioner demonstrate the movement required when he was "pulling steel" for the Respondent and opined that it was possible that the twisting required to pull steel caused the Petitioner's meniscal tear based upon that mechanism alone. Dr. Newcomer opined that based upon the timing of the onset of the Petitioner's left knee pain and the specific mechanism that would have loaded the medial side of the Petitioner's left knee, the Petitioner's left knee condition was more likely than not caused by the event described by the Petitioner.

Dr. Lehman, the Respondent's examining physician, diagnosed the Petitioner as having degenerative arthritis in his left knee and degenerative maceration of the medial meniscus. Dr. Lehman opined that the findings noted in the Petitioner's MRI predated January 22, 2013 and that the condition of ill-being in the Petitioner's left knee was not related to the Petitioner's work. Dr. Lehman noted that there was no specific trauma to the Petitioner's knee, that the tear noted on the MRI was consistent with the degenerative arthritis in the Petitioner's knee and that the Petitioner had a varus knee. Dr. Lehman opined that an arthroscopic repair of the Petitioner's meniscus would be of limited benefit and that the Petitioner was in need of a partial knee replacement, but not as a result of his work activities.

While the Arbitrator notes the opinions of Dr. Lehman, the Arbitrator finds that the opinions of Dr. Newcomer, together with the credible testimony of the Petitioner and the medical records of Dr. Gross and Dr. Below, are sufficiently credible, reliable and persuasive so as to satisfy the Petitioner's burden of proof.

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 injury of January 22, 2013.The Arbitrator further finds that the arthroscopic surgery prescribed for the Petitioner by Dr. Below is reasonable and necessary medical care which is causally related to the injury of January 22, 2013.

15IWCC0144

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:

The Petitioner introduced evidence of medical expenses totaling $7,254.00. The Respondent objected to liability for those expenses based upon the dispute as to the issues of accident and causation. Having found that the Petitioner sustained an accidental injury that arose out of and in the course of his employment with the Respondent on January 22, 2013 and that the Petitioner's current condition of ill-being is causally related to the injury of January 22, 2013, the Arbitrator finds that the medical expenses incurred by the Petitioner were reasonable, necessary and causally related to the injury, and the Respondent is liable for those expenses, subject to the limitations of the Medical Fee Schedule provided for in the Act.

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILLIAMSON	)	☐ 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

David Overturf,

Petitioner,

vs. NO: 12 WC 7329

15IWCC0145

Wal-Mart,

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, prospective 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 May 15, 2014, is hereby affirmed and adopted.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 20 2015
TJT:yl
o 1/26/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

OVERTURF, DAVID
Employee/Petitioner

Case# **12WC007329**

WAL-MART
Employer/Respondent

15IWCC0145

On 5/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

LAW OFFICE OF FOLEY & DENNY
TIM DENNY
PO BOX 685
ANNA, IL 62906

2593 GANAN & SHAPIRO PC
IAN M WHITE
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Overturf
Employee/Petitioner

v.

Wal-Mart
Employer/Respondent

Case # **12** WC **007329**

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 **Belleville**, on **March 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. [ ] What was the date of the accident?

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

K. [ ] 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, **01/25/2012**, 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 $**21,109.86**; the average weekly wage was $**405.96**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**3186.00** 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 $**unknown** under Section 8(j) of the Act.

ORDER

Respondent shall pay petitioner temporary total disability benefits of $319.00 per week for a period of 112 2/7 weeks from January 26, 2012 through March 21, 2014, and continuing until the petitioner reaches maximum medical improvement as the petitioner's current condition of ill-being is causally related to the work accident.

Respondent shall pay causally related medical bills to the petitioner contained in Petitioner's exhibit 10 pursuant to sections 8(a) and 8.2 of the Act as the treatment rendered to the petitioner has been reasonable and necessary and causally related to the work accident.

Respondent shall receive credit for $3,186.00 in temporary total disability benefits paid and for any amounts paid pursuant to section 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

5/12/14
Date

ICArbDec19(b)

MAY 15 2014

Findings of Fact:

The Petitioner, David Overturf is married and has two children of the ages of 9 and 7. He was employed at the Marion Wal-Mart Tire and Lube Express as a technician, but was let go after he hurt his back because he has not returned work in more than a year. He worked for the Wal-Mart Tire and Lube Express for approximately 4 ½ years through January of 2012. His day to day responsibilities consisted of oil changes on vehicles, changing batteries, and changing headlights. He also performed tire changes on all vehicles. He was also responsible for cleaning up the shop, all of the machines, the oil pit as well as other general duties. The Petitioner had prior back problems in 2007 but never missed a day of work due to neck or back pain in 4 ½ years.

On January 25, 2012, he was doing a tire job and lifted a tire with the rim up and he had a popping, snapping sensation from his neck down to the middle of his back when he went to put the tire on the balancer. He reported the injury to Keith who was a supervisor at the Tire and Lube Express the following morning at approximately 9:00 a.m. The Petitioner confirmed that Respondent's Exhibit 2 contained his signature and is the accident report he completed on January 26, 2012.

The Petitioner went to the Carbondale Memorial Hospital and they recommended he follow-up with his primary care physician. He then went to Dr. Parks at Logan Primary Care who performed some tests including MRIs of his neck and low back. Dr. Parks referred him to Dr. Fonn who performed shots in his neck. After the injections Dr. Fonn performed a neck surgery on September 16, 2013 which was a two level fusion at C5-6 and C6-7. The Arbitrator observed the scar on the front of the Petitioner's neck. Dr. Fonn has him on restrictions not to work until there is further evaluation.

The Petitioner has not missed any work in the prior four years due to neck or back injuries while he was working for Wal-Mart.

The Petitioner was cross-examined regarding his chiropractic care for his back in 2007. Petitioner was advised by his physician that everything was fine at that time. The Petitioner testified that he noted

pain in his neck that day when he lifted the tire up off of the rack but he felt most of the pain was in the middle of his back. He reiterated that the pain began on January 25, 2012 and it stayed there until he received treatment at Carbondale Memorial Hospital. The Petitioner confirmed that he signed the original Application for Adjustment which was prepared by a prior attorney indicating he injured his lumbar spine which was hurting at the time. During cross-examination the Petitioner repeatedly pointed to the upper thoracic and the lower cervical area in demonstrating where his pain was.

The Petitioner reiterated on redirect examination that the MRI taken on March 4, 2012 was because he had advised his treating physicians that he was having cervical pain.

The Petitioner offered medical records from the Memorial Hospital of Carbondale into evidence as Petitioner's Exhibit 1. The Petitioner reported to the Hospital on January 26, 2012 reporting he lifted heavy tires at work yesterday causing pain.

Medical records from Dr. Parks at Logan Primary Care were admitted into evidence as Petitioner's Exhibit 3. The Petitioner presented to Logan Primary Care on January 27, 2012 reporting he had severe pain in the middle of work while he was putting two tires in the back of a truck. Petitioner was re-examined at Logan Primary Care on January 30, 2012 reporting onset of symptoms on January 25, 2012. The Petitioner reported the right arm and leg were going numb, which was worse after lying around and the pain medications were keeping the pain improved. (PE 3, p.10).

MRIs of the lumbar and thoracic spine were obtained from Herrin Hosiptal on February 6, 2012. (PE 2). On February 15, 2012 the Petitioner reported pain in the center of his back traveling down and his shoulders hurt if moving. Records from March 2, 2012 indicate the Petitioner is still suffering with pain and is taking physical therapy with pain radiating into the neck. A cervical MRI was obtained from the Herrin Hospital on March 4, 2012. (PE 2, p.7).

The records from Logan Primary Care confirm that the Petitioner was referred by Dr. Parks to Dr. Fonn. Medical records from Dr. Fonn were admitted into evidence as Petitioner's Exhibit 7. The

patient's intake form from Dr. Fonn's office was admitted into evidence as Respondent's Exhibit 9. The Patient intake form indicates the Petitioner hurt his neck and back at work on January 25, 2012. He specified that he hurt his neck and back doing a tire job. Petitioner reported to Dr. Fonn a lot of grinding in his neck and the pain in the thoracic spine was most notable between the shoulder blades. After review of the MRIs Dr. Fonn noted the Petitioner presented with signs of cervical radiculopathy and recommended three cervical epidural steroid injections at the C5-6 level. The Petitioner returned to Dr. Fonn on July 10, 2013 reporting minimal relief of symptomology. Dr. Fonn recommended a new MRI of the cervical spine and was particularly concerned with multiple levels from C4-5 through C6-7. On July 31, 2013 Dr. Fonn reviewed the MRI of the cervical spine which showed disc osteophyte complex at C4-5, C5-6 and C6-7 with mild central canal stenosis which was most pronounced at the C5-6 and C6-7 levels. Dr. Fonn recommended anterior cervical discectomy with fusion at C5-6 and C6-7 pending the results of a CT Myleogram. On September 5, 2013, Dr. Fonn examined the Petitioner and reviewed the studies noting that the primary surgical pathology had been identified at the C5-6 and C6-7 levels. The anterior cervical discectomy and fusion was scheduled. That surgery was performed at the St. Francis Medical Center on September 16, 2013. On October 16, 2013, the Petitioner was examined by Dr. Fonn who advanced him to 20 pound weight limit with no excessive bending or stooping and recommended follow up in ten weeks for a CT scan of the surgical site.

The evidence deposition of Dr. Sonjay Fonn was admitted into evidence as Petitioner's exhibit 9. Dr. Fonn is licensed to perform neurosurgery in the State of Missouri. (PE 9, p.4). Eighty to ninety percent of his practice is dedicated to the surgical treatment of the spine. Dr. Fonn first examined the Petitioner on December 27, 2012 and was provided a history that Mr. Overturf had cervical, thoracic and lumbar pain which developed after an injury at work on January 25, 2012. (PE 9, p.6). Specifically, he was working in his capacity of a lube express technician and was changing a tire on a car. (PE 9, p.6). At that time of his initial examination the chief complaint was neck, upper and low back pain. (PE 9,

p.6-7). At the time of the initial evaluation the patient had pain in all three areas of the spine but the cervical spine appeared to bother him most. (PE 9, p.9).

Dr. Fonn indicated his treatment plan was to be as conservative as possible which included a course of injections. (PE 9, p. 9-10). After the initial injection the patient returned on January 13, 2013 reporting excellent relief and indicated he preferred to hold off on any further intervention. (PE 9, p.10). On follow up, his pain has returned and injections were repeated, but none of the conservative modalities were working. (PE, 9. P.10-11). Dr. Fonn noted that it is quite common for injections to provide only temporary relief and also as a diagnostic modality for possible surgical intervention. (PE 9, p.11).

Dr. Fonn recommended that the Petitioner proceed with a CT myleogram which was done on August 21, 2013 which did show a disc osteophyte complex at the C4-5, C5-6 and C6-7 levels of which is was most severe at C5-6 and C6-7 levels. (PE 9, p.12). Dr. Fonn notified that a disc osteophyte complex is usually a combination of a hard disc which is an osteophyte or calciophyte part of the ligament and a fresh, soft protrusion from the disc itself. (PE 9, p.12).

During surgery Dr. Fonn observed a disc herniation at both the C5-6 and C6-7 levels which were completely removed. (PE 9, p. 13). Dr. Fonn indicated that the Petitioner remains under care with plans for trigger point injections and physical therapy followed by a functional capacity evaluation to determine a final release. (PE 9, p.14). Dr. Fonn confirmed the Petitioner was temporarily totally disabled since his initial exam on December 27, 2013. (PE 9, p.16).

Dr. Fonn testified that based upon a reasonable degree of medical certainty the mechanism of injury, physical exam and history as well as the finding of review on the MRI and interoperatively the work accident the patient described to him as occurring on January 25, 2012 was indeed the cause of the diagnosis that he had for the patient and the need for subsequent treatment. (PE 9, p.17).

Dr. Fonn was questioned repeatedly regarding the certified medical board records from Ohio. Dr. Fonn testified that as part of a consent to reprimand he was required to sign off on a document that stated

certain alleged items. (PE 9, p.27). A consent agreement regarding a reprimand by a government body is inadmissible for impeach purposes as a prior bad act. There is no indication of any crime of dishonestly or felony committed on behalf of Dr. Fonn. Furthermore, the Workers' Compensation Commission has found Dr. Fonn to be more credible than other orthopedic spine surgeons. See *Thomas Wright v. Village of Cambria*, 8 W.C. 39769/10 IWCC 0893.

With regards to repeated cross-examination about the Petitioner's mid back or thoracic pain, Dr. Fonn stated that it is well known fact that the C6-7 level radiates to the mid scapular region which is actually sometimes described as the mid thoracic spine. (PE 9, p.59-60). Dr. Fonn clarified that if a patient had a problem at the C6-7 level which he did, that should radiate to the mid scapular region which is the general mid thoracic region.

Respondent's Exhibit 2 is the Associate Incident Log Form which was signed by the Petitioner on January 26, 2012. It confirms the Petitioner hurt his back while doing a four tire job lifting tires with his back. Respondent's Exhibit 3 is the Associate Statement for Workers' Compensation which was completed by the Petitioner on February 15, 2012. This forms shows the Petitioner reported that he injured his back on January 25, 2012 while lifting tires on a tire job on a vehicle. Respondent's Exhibit 6 are medical records from Carbondale Memorial Hospital dated January 26, 2012 that show the Petitioner reported pain in the thoracic and lumbar spine as a result of lifting heavy tires at work. Respondent' Exhibit 7 is records from Logan Primary Care from January 27, 2012 through February 24, 2012. Most notably on February 24, 2012 the physician noted the patient is having neck pain and feeling spasms in his neck.

Respondent's Exhibit 8 is records from HR Physical Therapy which report a consistent mechanism of injury as reported by the Petitioner on multiple occasions. The initial treatment provided indicated treatment to both the lumbar and cervical spine.

Medical records from Carterville Family Practice were offered into evidence as Respondent's Exhibit 10. Records illustrate the Petitioner received treatment for his lumbar spine in 2007 consistent with this testimony regarding his prior back complaints.

Evidence depositions of Richard Lehman, M.D., were offered into evidence as Respondent's Exhibits 4 and 5. Dr. Lehman examined the Petitioner initially on July 19, 2012 and confirmed the Petitioner reported neck pain at that time. (RE 5, p.7). Dr. Lehman indicated the majority of his complaints were primarily in the low back and legs with very few complaints relating to the cervical spine, just noting the Petitioner said his neck hurt. Dr. Lehman did not believe the need for the cervical fusion was related to the January 25, 2012 accident. (RE 5, p.12). However, Dr. Lehman contradicted himself by stating the basis of his opinion that the patient had no cervical spine symptoms. (RE 5, p.12).

Dr. Lehman confirmed he felt the Petitioner suffered an injury to his lower spine on January 25, 2012. (RE 5, p.23). Dr. Lehman confirmed that a problem at C5-6 may manifest itself by pain radiating down the arm. (RE 5, p.26). Dr. Lehman confirmed there was an acute disc which one would expect to present with radicular pain in the arm along the C5-6 nerve root. (RE 5, p.27). Dr. Lehman agreed that the fact an MRI was obtained on March 4th indicates the treating physicians were at least concerned about their being pathology in the cervical spine. (RE 5, p.28). Dr. Lehman is an orthopedic surgeon with no specialty certification in spine surgery and he has not performed a spine surgery in 15-20 years. (RE 5, p.28).

Dr. Lehman also testified that in his practice if a patient fails conservative treatment he refers them to a spine surgeon and he would defer to the spine surgeon regarding a recommendation for surgery. (RE 5, p.39).

The Arbitrator Hereby Makes the Following Conclusions:

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

The Petitioner's testimony regarding the accident which occurred while he was lifting tires at work on January 25, 2012 is consistent with all of the evidence presented at trial. The Petitioner reported the accident to him employer in writing the day after the accident. Respondent's Section 12 Examiner also confirmed that he believed the Petitioner suffered an accident on January 25, 2012 while in the employment of the Respondent. No contradictory evidence regarding the Petitioner's account of the accident was offered. Therefore, the Arbitrator concludes the Petitioner did suffer an accident which arose out of and in the course of his employment with the Respondent.

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

Petitioner testified he reported the accident to his supervisor on January 26, 2012 within 48 hours of the accident. The associate incident log offered into evidence as Respondent's Exhibit 12 confirms the Petitioner reported the accident to his supervisor as it was signed by the supervisor within two (2) days of the accident. Therefore, the Arbitrator concludes the Petitioner did provide notice to the Respondent pursuant to the requirements of the Act.

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

The Respondent's own Section 12 Examiner, Dr. Lehman confirmed he believed the Petitioner suffered an injury to him lumbar spine at the time of the accident. There does not appear to be a dispute regarding whether the Petitioner injured his lumbar spine at the time of his work accident. Therefore, the Arbitrator concludes the Petitioner's lumbar spine condition is causally related to the injury.

The Respondent's primary contention was that the Petitioner's cervical spine condition was not causally related to the work accident. The Petitioner testified and was cross-examined intensely regarding the location of his pain. The Petitioner repeatedly gestured that his pains were in the upper

thoracic and lower cervical area. Medical records from Logan Primary Care indicate that the Petitioner was reporting numbness in the right arm within days of the accident. Dr. Lehman confirmed this is indicative of a potential problem in the cervical spine. A cervical MRI was obtained less than 6 weeks after the accident. Dr. Fonn specifically testified that pathology in the cervical spine at the C6-7 level radiates to the mid scapular area. This analysis is consistent with the complaints reported by the Petitioner throughout his medical treatment and at Arbitration. The Arbitrator finds Dr. Fonn to be more authoritative on the issues of the spine that Dr. Lehman who has not performed a spine surgery in 15-20 years and acknowledged he would defer to a spine surgeon for such decisions with his own patients. Dr. Fonn has been found to be credible by the Workers' Compensation Commission over other Board Certified Spine Surgeons. See *Thomas Wright v. Village of Cambria*, 8 W.C. 39769/10 IWCC 0893. Therefore, the Arbitrator concludes the current condition of ill-being is related to the injury.

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

In addition to the Arbitrator's findings with regards to causation above the Arbitrator notes that Dr. Lehman has not performed a spine surgery in 15-20 years, and would defer to a spine surgeon for treatment of his own patients. Dr. Fonn is a licensed neurosurgeon who focuses on a surgical treatment of the spine and is more authoritative regarding the reasonableness and necessity of treatment and surgical intervention for the spine. Respondent has not paid all appropriate charges, the Respondent is ordered to pay to the Petitioner the medical bills outlined in Petitioner's Exhibit 10 in accordance with Section 8(a) and 8.2 of the Act. Therefore, the Arbitrator concludes the treatment rendered to the Petitioner to date has been reasonable and necessary.

L. What temporary total benefits are in dispute?

Respondent did not dispute the Petitioner's period of temporary total disability only liability as it pertains to its causation dispute. Based upon the Arbitrator's finding above the Arbitrator finds the

Petitioner is entitled to TTD benefits from January 26, 2012 to the present and continuing until such time as the Petitioner reaches maximum medical improvement.

N. Is Respondent due any credit?

The parties stipulated the Respondent is due a credit of $3,186.00 for TTD benefits paid. The Respondent is also entitled to a credit for any bills it has paid through its workers' compensation or group health insurance pursuant to Section 8(j).

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF LA SALLE	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Delancey,

Petitioner,

vs.

NO: 08 WC 33602
10 WC 06806
10 WC 06807

Streator Tire & Repair Inc./Injured Workers' Benefit Fund by Illinois State Treasurer as Ex Officio Custodian,

15IWCC0146

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 4, 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.

15IWCC0146

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

DATED: FEB 2 0 2015
TJT:yl
o 1/26/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DELANCEY, JOSEPH
Employee/Petitioner

Case# **08WC033602**
10WC006806
10WC006807

STREATOR TIRE & REPAIR INC/INJURED WORKERS' BENEFIT FUND BY ILLINOIS STATE TREASURER AS EX OFFICIO CUSTODIAN
Employer/Respondent

15IWCC0146

On 4/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

1097 SCHWEICKERT & GANASSIN
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

0263 HERBOLSHEIMER LAW OFFICES
WILLIAM P HINTE
654 FIRST ST SUITE 400
LASALLE, IL 61301

5132 ASSISTANT ATTORNEY GENERAL
STACEY R LASKIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

15IWCC0146

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Joseph Delancey
Employee/Petitioner

Case # 08 WC 33602

v.

Consolidated cases: 10 WC 6806
10 WC 6807

Streator Tire & Repair, Inc. / Injured Workers' Benefit Fund by Illinois State Treasurer as ex officio custodian
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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Ottawa**, on **January 31, 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. [x] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [x] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [x] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [x] What was Petitioner's age at the time of the accident?
I. [x] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **December 21, 2006, February 10, 2007,** and **April 9, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

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

Timely notice of these accidents ***was not*** given to Respondent.

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

As stipulated by Petitioner and Respondent, for the portion of the year worked preceding the injuries, Petitioner earned $**20,800.00**; the average weekly wage was $**400.00**. *See* AX1-AX3.

On the dates of accident, Petitioner was **44** 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.

Respondent shall be given a credit of $**43,195.79** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**43,195.79**.

Respondent is entitled to a credit of $**5,744.35** under Section 8(j) of the Act.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner failed to establish that he sustained a compensable accident at work on any of the claimed dates of injury. Thus, Petitioner's claim for all compensation and benefits is denied. Respondent shall be given a credit of $43,195.79 for TTD paid and a credit of $5,744.35 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.

Signature of Arbitrator

March 26, 2014
Date

APR 4- 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Joseph Delancey
Employee/Petitioner

Case # **08** WC **33602**

v.

Consolidated cases: **10** WC **6806**
10 WC **6807**

Streator Tire & Repair, Inc. / Injured Workers' Benefit Fund by Illinois State Treasurer as ex officio custodian
Employer/Respondent

FINDINGS OF FACT

Petitioner claims that he was originally injured while working for Respondent on December 21, 2006. Arbitrator's Exhibit[1] ("AX") 2. Respondent disputes Petitioner's claims regarding accident, notice, causal connection, medical bills, temporary total disability, the nature and extent of Petitioner's injury, and penalties pursuant to Sections 16, 19(k), 19(l). AX2. Petitioner claims that he was again injured at work on February 10, 2007. AX1. Respondent disputes Petitioner's claims regarding accident, notice, causal connection, medical bills, temporary total disability, the nature and extent of Petitioner's injury, and penalties pursuant to Sections 16, 19(k), 19(l). *Id.* Petitioner also claims that he was injured a third time on April 9, 2007. AX3. Respondent disputes Petitioner's claims regarding employer-employee relationship, accident, notice, causal connection, medical bills, temporary total disability, the nature and extent of Petitioner's injury, and penalties pursuant to Sections 16, 19(k), 19(l). *Id.* The IWBF disputes all issues with regard to all of Petitioner's claimed injuries. AX1-AX3.

The Arbitrator takes judicial notice of the Commission's own files which reflect that Petitioner filed Case No. 08WC33602 on July 30, 2008 alleging an accident on February 10, 2007 and that he then filed two additional cases on February 23, 2010; Case No. 10WC6806 alleging an accident occurring on December 21, 2006 and Case No. 10WC6807 alleging an accident occurring on April 9, 2007.

Background

Petitioner testified that he resides in Streator, Illinois and that he was previously employed by Respondent, Streator Tire & Repair, which is owned by Cary Bryan ("Mr. Bryan"). Petitioner testified that Mr. Bryan hired by him approximately 1 ½ years before his first claimed accident at work on December 21, 2006 and this claimed date of accident on February 10, 2007. *See* AX2. Petitioner testified that he was a mechanic and performed duties relating to car repairs including work with motors, transmissions, and brakes, etc. Petitioner testified that motors are heavy and when working on them the cars are placed overhead on lifts. He testified that he made $28,800 per year and $400 per week while working for Respondent. Petitioner also submitted a 2006 W-2 form showing yearly earnings of $5,488.50 and a 2007 W-2 form showing yearly earnings of $8419.46. PX10. Petitioner and Respondent stipulated to Petitioner's earnings and average weekly wage at the hearing. AX1-AX3.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party. Joint exhibits are denominated "JX." Exhibits attached to depositions will be further denominated with "(Dep. Exh. _)."

December 21, 2006 15IWCC0146

On December 21, 2006, Petitioner testified that he was re-doing a transmission on a 4-wheel drive truck with another employee, Mark Overocker ("Mr. Overocker"). When he took the transmission out of the truck and placing it down onto a transmission jack, he hurt himself a little bit. Petitioner testified that they put straps around the transmission which was then was lifted into the air and then lowered as much as possible, but that with this vehicle the transmission needed to be lifted off of the jack by hand to be placed into the truck. Petitioner estimated that the transmission weighed 200-300 pounds.

Petitioner testified that when he and Mr. Overocker attempted to move the transmission, his back got very sore and he was in a lot of pain. Petitioner added that he thought he hurt his muscles and that he felt pain and soreness with moments. Petitioner testified that he had no back pain before this occurrence.

Petitioner testified that he reported his pain and discomfort to Mr. Bryan. At the time, Petitioner testified that Mr. Bryan was in his office and that he told Mr. Bryan that he was taking a transmission off of a jack and that he believed he hurt his back.

Petitioner testified that he continued to work for several months and did not see a doctor because he thought he only hurt his muscles at the time.

February 10, 2007 & April 9, 2007

On February 10, 2007, Petitioner testified that he was performing the same type of transmission work on another vehicle along with Mr. Overocker again. He testified that he unbolted the transmission and strapped it to the jack, but realized that he needed help to get it off of the jack, so he got Mr. Overocker and Mr. Bryan to help him. Petitioner testified that while the three of them were lifting the transmission off of the jack, Petitioner felt his back "pop pop pop pop." He testified that he was the shortest of the three men.

Petitioner testified that Mr. Bryan did not do anything at the time, but he told Petitioner to be careful. Mr. Overocker helped Petitioner up. Petitioner testified that his pain and discomfort got worse and he went home for lunch. He testified that he was very sore and hurting bad. He had a previous knee injury, so he wrapped himself in an ace bandage from his chest to his waist. Petitioner testified that he did not go to the hospital or doctor because he wanted to continue working.

Petitioner testified that he also talked to Mr. Bryan and told him what happened. Petitioner testified that Mr. Bryan told him that he had no "workman's comp" so Petitioner did not go to the doctor. Petitioner also testified that he continued to try to work, but one day while working on spark plugs and he told Mr. Bryan he could not work anymore. On cross examination, Petitioner testified that this incident occurred on April 9, 2007.

Medical Treatment

The medical records reflect that on April 9, 2007, Petitioner went to the emergency room at St. Mary's hospital reporting back pain. PX5. A nurse's note reflects that Petitioner was a "44 year old male admitted ER relates Hx that [approximately] month ago, while working at Streator Tire and Repair he [illegible] lifting a transmission. States he 'hurt' his back. Since [increase] soreness thoracic back area. States constant but worse [with] movement. Denies any prior Hx of back problems [illegible] States that pain is now at a 3. Hurts a little less [with] movement." *Id.* An emergency room physician's note reflects that Petitioner was a "44 y.o. [male]

well known to [emergency department] staff. c/o thoracic back pain for past month. Started at work with lifting a transmission. No relief [with] Tylenol & warm packs. Worse [with] movement & deep palpation States unable to do job due to its physical nature." *Id.*

On examination, Petitioner had diffuse tenderness in the mid-thoracic, paraspinal and spinal areas. *Id.* The physician noted "Jumps with the slightest touch. Pt v. dramatic." *Id.* Dr. Zendejas ordered thoracic x-rays which showed degenerative change in the thoracic spine with dextroscoliosis, possible mild anterior wedging (mild compression fracture) of an upper thoracic vertebral body of undetermined age, and was otherwise noted as relatively unremarkable. *Id.* Dr. Zendejas placed Petitioner off work for two days, prescribed Tramadol and Dolobid, and diagnosed him with musculoskeletal back pain. *Id.* Petitioner testified that he was told to follow up with a back doctor. He also testified that he has not been back to work since April 9, 2007.

Dr. DePhillips

Petitioner then went to see Dr. George DePhillips on May 4, 2007. PX8. Petitioner testified that he complained of some neck pain at this time, but that his pain was mostly located in the mid-back and low back. Dr. DePhillips' medical records reflect Petitioner's report that he "was doing well until 5 months ago when he injured his back while lifting a transmission out of a car. He has mid thoracic pain which has progressively worsened. He went to the emergency room one month ago because the pain became unbearable." *Id.* Petitioner also reported pain and numbness in the upper extremities with overhead reaching. *Id.* Dr. DePhillips reviewed Petitioner's thoracic x-ray films which showed scoliosis, degenerative disease, and osteophyte formation. *Id.* He ordered a thoracic and cervical spine MRI and prescribed Vicodin as needed. *Id.* Petitioner was not placed off work.

Petitioner underwent the recommended thoracic MRI on May 11, 2007, which the interpreting radiologist noted showed a right paracentral disc herniation at T8-9 compressing the thecal san, mild degenerative disease throughout, a cavernous hemangioma within the T6 vertebral body, and mild dextroscoliosis. PX8. The cervical MRI showed moderate degenerative disc disease at C5-6 and C6-7 with disc space narrowing, subchondral sclerosis and hypertrophic osteophyte formation, diffuse disc protrusion at C5-6 with flattening of the thecal sac and in close approximation to the cervical cord, moderate diffuse disc bulging at C6-7 with flattening of the thecal sac and in close approximation to the cervical cord, moderate bilateral foraminal narrowing and mild cord contact could not be excluded, and moderate left-sided foraminal narrowing at C3-4 due to diffuse disc bulging in combination with left-sided uncovertebral osteophyte formation. *Id.*

On May 18, 2007, Petitioner reported continued mid-thoracic pain as well as aching and numbness in both upper extremities. PX8. Dr. DePhillips reviewed Petitioner's MRIs and recommended trigger point injections and a thoracic epidural steroid injection. *Id.* He noted that Petitioner was going to try to continue working and noted that, if Petitioner's pain became intolerable, he would place Petitioner on light duty or take him off work. *Id.* Dr. DePhillips refilled Petitioner's medications and added Valium. *Id.*

On May 25, 2007, Dr. DePhillips placed Petitioner off work through October 25, 2007 indicating that this was due to a work injury and until further evaluation. PX8.

On June 22, 2007, Petitioner returned to Dr. DePhillips reporting that his pain did not improve even temporarily with the injections and that he had severe pain in the mid back as well as headaches and neck pain. PX8. Petitioner indicated that he wanted to consider surgery. Dr. DePhillips recommended a thoracic discectomy and/or fusion and referred Petitioner to Northwestern Medical Faculty Foundation for a second opinion. *Id.*

Dr. Koski – Second Opinion

Petitioner saw Dr. Tyler Koski on August 9, 2007. PX8, RX3. At that time, Petitioner reported that he was injured on the job in December 2006 while he was lifting a transmission out of a car. *Id.* "He said he felt acute onset of back pain in his upper thoracic spine, which was initially mildly bothersome, but progressed over the next several days to become significantly debilitating. Since that time, he has had terrible and progressive pain that has been refractory to conservative therapy. His pain is described as mid- to upper thoracic. It is painful at rest and worsened with any movement. He said even light touch is excruciatingly painful for him and he is unable to lift anything of any significant weight, and overall is fairly debilitated by the pain." *Id.* Petitioner also reported wearing a brace over the past several months, using what seemed to Dr. Koski to be a TENS unit which sometimes alleviated pain and sometimes made his pain worse when it contracted his muscles, and taking two tablets of narcotic pain medication every four hours as well as valium and amitryptyline. *Id.*

On examination, Dr. Koski noted that Petitioner had weakness in the middle of his back. *Id.* Petitioner had severe pain with palpation to even the slightest touch over the mid-thoracic spine, but no significant pain in the cervical spine, upper thoracic spine, or lower lumbar spine. *Id.* Petitioner also ambulated with a cane[2] and ambulated with a slightly antalgic and slow gait. *Id.* He was able to walk on his heels and toes, but with assistance for balance. *Id.* Petitioner reported no symptoms radiating into the lower extremities and Dr. Koski noted that Petitioner was pain-limited due to back pain but with reasonable strength. *Id.* Dr. Koski noted no focal deficits, "but the best strength I can get out of him is 4/5 in all motor groups." *Id.* He also noted that Petitioner was able to bend forward and backward which caused some exacerbation of pain, but without any deformities noted. *Id.* Petitioner denied alcohol or illicit drug use. *Id.*

Dr. Koski also reviewed Petitioner's MRIs and x-rays done on the date of this examination. *Id.* He noted that Petitioner's thoracic MRI showed a "very small disc bulge in his thoracic spine" which "in my opinion, does not show any significant findings." *Id.* Dr. Koski also reviewed Petitioner's cervical MRI which in his opinion showed a "congenitally narrow canal with some multilevel degenerative disease with some loss of ventral CSF space but no spinal cord compression or significant foraminal stenosis." *Id.* He noted that the remainder of the cervical MRI was within normal limits and that the radiologist's comment on scoliosis did "not meet the clinical criteria for scoliosis...." *Id.*

Ultimately, Dr. Koski opined that Petitioner's examination "*does not point to spinal pathology for his pain.* He appears more likely to have a myofascial pain syndrome, in my opinion, and *I do not believe he has any structural abnormalities in his thoracic spine or any evidence of instability that would explain his pain and findings*." *Id* (*emphasis* added). Regarding the cervical spine, he opined that while Petitioner did have some degenerative disease, it would not lead him to consider operative intervention. *Id.* Dr. Koski told Petitioner that long-term bracing[3] was not a good idea and recommended that he wean himself off of that. *Id.*

Petitioner testified that Dr. Koski told him that he was too young to have anything done.

Pain Management

Dr. DePhillips' records note various calls requesting narcotic medication refills for various reasons. PX8. On

[2] Petitioner testified that he walks with a cane as prescribed by Dr. DePhillips. *But see* PX8.

[3] Petitioner testified that he wears bracing around the back as prescribed by Dr. DePhillips. *But see* PX8.

September 27, 2007, she requested a refill of Vicodin and some valium because after a party the whole bottle was stolen by a family member, she believed. PX8. Dr. DePhillips refilled three days worth of Vicodin. *Id.* On November 14, 2007, a pharmacy called requesting a refill, but Dr. DePhillips' office denied it because a refill of 150 Vicodin tablets had been filled ten days earlier. *Id.* Five days later, on November 19, 2007, Petitioner's wife indicated that they were going out of town for the holiday and requested a few weeks of Vicodin. *Id.* Dr. DePhillips' office contacted Petitioner and indicated that they would only post-date a refill prescription for when he returned from his trip and noted that they cancelled his called-in prescription since he had 150 tablets refilled on November 4, 2007 which was a violation of his contract with the office. *Id.* On November 27, 2007, Dr. DePhillips' office staff told Petitioner that they would only refill his medication until he went to a pain clinic and that they would no longer refill medications thereafter. *Id.* On January 17, 2008, another doctor's office (Dr. Kloc) called indicating that Petitioner's wife was seeking prescription refills for Petitioner. *Id.* Petitioner's wife was again advised that Petitioner would need to find a pain clinic. *Id.* By February 6, 2008, Petitioner "was advised at this point [Dr. DePhillips] is not recommending surg. for his neck nor thoracic spine benefits do not outweigh the risks. pt. was referred to Dr. Sharma for pain management." *Id.*

In the interim, on December 21, 2007, Petitioner saw Dr. Ronald Kloc as referred by Dr. DePhillips. PX7, PX8, RX4. Petitioner reported thoracic and cervical spine pain at a level of 7.5/10 that ranged from 5/10 up to 10/10. *Id.* After an examination, Dr. Kloc noted that "things in Mr. Delancey's story are suspect[,]" and indicated that he would go ahead with trigger point injections "and check on Mr. Delancey's stories." *Id.*

In a note dictated on January 16, 2008, Dr. Kloc states the following:

> *This 45-year-old male was removed from our pain clinic roster due to a string of falsehoods that he told us while he was here for his first visit.* ... Joseph stated that he was injured at work, however his employer did not carry workmen's compensation insurance, but was willing to pay the full undiscounted medical payments through his own pocket[4]. This in and of itself is very unusual. He stated that there was a signed contract in which his employer stated that he would pay for all of his payments. This is also very unusual. There is no precedent for it, for employers not to sign contracts with employees for medical payments. He states that his bills have been paid. He specifically mentioned a bill over $1800 that he states he say his employer pay to Dr. DePhillips office. We had checked with Dr. DePhillips office. All is payments were closed out as bad debt; there were no payments made. He also stated that he was still working actively with an attorney for his workmen's compensation case. We called him at home later that day to ask him for the name of his attorney. He was evasive, stated that he had many attorneys and which one did we want. We never got the name of any attorney that we could check his case with. On the initial visit he also states that he had a thoracic epidural done at Streator hospital. He described the procedure in a way that is not done by anyone in or outside the pain medicine field. ... Also, Mr. Delancey states that all he wanted me to do was a trigger point injection which struck me as a little unusual. However, I went ahead of this as a procedure during the first visit. His MRI does show a right paracentral disc herniation at T8-T9. *He also arrives wearing an enormous chest corset, the likes of which I have not seen in modern medical practice. It is very bulky and almost comic-looking. Joseph did want us to continue filling his medications, which included Valium #90 in a month, Vicodin Extra Strength #120 in a month, Elavil 100 mg #30 in a month. I have a very strong suspicion that Mr. Delancey is a drug seeker and I am going to*

[4] Respondent did agree to pay some bills in a simple written agreement between the parties. PX9. Respondent also eventually paid some of Petitioner's medical bills, despite the lack of insurance. AX1-AX3.

refer him back to Dr. DePhillips. .... PX7, PX8, RX4 (*emphasis* added).

Petitioner testified that he became dependent on his medications at one point, but that he broke from that dependency and is no longer on pain medications or Vicodin. He added that he had no dependency before his accident at work. Petitioner testified that he followed up with another pain management doctor, Dr. Patel, because Dr. Kloc had concerns about his pain medication seeking behavior.

On February 27, 2008, Petitioner had his initial visit with Dr. Udit Patel. PX6. He reported mid-cervical spine pain and arm pain, numbness and weakness radiating down through the bilateral arms. *Id.* After an examination, Dr. Patel diagnosed Petitioner with cervical radiculopathy, upper back pain, and neck pain. *Id.* On March 24, 2008, Dr. Patel noted that Petitioner was applying for disability benefits. *Id.* On April 10, 2008, Dr. Patel recommended a trial spinal cord stimulator. *Id.* Petitioner testified that he had no way to pay for it.

On July 30, 2008, Petitioner returned to Dr. DePhillips who indicated that Petitioner was to remain off work until further evaluation and to be non-ambulatory to minimal ambulation. PX8.

St. Mary's and St. Joseph's Hospitals

On November 1, 2008, Petitioner went to the emergency room at St. Mary's Hospital and was transferred to Provena St. Joseph's Hospital. PX4. He was admitted with a diagnosis of intractable low back pain with chronic neck and midback pain status post work injury on February 10, 2007. *Id.* Petitioner reported experiencing low back pain, neck, and mid-back pain since an injury at work on February 10, 2007. *Id.* He also reported recently developing "worsening lower back pain when he felt a pop in the lower back." *Id.* Petitioner underwent cervical, thoracic, and lumbar MRI's as ordered by Dr. DePhillips. *Id.*

The cervical MRI showed mild degenerative changes with spondylosis at C5-6 and C6-7 with small posterior osteophytes and prominent endplate degenerative change at C6-7. *Id.* The thoracic MRI showed a very mild amount of scattered degenerative changes to the mid to lower thoracic spine, without any other significant abnormality. *Id.* There were no focal disc herniations or significant spinal stenosis within the thoracic spine. *Id.* The lumbar MRI showed a mild degree of disc dehydration at L4-5 and L5-S1 with tiny focal probable annular tears seen. *Id.* There were no focal disc herniations or protrusions and there was no significant spinal stenosis detected. *Id.*

Before Petitioner was released from the hospital, Dr. DePhillips requested a consultation with Dr. Singla. *Id.* Dr. Singla evaluated Petitioner who reported a neck, thoracic spine, and lumbar spine injury occurring at work approximately 18 months earlier. *Id.* Petitioner reported that he went to St. Mary's for nausea and intractable pain. *Id.* Dr. Singla reviewed Petitioner's "medications that he has been on including Norco alternating with morphine every other month, Valium, Elavil, and Zanaflex. At the present time his pain is comfortable. He is sitting in a chair eating. He reports his pain for most part is approximately 5/10 while resting and does escalate to a 9 out of 10. It does interfere with his ability to work." *Id.* Dr. Singla reviewed Petitioner's MRI's, which showed scattered and degenerative changes in the thoracic spine, spondylosis at C5-C7 with some indentation of the ventral sac with end point degenerative change at C6-7, and mild disc degeneration from L4-S1 with annular tears. *Id.* He diagnosed Petitioner with chronic pain secondary to disc [left blank] and he referred Petitioner back to his pain management doctor recommending consideration of some modification of Petitioner's pain medication regimen. *Id.*

The medical records reflect that Petitioner continued to see Dr. Patel through November 9, 2008 during which

time he adjusted Petitioner's pain medications and noted his conversations with Petitioner and his wife about titrating off of the narcotics. PX6.

On November 14, 2008, Petitioner saw Dr. DePhillips after his admission to St. Joseph's hospital. PX8. Petitioner reported continued neck pain at a level of 7-8/10, bilateral arm pain, numbness and tingling at a level of 4-5/10, mid-back pain at a level of 4-5/10 and low back pain at a level of 9-10/10. *Id.* Dr. DePhillips reviewed Petitioner's cervical MRI, which he found showed spondylosis with degenerative disc disease at C5-6 and C6-7 with osteophytes or bone spurs. *Id.* Dr. DePhillips also indicated that Petitioner's work injury "might or could have aggravated the cervical spondylosis and degenerative disease." *Id.* He also reviewed Petitioner's lumbar MRI which he found showed mild degenerative disc disease at L4-5 and moderate degenerative disc disease at L5-S1 as well as a posterior tear in the annulus at L5-S1. *Id.* Dr. DePhillips ordered a lumbar epidural steroid injection and indicated that Petitioner "remain unemployable and is totally disabled from meaningful employment." *Id.*

Also on November 14, 2008, Petitioner saw Dr. Patel. PX6. He noted that Petitioner underwent a drug screen which was positive for THC. *Id.* Petitioner "said that he would stop immediately[,]" and Dr. Patel indicated that if Petitioner "messes up again, he will be discharged." *Id.* Dr. Patel noted that Petitioner had low back pain that was chronic and that the "event which precipitated this pain was lifting. This occurred at work. This occurred at the same time as the upper neck injury. However, his neck pain was worse, recently over the past few months, he has been complaining of more axial LBP." *Id.*

On November 24, 2008, Dr. DePhillips noted Petitioner's diagnosis of a thoracic disc herniation and prescribed a walker with wheels on front legs only and rubber on back legs. PX8.

Petitioner returned to Dr. Patel on December 21, 2008 and underwent another drug screen. PX6. Before returning to see Dr. Patel, on January 6, 2009 Petitioner went to the emergency room at St. Mary's hospital reporting severe back pain that began yesterday and increased today with no relief from morphine and valium. PX5. Petitioner's wife provided much of the history at this visit indicating that Petitioner had not slept for three days and that he did not take his Norco, Norflex, Valium or morphine because they did not work when his pain was this bad, only IV medications worked. *Id.* Dr. Patras noted on examination that Petitioner was pointing to his L3-L5 region and his wife was indicating pain in the entire back area. *Id.* "Pt refusing to take his back brace off. Pt in w/c able to flex & extend at knees. Pt seen to stand [with] usual assist of wife. pt not relaxing for exam. Unreliable." *Id.* Petitioner was diagnosed with an exacerbation of low back pain and discharged. *Id.*

Dr. Patel discussed the results of the test with Petitioner at a follow up visit on January 26, 2009. PX6. Petitioner "states that he is in a room with other people smoking THC all the time. I told him that it wasn't an excuse and he needs to refrain from any activity with people smoking it around him. He understands and agrees. He was also seen in the ER last since last visit for pain." *Id.* Petitioner continued to see Dr. Patel for pain management through a final visit on February 15, 2010. *Id.*

A few weeks later on March 22, 2009, Mr. Delancy appeared at St. Mary's emergency room and reported falling at home after he tripped over his own dog and reinjuring his back. PX5. The emergency room physician noted "pt dramatic refuses to turn self over to be examined refuses to place gown[.]" *Id.* On examination, Petitioner "won't cooperate" during neurological examination and he was tender " 'all over' no step off [no] sx of trauma" during musculoskeletal testing. *Id.* The emergency room physician, Dr. Patras, consulted with Dr. DePhillips

who indicated he did not "think much new is going on but to give [Petitioner]" an IV drip with Phenergan[5]. *Id.* Petitioner was discharged. *Id.*

Petitioner returned to the emergency room at St. Mary's two days later on March 24, 2009 reporting that he twisted his back and his pain returned. PX5. On examination, Petitioner had "diffuse [low back pain] no deformity no [costovertebral angle tenderness]" and negative straight leg raising and Patrick's sign. *Id.* His neuro examination indicated scattered sensory deficits, no physical pattern, and a positive Hoover's test. *Id.* Petitioner reported pain at a level of 8 out of 10, no nausea and indicated that the Phenergan "this is good for me[.]" *Id.* Petitioner was discharged with a diagnosis of acute exacerbation of chronic low back pain and nausea. *Id.*

Dr. DePhillips saw Petitioner in his office on March 27, 2009 reporting worsening low back pain with pain radiating into both lower extremities. PX8. He reported that his legs gave out causing him to fall[6] which precipitated his visit to the emergency room on March 22, 2009. *Id.* Dr. DePhillips noted that Petitioner's lumbar MRI scan was essentially unchanged from the prior study showing bulging at L5-S1 with a small tear in the posterior annulus. *Id.* He recommended lumbar discography to confirm whether the tear may have extended causing an increase in inflammation and worsening pain, and whether it is related to his injury. *Id.*

On April 21, 2009, Petitioner returned to the emergency room at St. Mary's hospital. PX5. Petitioner reported that he could not get out of bed or stand, but was able to get to a car to come to the hospital, and he denied any specific trauma precipitating the low back pain. *Id.* On examination, Petitioner had diffuse low back pain, no signs of injury, a negative straight leg raise test and Patrick's sign, and a positive Hoover's test. *Id.* Dr. Patras noted that Petitioner had 180 Vicodin tabs filled approximately two weeks earlier and his discussion with Petitioner about "importance to follow up with his physicians + my reluctance to add additional narcotics to multiple drugs he is already taking." *Id.* Petitioner was discharged to follow up with Dr. DePhillips. *Id.*

On June 20, 2009, Petitioner returned to the emergency room reporting back pain and vomiting. PX5. He was discharged the same day. *Id.*

On August 7, 2009, Petitioner was admitted again to St. Mary's emergency room reporting persistent nausea, vomiting and weakness for the last 3-4 days after a fall at home when he heard some noise and slipped on his steps and fell on his back. PX5. Petitioner reported upper back pain followed by nausea and vomiting thereafter. *Id.* Petitioner was treated with IV fluids and medications to address vomiting, dehydration, marked leukocytosis and possibly occult sepsis. *Id.* He was discharged on August 9, 2009 with instructions to follow up with his physicians. *Id.*

On November 19, 2009, Petitioner went to the emergency room reporting vomiting and exacerbation of low back pain. PX5. He was discharged the same day. *Id.*

On December 4, 2009, Petitioner returned to the St. Mary's emergency room reporting vomiting. PX5. However, the emergency room nursing intake note reflects that Petitioner "appears to be resting comfortably at

---

[5] "Promethazine [a.k.a. Phenergan] is used to relieve or prevent the symptoms of hay fever, allergic conjunctivitis (inflammation of the eye), and other types of allergy or allergic reactions. ... Promethazine is also used to prevent and control motion sickness, nausea, vomiting, and dizziness. In addition, it may be used to help people go to sleep and control their pain or anxiety before or after surgery or other procedures ." http://www.mayoclinic.org/drugs-supplements/promethazine-oral-route/description/drg-20070609 (last visited March 25, 2014).

[6] *But see* PX5 (Petitioner reported that he fell at home after he tripped over his own dog).

present./When questioned continued to c/o persistent back and abdomen pain. No vomiting." *Id.* After an examination noting an unrelated polyp, Petitioner was discharged. *Id.* Four days later, on December 8, 2009, Petitioner returned to the emergency room reporting back pain and vomiting. *Id.* Dr. Patras noted that Petitioner's complaints, symptoms, and examination were the same as during his prior visits to the emergency room. *Id.* He told Petitioner and his wife that his back pain needed to be treated by his physician and that the emergency room would treat his other complaints. *Id.* Petitioner was discharged. *Id.*

Petitioner's last medical treatment was on October 4, 2010 when he saw Dr. DePhillips. PX8. Dr. DePhillips diagnosed Petitioner with discogenic pain in the low back and bilateral radiculitis, cervical spondylosis with degenerative disc disease and degenerative disc disease and spondylosis in the thoracic spine, all of which he opined were aggravated, exacerbated or causally related to his injury at work in February 2007. *Id.* Dr. DePhillips also indicated that Petitioner was unemployable and disabled. *Id.*

Dr. Rezin – Section 12 Examination & Testimony

Petitioner submitted to an independent medical evaluation at Respondent's request on May 1, 2012 with Dr. Keith Rezin. RX2. At the time of his examination, Petitioner reported chronic neck, thoracic, and lumbar back pain as well as weakness in his legs since an injury at work in 2007 while working on a transmission. *Id.* Petitioner also reported that he was declared disabled in 2008. *Id.* Petitioner reported that there was a period of time that he could not even walk after his injuries and even used a scooter at one point, and that while his condition has improved somewhat, he still uses a cane or walker and wears two braces. *Id.* On examination, Dr. Rezin noted that Petitioner's "symptoms do seem to be out of proportion to the stimuli that was provoked, especially with fine touch…." *Id.*

After examining Petitioner and reviewing certain medical records, Dr. Rezin rendered various opinions. *Id.* He diagnosed Petitioner with degenerative arthritis of the cervical spine and lumbar spine. *Id.* He indicated that "at the very most, he may have suffered a small herniated disc in the thoracic spine, but I believe that this has resolved, especially due to the fact that the followup MRI showed that the disc had resolved." *Id.* Dr. Rezin opined that undoubtedly the "degenerative changes noted on his numerous studies were preexisting and not the result of the injury that he describes." *Id.* He also opined that Petitioner did not sustain any specific lumbar injury. *Id.* Finally, Dr. Rezin noted various Waddell's signs during his examination of Petitioner and those referenced in the treating medical records that he reviewed. *Id.* At most, Dr. Rezin opined that Petitioner suffered a herniated disc in the thoracic spine that resolved, a cervical sprain that also resolved, and that Petitioner was not prevented from working as a result of such injuries. *Id.*

Dr. Rezin, a board-certified orthopedic surgeon, was called as a witness by Respondent and testified via deposition on August 8, 2012. RX5. He testified about various unusual occurrences during his examination of Petitioner including his inability to go up on his toes and heels, which even patients with herniated discs can usually do. RX5 at 10-11. Dr. Rezin also noted that Petitioner reported pain with normal touching of the skin, which is a Waddell sign, a sign of a certain psychological aspect to the pain. RX5 at 11. Petitioner's Spurling test in the neck was negative, which meant that Petitioner reported no numbness, tingling or pain down the arms. RX5 at 11-12. And he discussed his finding that Petitioner had "break-away" weakness in all muscle groups, which was significant to determine whether there was a psychological component to Petitioner's reported pain, and Petitioner's lack of any dermatomal pattern in reported symptoms; that is he found additional Waddell findings. RX5 at 12. In describing a Waddell finding, Dr. Rezin indicated that certain tests were used to determine whether the patient was manipulating the physician regarding the degree of his symptoms. RX5 at 13.

Ultimately, Dr. Rezin maintained his opinion that Petitioner suffered a small herniated disc in the thoracic spine based on an MRI report that showed findings in the mid-thoracic area and that resolved based on a follow up MRI report two years later noting that the disc was gone. RX5 at 23. He also maintained his opinion that Petitioner did not suffer any injury to his lumbar spine. RX5 at 23-24. Dr. Rezin also testified that Petitioner did not need surgery as a result of any work-related injury and that his thoracic disc herniation would have prevented Petitioner from working for some time, but that issue resolved and should not prevent him from working now. RX5 at 25-26.

In an addendum report dated October 10, 2012, Dr. Rezin noted his review of Petitioner's actual MRI films and indicated that this review did not change his opinions. RX6.

Additional Information

Petitioner testified that at some point he applied for and now receives social security disability benefits. He also testified that, while he was off work, his condition did not change; some days were more painful than others.

Regarding his current condition, Petitioner testified that he generally sits around the house. He testified that he has pain in his thoracic and lower lumbar spine at a level of 5/10, which is normal, but sometimes excruciating pain depending on how he moves (i.e., trying to bend over or lean too fast) which happens basically every day. Petitioner testified that he has trouble around the house he cannot stand there and do dishes. He testified that he has help from his family members who come by every few days, particularly his sister-in-law (Mrs. Delancey). Petitioner makes TV dinners for himself and tries to clean his home a little bit at a time, but what he cannot do his sister-in-law will do for him.

Petitioner testified that Mr. Bryan told him that he was fired and no longer paid him. Regarding his medical bills, Petitioner testified that some were paid by Respondent, some were paid by Medicare, and some were paid by him out of pocket ($5,136.20). *See* PX1.

Mark Overocker Testimony

Mr. Overocker was called as a witness by Petitioner and testified via deposition on May 1, 2013. PX12. He testified that he worked for Respondent during an overlapping period of time with Petitioner and in December of 2006 and February of 2007. PX12 at 5-8. He testified that in December of 2006, he was working on a transmission with Petitioner when, while handling the new transmission, "Joe and I lifted at the same time and we heard a pop in Joe's back." PX12 at 8-11. Mr. Overocker also testified that "[w]e both, as in Joe and myself, heard a big pop and him showing severe pain." PX12 at 11. Mr. Overocker then testified that he went to Mr. Bryan and told him that Petitioner hurt his back after which Mr. Bryan came out to ask Petitioner what he wanted to do. PX12 at 11-12. According to Mr. Overocker, Petitioner responded that he would probably be alright but he just needed some time to be ok, that he went home, and did not work for another 4-5 days when he returned and told Mr. Overocker that he was still feeling sore and stiff and that he had a doctor's appointment. PX12 at 12.

Mr. Overocker testified that the next time he saw Petitioner was when he returned to work in February 2007 and worked on the same jeep involved in the December 2006 incident. PX12 at 12-13. They attempted to put the transmission into the jeep when "basically the same thing happened, where his back popped again." PX12 at 13-14. Mr. Overocker testified that he heard a pop on this occasion also. PX12 at 14. Also, Mr. Overocker

testified that he and Petitioner talked to Mr. Bryan about the incident in December 2006 as well as the one in February 2007. PX12 at 15.

Cary Bryan Testimony

Mr. Bryan testified that he is the owner of Streator Tire & Repair, a business that he opened sometime in 2005, and which now has three employees. He testified that he has been working on vehicles for about 40 years. Petitioner began working for him in the middle of 2006.

On December 21, 2006, Mr. Bryan testified that he did not see the accident, but he was told about it about one week later. He recalled Petitioner telling him that he had a little pain and that it was not too bad.

Mr. Bryan testified that he was present for the February 2007 incident. Petitioner said he was hurt, but Mr. Bryan did not hear any noises or popping. He did not recall what Petitioner told him.

Mr. Bryan testified that he paid Petitioner some money because he said he was hurt and he could not work. He testified that he did so out of compassion through April of 2007, which is the first time he thought Petitioner was making a claim. Mr. Bryan also testified that he paid some medical bills because he thought Petitioner was telling him the truth. He acknowledged that he had a lapse in workers' compensation insurance at the time, but relied on the representations of an insurance person he knew for 25 years to do so. Nonetheless, there was a lapse in coverage which he discovered when he called his insurance agent.

Mr. Bryan then testified that he found out about something "suspicious" going on. He testified that he did not remember if Petitioner was working for him in April 2007. He also testified that he had no indication that Petitioner had any back injury between December 2006 and February 2007. He did pay some of Petitioner's medical bills as reflected in Respondent's Exhibit 1.

Jaime Deleon Testimony

Mr. Deleon was called as a witness by Respondent. He testified that he knows Petitioner and first met Petitioner with he came to Streator, Illinois. Mr. Deleon testified that he had an Astro van with a broken water pump and that his wife's cousin referred Petitioner to him for the repair work sometime in 2007. Petitioner came to Mr. Deleon's apartment wearing a back brace.

Mr. Deleon testified that he asked Petitioner why he had a back brace and whether he was able to work. He testified that Petitioner then took off the back brace, threw it on ground and said there was nothing wrong with him. Petitioner had his tools with him at the time. Mr. Deleon testified that he helped Petitioner lift the hood of the van and, although he told Petitioner it was a difficult job, Petitioner went right into his van, bent over it and fixed the water pump.

Mr. Deleon also testified that Petitioner told him that he got hurt while working for Streator Tire, but that it really did not happen there. Mr. Deleon testified that he felt bad after learning this information, so he called Mr. Bryan to tell him. Mr. Deleon testified that he did not know Mr. Bryan or anyone there at the time.

On cross examination, Mr. Deleon testified that he first met Petitioner when he came over to Mr. Deleon's home. Mr. Deleon testified that he and Petitioner were drinking. Specifically, he testified that Mr. Deleon had to buy Petitioner a case of beer and pay him "X" amount of money to repair the water pump. He testified that he

had one beer, but that he estimated that Petitioner had already been drinking because he could smell it on Petitioner. He further testified that Petitioner insisted on fixing his van and that during that time Petitioner continued to drink more and more beer. Mr. Deleon did not believe that Petitioner drank the whole case, but maybe two to three beers.

During the conversation with Petitioner about his alleged work injury, Mr. Deleon testified that the conversation lasted a little bit and that Petitioner's now-deceased wife was also there and that she was outspoken telling him how they were going to own the company.

Also on cross examination, Mr. Deleon testified that he was aware that Petitioner continued to work after his alleged injury because his wife's cousin told him that Petitioner was doing a lot of side jobs. Mr. Deleon recalls these events occurring sometime around the beginning of April because he remembered his grandson having a birthday party at the time.

On another occasion, Mr. Deleon testified that Petitioner's wife called him and he went over to Petitioner's home. According to Mr. Deleon, Petitioner had a great big dog at that time that has since been put down, and that Petitioner told him that he had something to show Mr. Deleon; it was an exotic cat, a bobcat. Mr. Deleon testified that he observed Petitioner being able to dive for the cat.

Tony Ross Testimony

Mr. Ross was called as a witness by Respondent. Mr. Ross testified that he knows Petitioner because he worked with him at Streator Tire and with Mr. Bryan. Mr. Ross testified that he worked on and off for Mr. Bryan since he bought the business. He is a friend of Mr. Bryan.

Mr. Ross testified that he spoke with Petitioner about his workers' compensation injury in 2006/2007 while at Streator Tire. He testified that the conversation was about Petitioner hurting his back somewhere else. Mr. Ross testified that they were working together on a car and Petitioner said something like he could tell them that he hurt his back here [at Streator Tire] and he would not have to work anymore.

On the same day, Mr. Ross testified that he spoke with Petitioner again while working on an auto. He testified that Petitioner was saying that he hurt his back at Streator Tire and that, as the conversation went on, Petitioner said words to the effect of "all this could be mine." On cross examination, Mr. Ross testified that he understood Petitioner to be referring to owning Streator Tire. He also testified that on cross examination that he did not believe Petitioner to be teasing in making such a statement. Mr. Ross also testified that Petitioner told him about other car wrecks in which he had been involved and some factory where he hurt his back before working for Respondent.

On cross examination, Mr. Ross testified that he no longer works for Mr. Bryan and that they are friends, that he was grateful for the job there and that he came to testify at Mr. Bryan's request.

Jeff Burgwald Testimony

Mr. Burgwald was called as a witness by Respondent. Mr. Burgwald has worked for Mr. Bryan at Streator Tire over the years doing some carpentry work. He testified that he had a conversation with Petitioner prior to going to work for Mr. Bryan, but he was unsure of the year which could have been 2005, 2006 or 2007. Mr. Burgwald testified that Petitioner told him that he was in an accident in a mail truck and got a DUI while working as a

mailman before working for Respondent. He testified that Petitioner told him that he injured his back prior to working for Respondent, but he did not say whether the injuries from this mail truck accident had resolved. Mr. Burgwald testified that this conversation came about around lunchtime when Petitioner indicated that his back was hurting and he told Mr. Burgwald how it happened.

On cross examination, Mr. Burgwald testified that Petitioner's work was easy and that he did not have to move engines, transmissions, etc. He also testified that Mr. Ross is his uncle and that he is an acquaintance of Mr. Bryan. Mr. Burgwald testified that he did not talk to Mr. Bryan or his attorney before testifying. Mr. Burgwald also testified that he did not talk to his uncle about this either; he knew what this [hearing] was about from Mr. Bryan dealing with the "situation" with Petitioner. Mr. Burgwald further testified that on cross examination that Petitioner told him that he was going to sue Mr. Bryan sometime in 2007 and Mr. Burgwald knew that Mr. Bryan did not have workers' compensation insurance.

Petitioner's Rebuttal Testimony

Petitioner testified that he was never involved in a mail truck accident in the past and he denied making any false claim. On cross examination, however, Petitioner testified that he was previously contracted to work for the Postal Service.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are hereby made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (A), whether Respondent was operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act, the Arbitrator finds the following:

The Illinois Workers' Compensation Act ("Act") defines those businesses that are considered "employers" and, thus, come under its jurisdiction. Under Section 3, various types of businesses automatically come under the Act's jurisdiction due to their extra-hazardous activities including "[a]ny enterprise in which explosive materials are … handled or used in dangerous quantities[,]" or "[a]ny business … in which electric, gasoline, or other power driven equipment is used in the operation thereof." 820 ILCS 305/3 (LEXIS 2005). The testimonial evidence elicited from witnesses at the hearing confirm that Respondent's business was an auto repair shop in which such materials and power-driven equipment was used. Thus, the Arbitrator finds that Respondent was operating as an employer on the claimed dates of accident under and subject to the Act.

In support of the Arbitrator's decision relating to Issue (B), whether there was an employee-employer relationship on the claimed dates of accident, the Arbitrator finds the following:

The existence of an employer-employee relationship between Petitioner and Respondent is a prerequisite to determining further compensability of his claim. The Illinois Supreme Court has articulated various factors to be considered in determining whether a claimant is an employee under the Act including: "whether the employer may control the manner in which the person performs the work; whether the employer dictates the person's schedule; whether the employer pays the person hourly; whether the employer withholds income and social security taxes from the person's compensation; whether the employer may discharge the person at will; and whether the employer supplies the person with materials and equipment." *Roberson v. Industrial Commission*, 225 Ill.2d 159, 175 (2007) (*citing Wenholdt v. Industrial Commission*, 95 Ill. 2d 76, 81 (1983), *quoting Morgan Cab Co. v. Industrial Commission*, 60 Ill. 2d 92, 97 (1975)). Determination of the existence of an employer-employee relationship rests on the totality of the circumstances in each case; however, the "right to control the manner in which work is performed is the most important consideration, among others, in determining whether an employer/employee relationship existed." *Roberson*, 225 Ill.2d at 175. The evidence proffered at the hearing establishes that Petitioner was hired by Mr. Bryan, paid by Mr. Bryan, and given work to perform by Mr. Bryan. Thus, the Arbitrator finds that Respondent had and exercised the right to control Petitioner in the performance of his duties as a mechanic such that an employee-employer relationship existed on the claimed dates of injury.

In support of the Arbitrator's decision relating to Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent as claimed and the dates of such accidents, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (Lexis 2005). The Arbitrator finds that the record does not support Petitioner's claim that he sustained a compensable accident at work on December 21, 2006, February 10, 2007 or April 9, 2007.

As an initial matter, the Arbitrator finds that Petitioner's claim that he was injured at work on December 21,

2006 is time-barred pursuant to Section 6(d) of the Act. 820 ILCS 305/6(d) (LEXIS 2005); *Tegeler v. Industrial Commission*, 173 Ill.2d 498, 504-505 (1996). Petitioner filed Case No. 10WC6806 on February 23, 2010, which alleges an accident occurring on December 21, 2006. The filing of this claim is over three years after the alleged injury. Thus, Petitioner's claim for any benefits related to this date of accident is barred by the Act's limitations period and denied.

Notwithstanding, after careful observation of the witnesses and detailed consideration of the evidence proffered, the Arbitrator also finds that Petitioner failed to establish through credible evidence that he sustained a compensable injury at work as claimed on either December 21, 2006, February 10, 2007 or April 9, 2007. Petitioner's testimony was inconsistent during direct and cross examination, repeatedly contradicted by the medical records and other witnesses, and is simply not credible.

Petitioner often referenced one mechanism of injury at work as reflected in the medical records and his several applications for adjustment of claim. He alleged that he sustained three accidents while lifting a transmission on three separate dates. At the hearing, however, Petitioner testified about a mechanism of injury on December 21, 2006 and February 10, 2007 that involved lifting a transmission while the mechanism of injury on April 9, 2007 involved working with spark plugs. First, Petitioner's testimony about the mechanism of injury on these dates of accident in light of the testimony of his own witness, Mr. Overocker, is addressed.

Petitioner testified at trial that he did not seek any medical treatment for his mid-back pain after his first or second claimed accident—both of which involved performing the exact same task of replacing a transmission in a truck—because he thought he only injured his muscles. Petitioner called Mr. Overocker as a witness who testified via deposition that he was present on the first two claimed dates of accident in December 2006 and February 2007. Mr. Overocker testified that he actually heard Petitioner's back "pop" while lifting a transmission on both occasions. Petitioner testified that he was able to continue to work and that on the second date of accident in February 2007, he had assistance from both Mr. Overocker and Respondent's owner, Mr. Bryan. Mr. Bryan denied observing the alleged occurrences on any of the claimed dates of accident. With regard to the February 2007 incident, Petitioner elaborated that he was the shortest of all three men lifting the transmission, presumably to indicate that he had more difficulty with the transmission task than Mr. Overocker or Mr. Bryan. Mr. Overocker's testimony contradicts Petitioner's version of the February incident. He testified that only he and Petitioner were lifting the transmission in February. Indeed, Mr. Overocker testified that it was not until after he heard the pop in Petitioner's back—which he also heard in December 2006 when he was performing the exact same task of replacing a transmission in not just any truck, but the very same truck months later—that he went to Mr. Bryan to report that Petitioner had injured himself. In light of these contradictions and the testimony of other witnesses about whether Petitioner sustained any injury at work on any of the claimed dates of accident in the manner alleged, the Arbitrator does not find Mr. Overocker's testimony to be credible and assigns it little weight.

According to Petitioner's testimony, he then suffered a third injury at work also involving his back on April 9, 2007 while leaning down to pick up or work with spark plugs. No one was present for this incident. Petitioner testified that it was this injury that finally prompted him to seek medical attention, and not an incident while lifting a transmission in either December or February or any pain that had worsened over those months after lifting a transmission before April 9, 2007.

The first record of medical treatment for any of Petitioner's claimed injuries is an emergency room note from April 9, 2007. The emergency room staff noted that Petitioner was a patient "well known" to them reporting thoracic—not neck or low back—pain at a level of 3/10. Notably, the emergency room physician noted

Petitioner to be "v. dramatic" during the physical examination and that he jumped at the slightest touch. The record also reflects Petitioner's report that his back pain began one month or so earlier, placing the date of injury sometime in March of 2007, when he was lifting a transmission. There is no indication in the record anywhere that any incident involving spark plugs was the tipping point causing him to see a doctor after continually worsening back (or neck) pain after an incident involving lifting a transmission in either December 2006 or February 2007.

While these indications and discrepancies alone might be considered *de minimus* in assigning weight to Petitioner's testimony, in the context of this record they are not singular. Indeed, it is not solely Petitioner's admitted drug seeking behavior or addiction after his claimed accidents at work—which he claims he now conquered—that erode his credibility so extensively. Rather, Petitioner's credibility is worn down by a variety of problems.

Petitioner's dramatic behavior is repeatedly noted by his own treating physicians, emergency room doctors, and Respondent's Section 12 examiner. Petitioner presented to Dr. DePhillips, Dr. Koski, Dr. Kloc, and other doctors wearing multiple braces and using canes and walkers without a prescription during a period of time that diagnostic tests revealed minimal findings in the neck and back. Moreover, while Petitioner initially reported no radiating symptoms into his legs for months and did not report any lumbar pain whatsoever until almost two years after his first claimed date of accident, when he did report such symptoms they could not be correlated by clinical examinations revealing objective evidence of lumbar pathology that would cause such radiculopathy or disability.

By May 4, 2007, when Petitioner saw Dr. DePhillips for the first time, he reported that his pain one month earlier when he finally went to the emergency room had worsened after an incident lifting a transmission at work—not after working with spark plugs—to such a degree that his pain was not 3/10 as reflected in those records, but rather that the pain was "unbearable." Then despite pain that Petitioner localized only to the thoracic spine, Petitioner also reported pain and numbness in both upper extremities and difficulty with overhead reaching. Petitioner did not report any symptoms in the neck or cervical spine and his examination there was normal. In an effort to diagnose Petitioner, however, Dr. DePhillips ordered both thoracic and cervical spine MRIs which revealed a disc herniation at T8-9 and otherwise minimal degenerative changes in the cervical and thoracic spine. Dr. DePhillips prescibed Vicodin and recommended trigger point injections and an epidural steroid injection, which he administered. By June 22, 2007, however, Petitioner subjectively reported for the first time that he had neck pain and headaches and that the injections provided no relief. While Petitioner reported continued "severe" diffuse and debilitating pain, it is notable that Dr. DePhillips did not place Petitioner off work during this period of time or even impose light duty work restrictions, but rather he referred Petitioner to Dr. Koski for a second opinion.

When Petitioner saw Dr. Koski on August 9, 2007, his reported history stemmed back to lifting a transmission in December 2006 with an acute onset of upper thoracic pain that was initially mild but then "progressed over the next several days [not the next several months as Petitioner testified at the hearing] to become significantly debilitating." Petitioner also reported to Dr. Koski that since that time he "had terrible and progressive pain that has been refractory to conservative therapy." Dr. Koski noted no pain in the cervical, upper thoracic, or lumbar spine and Petitioner reported no radiating symptoms into the lower extremities. Dr. Koski also noted Petitioner's bracing, which he recommended should stop, and opined that Petitioner's examination did "not point to spinal pathology for his pain." Dr. Koski did not "believe [that Petitioner had] any structural abnormalities in his thoracic spine or any evidence of instability that would explain his pain and findings." Petitioner testified that his cane and bracing were prescribed by Dr. DePhillips, but his records are devoid of any

such recommendation.

Based on the inconsistencies between Petitioner's testimony, Mr. Overocker's testimony, and Petitioner's documented representations to his physicians to this point in the medical treatment alone, the Arbitrator finds sufficient basis to find that Petitioner did not sustain any accident as alleged. Nonetheless, the record reveals other inconsistencies bringing Petitioner's recitation of events into question and further undermining his claim that he sustained any accident at work as alleged. Indeed, the myriad physicians that examined Petitioner were consistently unable to find objective clinical support or diagnostically evident pathology in the spine to explain any of Petitioner's ever-changing and ever-worsening symptoms.

Petitioner did not return to see Dr. DePhillips after being referred to Dr. Koski for some time. However, Dr. DePhillips' records reveal that for several months thereafter Petitioner or his wife made repeated calls seeking large refills of narcotic pain medications for various reasons including being out of town, someone having stolen his prescription narcotics during a party, etc. Dr. DePhillips refused to refill these medications as requested. Rather, he again referred Petitioner to another physician for further treatment; this time, to Dr. Kloc, a pain management specialist, that discontinued treating Petitioner after one visit.

Dr. Kloc noted that "things in Mr. Delancey's story are suspect[,]" and indicated that he would go ahead with trigger point injections "and check on Mr. Delancey's stories." Once Dr. Kloc did so, he indicated that Petitioner was being "removed from our pain clinic roster due to a string of falsehoods that he told us while he was here for his first visit." These "falsehoods" included Petitioner's report of an epidural injection performed at Streator hospital in a manner "that is not done by anyone in or outside the pain medicine field." While Dr. Kloc acknowledged that Petitioner was not a physician and could not be expected to report exactly how this procedure was done, he also noted that Petitioner arrived "wearing an enormous chest corset, the likes of which I have not seen in modern medical practice. It is very bulky and almost comic-looking." The Arbitrator notes that Petitioner also arrived at the hearing wearing a back brace which no physician seems to have ever prescribed. Dr. Kloc also iterated Petitioner's request to refill his narcotic medications and, ultimately, his "very strong suspicion that Mr. Delancey is a drug seeker and I am going to refer him back to Dr. DePhillips."

Petitioner did not immediately see Dr. DePhillips after being released by Dr. Kloc, but rather returned to the emergency room. When contacted by emergency room staff, Dr. DePhillips referred Petitioner to yet another physician, Dr. Singla, for consultation. Dr. Singla, after an evaluation, referred Petitioner back to his pain management doctor which he did not have at that time. Dr. DePhillips did not see Petitioner again until November 14, 2008 and, again, only after an emergency room visit. While Petitioner seems to contend that the reason he saw various physicians and went to the emergency room is because of his financial constraints, the medical records paint a different picture of physicians seeking to shuffle Petitioner off to other physicians for non-compliant, if not flat out untruthful, behavior.

Petitioner eventually went to see another pain management physician, Dr. Patel, in February 2008 who managed his medications for approximately two years through February 2010. Throughout this course of treatment, Dr. Patel noted his conversations with Petitioner about titrating off of the narcotic pain medication. He also noted Petitioner and his wife's requests for additional refills of narcotic pain medications which he adjusted or refilled limitedly. Finally, Dr. Patel noted Petitioner's positive THC drug screens for which Petitioner apologized or blamed family members who smoked in his presence while simultaneously denying that he continued to engage in the drug use.

Additionally, from 2008 through 2010 Petitioner continued to visit St. Mary's or St. Joseph's emergency rooms

regularly reporting symptoms such as nausea that quickly resolved and were replaced by diffuse back pain and during which time he was consistently reportedly unable to withstand any touch during examinations. On occasion, Petitioner refused to be examined. Incidentally, on cross examination questioning about some of these emergency room visits and the events precipitating them, Petitioner denied that he fell at home or over his dog, and then when confronted with documentation to the contrary attributed the contradictions to a faulty memory. In any event, when Petitioner did allow his treating physicians, emergency room doctors, and Respondent's Section 12 examiner, Dr. Rezin, to examine him he had such sensitivity to touch and reported such extreme pain throughout the entirety of the neck and back that no physician was able to objectively localize pathology through clinical or diagnostic tests with Petitioner's reported areas of pain. That is, Petitioner reported severe pain all over the back to every doctor which he attributed to some accident at work occurring on one of three dates with differing symptom onsets as reflected in the records which symptoms did not correlate to their clinical findings or to the extent claimed by Petitioner given the small thoracic disc herniation that eventually resorbed or the minimal degeneration indicated in his cervical, thoracic or lumbar spine MRIs.

In addition to the lack of credible evidence that Petitioner sustained any injury to any part of his spine on December 21, 2006, February 10, 2007 or April 9, 2007 as reported by him or Mr. Overocker while lifting a transmission or working with spark plugs, the lack of objective medical evidence corroborating Petitioner's reported symptoms with any work accident involving the neck or back as a result of his alleged and varied mechanisms of injury, and Petitioner's inconsistent testimony when compared to that on cross examination and the medical records, Respondent also provided four witnesses in support of its defense against Petitioner's claims. Petitioner's repentant admission about his prior drug-seeking behavior as a reason for some of the aforementioned discrepancies—from which he states he did not suffer before his accidents at work—is unpersuasive. Mr. Bryan, Mr. Deleon, Mr. Burgwald and Mr. Ross' testimony further erodes Petitioner's recitation of events.

Mr. Deleon testified that he observed Petitioner perform mechanic services on his van the likes of which Petitioner could not have possibly performed had he truly been in the amount of pain he reported to any treating physician after his claimed dates of accident. Mr. Deleon testified that he observed Petitioner remove and throw his back brace on the floor when he initially inquired whether Petitioner could change the water pump on his van in that condition. He also testified that Petitioner told him that there was nothing wrong with his back and that his claimed accident at work really did not happen while working for Respondent. Mr. Deleon testified that he felt bad after learning this information, so he called Mr. Bryan to tell him and that he did not know Mr. Bryan or anyone there at the time. While Mr. Deleon's good Samaritan motivation may be called into question under different circumstances, given the totality of this record and after careful observation of his testimony the Arbitrator finds Mr. Deleon's testimony to be credible and further support a finding that Petitioner did not sustain any compensable injury while working for Respondent.

Mr. Ross and Mr. Burgwald also testified on Respondent's behalf. These witnesses worked directly or indirectly with Petitioner during the period of time that Petitioner claims to have been injured at work or shortly thereafter. Mr. Ross testified that he was working on a car with Petitioner who told him, essentially, that he could simply claim that he hurt his back while working for Respondent and that he would not have to work anymore. Mr. Ross also testified that Petitioner later boasted to him that same day that "all this could be mine" which he did not believe was said in jest. Mr. Burgwald testified that Petitioner told him at one point that he was involved in an accident while working in a mail truck for the Postal Service and that he had injured his back prior to working for Respondent. Notably, Mr. Burgwald is a relative of Mr. Ross and Mr. Ross indicated his appreciation for the employment by Respondent, which ended some time ago. While the Arbitrator finds that their testimony is credible overall, it is by no means the only evidence in this record of Petitioner's subjective

reports and exaggeration, which is most clearly documented by Petitioner's own treating physicians and their inability to correlate his symptoms to objective evidence of the broad injuries Petitioner claims to have suffered on any one of his three claimed dates of accident.

Finally, the Arbitrator finds Dr. DePhillips's opinions regarding Petitioner's condition and its relation, if any, to his claimed single accident at work—which if Petitioner is to be believed actually stems from three separate accidents at a work two or more of which involved lifting a transmission with one or two other persons over several months—are not persuasive. To the contrary, his causal connection opinion merely highlights Petitioner's lack of credibility and undermines the persuasiveness of such an opinion.

While Dr. DePhillips did not believe that Petitioner's lumbar spine condition was causally related to his lifting-a-transmission accident at work, which seems appropriate given that Petitioner's first report of low back pain was to Dr. DePhillips on November 14, 2008 almost two years after his first claimed accident at work in December 2006, he also opined that Petitioner's accident "might or could have aggravated" his underlying cervical degenerative condition. Dr. DePhillips did not place Petitioner off work or impose any work restrictions on Petitioner until May 25, 2007 at which time he did so for five months without explanation merely indicating that this was due to a work injury—although he does not indicate which of Petitioner's three alleged work injuries—and until further evaluation. Dr. DePhillips similarly unexplained July 30, 2008 note that Petitioner was to remain off work until further evaluation and to be non- or minimally ambulatory is also unaccompanied by an explanation or examination. Taken in conjunction with the aforementioned inconsistencies between Petitioner's testimony and medical records, the second opinion of the physician to whom he referred Petitioner (Dr. Koski) who indicated that Petitioner had *no* underlying spinal pathology in the neck or back, and the problematic matters referenced above raised by Dr. Kloc, Dr. Patel, various emergency room physicians, and Dr. DePhillips himself, the Arbitrator finds Dr. DePhillips' equivocal causation opinion to be wholly unpersuasive and assigns it no weight.

Rather, the Arbitrator finds the opinions of Respondent's Section 12 examiner, Dr. Rezin, to be persuasive given the record as a whole. He plausibly explained in his reports and through his testimony that Petitioner had evidence of a small disc herniation in the thoracic spine indentified in Petitioner's initial MRI which eventually resorbed and that may have been attributable to the mechanism of injury reported by Petitioner to him while lifting a transmission. Given the overwhelming evidence referenced herein undermining Petitioner's testimony and claims that he sustained an injury while working for Respondent on any of three dates of accident however, the Arbitrator declines to find this speculative concession on Dr. Rezin's part to be sufficient to establish that Petitioner did, in fact, sustain the now-resolved thoracic disc herniation while working for Respondent.

Based on all of the foregoing, the Arbitrator finds that Petitioner has failed to establish by a preponderance of credible evidence that he sustained an accident in the course and scope of his employment on December 21, 2006, February 10, 2007 or April 9, 2007. By extension, all other issues are moot and all requested compensation and benefits are denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0147

Bruce Estes,
Petitioner,

vs. NO: 13 WC 32568

MV Transportation,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of acididdent, 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 23, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $2,800.00. 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: FEB 2 6 2015
KWL/vf
O-2/17/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0147

ESTES, BRUCE Case# **13WC032568**
Employee/Petitioner

MV TRANSPORTATION
Employer/Respondent

On 7/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
124 S W ADAMS ST SUITE 200
PEORIA, IL 61602

0264 HEYL ROYSTER VOELKER & ALLEN
CRAIG S YOUNG
124 S W ADAMS ST SUITE 600
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

- [ ] 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)

15IWCC0147

Bruce Estes
Employee/Petitioner

Case # 13 WC 32568

v.

MV Transportation
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 **Peoria**, on **May 23, 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] Is Petitioner entitled to any prospective medical care?

L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other

FINDINGS

On the date of accident, **September 3, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**25,147.20**; the average weekly wage was $**483.60**.

On the date of accident, Petitioner was **60** years of age, ***single*** with **0** dependent children.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $**2,774.00**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay the reasonable and necessary expenses associated with medical treatment prescribed for the Petitioner's right condition by Dr. Merkley, as provided in Sections 8(a) and 8.2 of the Act.

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

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

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

Arbitrator Anthony C. Erbacci

July 18, 2014
Date

13 WC 32568
ICArbDec19(b)

JUL 23 2014

FACTS:

On September 3, 2013 the Petitioner was employed by the Respondent as bus driver, having been so employed since February 10, 2009. The Petitioner testified that his job duties include operating a small bus specially equipped to transport senior citizens and disabled individuals who cannot ride regular public transportation. He testified that the physical demands of this job include bus inspection and preparation, driving, sitting for long periods of time, and bending and kneeling on a repetitive basis as the driver secures and releases wheel chairs from restraints.

The Petitioner testified that he regularly works from 6:30 a.m. until 5:30 p.m., driving a dedicated bus and a specific route, four days a week with occasional weekend overtime. He testified that his work day habit is to arrive at the Respondent's facility around 5:00 a.m., as he does not own a vehicle and therefore walks to work or gets a ride from someone who works the earlier shift.

The Petitioner described the Respondent's facility as a large fenced in yard which is not open to the general public. He testified that the buses he and his co-workers drove were stored in the back of the yard overnight and had to be brought up to the Respondent's terminal each morning. He testified that while there is some limited lighting in the yard it is generally very dark at 5:00 in the morning, especially in the area where the buses were stored overnight. Through a series of pictures presented at arbitration, the Petitioner established that in various places around the yard, there are drainage grates which were at a lower level than the asphalt pavement of the yard and which had cracked and uneven concrete around them.

The Petitioner testified that on a regular basis, after arriving at the facility early, he would go to the back of the yard where the buses were parked overnight, and help prepare and stage the buses. This activity required him to walk to the back of the yard where the buses were stored, pull the buses up and line them up in a certain order, and "pre-check" the buses. The Petitioner testified that on some occasions he was specifically asked to come to work early and pull the buses out and other days he just did it because he was there early. He testified that when he was specifically asked to do the "pull out", he got paid for the time and when he did it on his own he did not get paid for the time.

The Petitioner testified that on September 3, 2013 he arrived at the Respondent's facility at 5:00 and he began pulling buses forward. The Petitioner testified that he pulled his own bus forward and then went back into the yard to get another bus for a co-worker, Erica Gordon. The Petitioner testified that Erica Gordon was afraid to go to the back of the yard so she asked the Petitioner to get her bus for her in the mornings. The Petitioner testified that as he was in the back of the yard looking for Erica Gordon's bus, he stepped into one of the drainage grates and his foot rolled and he felt his right knee crack.

The Petitioner testified that he reported the incident to Ted Garcia, the dispatch manager, and advised him that he had rolled his ankle and had pain in his knee. The Petitioner testified that he then started his regular route but by around noon his knee became

swollen and painful. The Petitioner testified that he reported his pain and was sent to IWIRC.

The records of IWIRC demonstrate that the Petitioner was seen there on September 3, 2013 with complaints of right knee pain. The Petitioner was noted to report a history of turning his right ankle on uneven pavement and felling a pop and pain in his right knee. The assessment was a right knee sprain with suspicion of a bucket handle medial meniscus tear and the Petitioner was prescribed an MRI. The Petitioner followed up at IWRIC on September 5, 2013 and it was noted that the MRI demonstrated a medial meniscus tear.

On September 13, 2013, the Petitioner was seen by Dr. Michael Merkley at Midwest Orthopaedic Center. Dr. Merkley noted that the Petitioner's MRI demonstrated a complex tear of the posterior horn of the medial meniscus. The Petitioner's knee was aspirated and injected with a cortical steroid and he was released to return to regular work.

In a January 6, 2014 narrative report, Dr. Merkley noted that the Petitioner provided a consistent history of injury and was seen on September 13, 2013. Dr. Merkley reported that the Petitioner returned for followup on October 25, 2013 and continued to complain of anterior knee pain and pain over the medial aspect of his right knee. The Petitioner's knee was aspirated and injected again. Dr. Markley opined that based upon his history, the symptoms, the MRI and x-ray findings, surgical intervention might be an appropriate option for the Petiotioner. Dr. Markley further opined that the Petitioner had preexisting patellofemoral degenerative changes and likely a preexisting degenerative medial meniscus tear which were aggravated by his work accident and left him with synovitis and effusion which has not responded to aspiration and corticosteroid injection. Dr. Merkley concluded that, therefore, the Petitioner would be a candidate for arthroscopic debridement at his knee due to the persistence of synovitis and effusion.

The Petitioner testified that he has not sustained any other injuries to his right knee since the date of work injury and that he continues to experience pain and swelling in his righ knee. The Petitioner testified that he wants to undergo the surgery suggested for him by Dr. Markley.

The Petitioner acknowledged at trial that the official duties of pulling the buses out of the garage and staging them for the day's routes are the responsibility of the road supervisor. The Petitioner further testified that at the time of his accident, the regular road supervisor had left due to an illness. On occasion, the Respondent would specifically ask the Petitioner to fill in and perform the duties of the road supervisor, and when he was scheduled to do so he was paid. On the date in question, Ted Garcia was working as the road supervisor.

The Petitioner acknowledged that there had been some communication from the Respondent's management with regard to not pulling the buses out prior to the start of a shift. He testified, however, that he would regularly help with pulling the buses out and was allowed to do so, even on those dates when he was not scheduled to perform the official duties of the road supervisor.

The Petitioner presented the testimony of Sammy Irvin, who operates as the union steward for the Respondent's bus drivers. Mr. Irvin testified that while he doesn't ever get his own bus out, he is aware that some drivers do remove their buses from the garage prior to the start of their shift. He further testified that the Respondent's management knows this and allows it to occur. He did acknowledge that policies had been put in place which dictate against this practice and further acknowledged that the policy is that if someone is performing such work, they should be paid for it. Despite this, Sam Irvin testified that some of the drivers do remove their own buses and prepare them for the day prior to the start of their shift.

The Respondent presented the testimony of Mark Nash, the Respondent's general manager. Mr. Nash testified that he is aware that bus drivers come into the bus yard and get into their buses early since they don't have a break room available. He reiterated that the drivers are not supposed to work until they clock-in and they are not supposed to clock in more than ten minutes prior to their scheduled start time. Mr. Nash testified that he had seen the Petitioner in the yard early, prior to September 3, 2013, but that he didn't see him working, and thought that he was only "hanging out". Mr. Nash also admitted that he didn't tell the Petitioner to leave the yard when he saw him there early and that he could not recall any formal disciplinary proceedings against a driver for being in the yard early. Finally, Mr. Nash confirmed that the bus yard has restricted access to employees only.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

It is well established by case law and the Act, that to be compensable, an accident must both "arise out of" and "within the course of" the employment with Respondent. The phrase "in the course of" refers to the time, place, and circumstances under which the accident occurred. An injury "arises out of" a claimant's employment when there is a causal connection between the employment and the injury, that is, the origin or cause of the injury must be some risk connected with, or incidental to, the claimant's employment.

The Arbitrator finds that Petitioner's accident "arises out" of the employment, as Petitioner was in a restricted access employer-controlled area and encountered a specific defect, causing his injury. The injury occurred incidental to his searching for a bus in a dimly lit parking lot.

As to the "in the course of" prong of the test, the term "employment" is said to contemplate not only actual work time, but a reasonable time before commencing and after concluding actual employment. In the present case, the Petitioner was in the bus yard at 5:15 a.m., with a clock in time of 6:30 a.m. The Respondent's general manager testified that

he knew that the Petitioner came into the yard early and that he had, on occasion, been scheduled to do so. While there was a great deal of testimony about the Respondent's efforts to prevent its employees from working non-scheduled hours, it is clear that the Petitioner was in a place and at a time that the employer could reasonably expect him to be, performing activity incidental to his employment.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that on September 3, 2013 an accident did occur which arose out of and in the course of the Petitioner's employment with the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner sought treatment for his right knee complaints on the same day as his work accident at IWIRC, the provider that the Respondent sent him to. The Petitioner was diagnosed as having a suspected torn medial meniscus and an MRI was prescribed. The MRI was performed that day and showed an oblique tear of the posterior horn of the medial meniscus.

The Petitioner then came under the care of Dr. Merkley at Midwest Orthopaedic Center. Dr. Merkley received an accident history consistent with Petitioner's testimony and noted that the Petitioner's MRI demonstrated a complex tear of the posterior horn of the medial meniscus. Dr. Merkley aspirated and injected the Petitioner's knee on two occasions. In his narrative report of January 6, 2014, Dr. Merkley opined that the Petitioner likely had a pre-existing degenerative tear that was aggravated by his accident, causing synovitis and effusion which has not responded to conservative treatment. Dr. Merkley opined that the Petitioner was a candidate for arthroscopic debridement.

Based upon the foregoing, and having considered the totality of the evidence adduced at hearing, the Arbitrator finds that the current condition of ill-being in the Petitioner's right knee is causally related to the work injury of September 3, 2013.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

Having found that on September 3, 2013 an accident did occur which arose out of and in the course of the Petitioner's employment with the Respondent and that the current condition of ill-being in the Petitioner's right knee is causally related to the work injury of September 3, 2013 the Arbitrator finds that the related outstanding medical bills and recommended prospective medical treatment are also properly awarded. Petitioner's Exhibit 4 contains itemized medical bills from IWIRC and Midwest Orthopedic Center in the total

amount of $2,774.98. The Arbitrator finds these bills to be reasonable, necessary and causally related to the Petitioner's work injury and awards payment of the bills, pursuant to the limitations provided in the medical fee schedule provided for in the Act.

In Support of the Arbitrator's Decision relating to (L.), Is Petitioner entitled to any prospective medical care, the Arbitrator finds and concludes as follows:

Dr. Merkley, the Petitioner's treating physician, opined that the Petitioner likely had a pre-existing degenerative tear that was aggravated by his accident, causing synovitis and effusion which has not responded to conservative treatment. Dr. Merkley further opined that the Petitioner was a candidate for arthroscopic debridement. No opinions contrary to those of Dr. Merkley were offered into the record. The Arbitrator concludes, therefore, that the Petitioner has not yet reached maximum medical improvement from his work injury and that additional recommended medical treatment would be reasonable, necessary and causally related to the Petitioner's work injury of September 3, 2013..

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Paul Martin,

Petitioner,

vs. NO: 06 WC 52575

City of Chicago,

15IWCC0148

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 credit, causal connection, 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 July 15, 2013, 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: FEB 2 6 2015
TJT:yl
o 2/3/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTIN, PAUL Case# **06WC052575**
Employee/Petitioner

CITY OF CHICAGO 15IWCC0148
Employer/Respondent

On 7/15/2013, 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 0.07% 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:

MULLEN LAW OFFICES
RICHARD C GLEASON
70 W MADISON ST SUITE 2060
CHICAGO, IL 60602

0464 CITY OF CHICAGO LAW DEPT
MICHAEL GENTITHES
30 N LASALLE ST 8TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS. 15IWCC0148
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

Paul Martin
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **06** WC **52575**

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **5/7/13**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 31, 2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**55,776.76**; the average weekly wage was $**1,072.63**.

On the date of accident, Petitioner was 64 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 $**3,576.30** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,576.30**.

Respondent is entitled to a credit of $**20,574.28** under Section 8(j) of the Act.

STATEMENT OF FACTS:

The petitioner, a sanitation laborer with Respondent City of Chicago's Streets and Sanitation Department, was injured on July 31, 2006; one of the hottest days on record in the City of Chicago. The temperature recorded at Midway International Airport reached 98 degrees Fahrenheit between 1:00 and 2:00 p.m. The petitioner testified that on that date, he was working behind a sanitation truck at approximately 1:30 p.m. when he began to feel dizzy and asked his partner to get him some water. They ceased work and Petitioner sat down to rest. Subsequently, a supervisor came to the scene and told the petitioner and his partner that they could not take a break and instructed them the finish clearing the alley. The petitioner returned to work, but began feeling dizzy again and passed out. His co-worker then drove him to the ward yard where a supervisor called an ambulance, which took him the University of Illinois Hospital. Tests were taken and Petitioner was then transferred to McNeal Hospital. According to his testimony, the petitioner never lost consciousness and recalls the entire incident. It is undisputed that the petitioner had no prior heart condition. *See,* RX1.

The petitioner was subsequently admitted to the University of Illinois Hospital, where he was diagnosed with heat exhaustion or a heat stroke. An EKG taken at that time, showed that the petitioner had had an atrial flutter. The petitioner did not have any infarction and had a structurally normal heart. The petitioner testified that his atrial flutter "converted" and his heart was in a normal rhythm three days after the accident. The petitioner added that he was given several medications at that time, but that he stopped taking all of them except 82mm aspirin and Cartia, to help prevent a recurrence of atrial flutter. The petitioner has not experienced any atrial flutter symptoms since July 31, 2006. He has not scheduled any additional doctor's appointments seeking treatment or additional medication relating to this injury. *See,* RX2, p. 1.

The petitioner returned to his position as a sanitation laborer on September 4, 2006, thirty-two days after the incident. He returned full duty: none of his treating doctors restricted him from performing any of his normal job functions. According to his testimony, the petitioner continued to receive the same pay and work the same hours he did prior to his injury. The petitioner testified that he performed all of the same job duties he performed prior to his injury until he retired in the spring of 2010. At the time of his retirement, the petitioner had worked for the respondent for approximately 29 years. Petitioner testified that he took early retirement, at a loss of pension benefits, because he felt that he could no longer do the work. The petitioner has been collecting pension benefits from the respondent since his retirement. The petitioner also testified that he treated for unrelated cancer symptoms in 2010 and 2011.

At the request of the respondent, Dr. Hemal Nayak examined the petitioner, on September 26, 2012, regarding his injuries. Dr. Nayak prepared a report of his findings following that examination. According to that report, the petitioner has not had any documented recurrences of his atrial flutter and hence has discontinued his use of Warfarin. The petitioner continues to take diltiazem to treat hypertension. Dr. Nayak stated that although the petitioner had an atrial flutter two days after the work accident, "it is impossible to state at what point the patient went into the atrial flutter," noting that the diagnosis of heat stroke was made by the treating physicians when the petitioner was admitted to the hospital. Dr. Nayak concluded that the petitioner does not have any present cardiac symptoms or any restrictions upon his ability to work. *See,* RX2, pgs.1-2.

One of Petitioner's treating doctor, Dr. Lichtenberg stated in a September 26, 2009 letter to another treater, i.e., Dr. John Terando, that the petitioner was following-up with him stating that "the situation surrounding the atrial fibrillation appears to have been quite an extreme stress with the heat and intensity of work that he was performing. I believe that we have a precipitating cause for which I believe if he remains in sinus rhythm would not warrant long-term anticoagulation." Heat exhaustion was also listed in the petitioner's discharge summary for McNeal Hospital. *See,* PX2 & PX3.

Petitioner testified that his doctors have warned him to avoid overstraining, and that this made it difficult for him to work because he was concerned about additional health problems. However, the petitioner did not experience any atrial flutter symptoms or other work-related health problems between his return to work in September of 2006 and his retirement in the spring of 2010.

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 demonstrating that his injuries are causally related to the employment, as well as the nature and extent of the injury. *Newgard v. Industrial Comm'n*, 58 Ill.2d 164, 169, 317 N.E.2d 524 (1974). Thus, an accident alleged for the purpose of claiming benefits under the Act must be traceable to a definite time, place, and cause. *Mithiessen & Hageler Zinc Co. v. Industrial Comm'n*, 284 Ill. 378, 120 N.E. 249 (1918). This is a longstanding and necessary requirement that must be met to trigger the protections of the Act.

In this case, the petitioner has met his burden regarding causal connection. The credible evidence has shown that petitioner suffered from heat stroke while working outside on one of the hottest days on record in Chicago. Two days later, an EKG revealed that petitioner's heart had an atrial flutter, which was resolved chemically shortly thereafter. The petitioner has provided medical evidence demonstrating that causal link. The atrial flutter "converted" to a normal heart rhythm chemically several days after the accident, and the petitioner testified that he has not had a recurrence of the atrial flutter since that time.

ORDER

Respondent shall pay Petitioner compensation for a 3.5% loss of use of the man as a whole, or 17.5 weeks at a weekly PPD rate of $619.97 per week, pursuant to Section 8(b)2 of the Act.

Respondent is entitled to a credit of $20,574.28 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.

Thompson Smith
Signature of Arbitrator

July 12, 2013

ICArbDec p. 2

JUL 15 2013

STATE OF ILLINOIS	)	☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILLAMSON	)	☐ 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

Mark Kingston,

Petitioner,

vs. NO: 12 WC 11232

15IWCC0149

Wal-Mart,

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 June 9, 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.

15IWCC0149

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

DATED: FEB 2 0 2015
TJT:yl
o 2/17/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KINGSTON, MARK
Employee/Petitioner

Case# **12WC011232**

WAL-MART
Employer/Respondent

15IWCC0149

On 6/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5236 CULLEY FEIST KUPPART & TAYLOR
KREIG B TAYLOR
617 E CHURCH ST SUITE 1
HARRISBURG, IL 62946

0560 WIEDNER & McAULIFFE LTD
MATTHEW J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CLAYTON, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARK KINGSTON
Employee/Petitioner

Case # 12 WC 11232

v.

WAL-MART
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 **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Herrin**, on **April 2, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 1, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$19,416.89**; the average weekly wage was **$373.40**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$895.70** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$895.70**. (This credit is not applied toward the TTD award below – see Memorandum of Decision of Arbitrator).

Respondent is entitled to a credit of **$26,638.79** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as set forth in Petitioner's Exhibit 15 and as provided in Sections 8(a) and 8.2 of the Act. Respondent shall have all applicable credit pursuant to Section 8(j) of the Act (as noted above).

Respondent shall Petitioner temporary total disability benefits of $248.93 for 12 3/7 weeks, commencing September 17, 2012 through December 12, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $224.04/week for 50 weeks, because the injuries sustained caused the 10% loss of use to the body 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

05/29/2014
Date

JUN 9 - 2014

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARK KINGSTON
Employee/Petitioner

v. Case # 12 WC 11232

WAL-MART
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On February 1, 2012, Petitioner, Mark Kingston, was employed as an inventory management employee for Respondent, Wal-Mart. On that date between the time of approximately 1:00-1:30 a.m., Petitioner claims he injured his left shoulder while performing his regular work duties. Petitioner testified that he was in the storage area of Respondent's Harrisburg, Illinois facility and on a ladder when the accident took place. Petitioner testified that while on the ladder he was reaching into a box of candy, which was on an upper shelf and which required him to reach across his body and above his head. Petitioner also testified that the box in which he was reaching in to retrieve the candy items was closed with the flaps down. Petitioner testified that immediately after reaching into said box, he felt a sudden and intense pain his left shoulder. Hoping that the pain would alleviate itself, Petitioner continued working until his lunch break at around 2:00 a.m. After finishing lunch and still continuing to have pain in his shoulder, Petitioner notified the onsite supervisor of his accident and completed accident forms. Petitioner finished out his shift on the date of the accident.

Following this incident, Petitioner sought treatment from his primary care physicians at the Primary Care Group in Harrisburg on February 2, 2012. The office note from the February 2, 2012 visit indicates that Petitioner reported an injury while on a ladder at work the day before at around 1:00 a.m. when he was reaching to get a box. He also reported his shoulder pain increased significantly following the accident. (Petitioner's Exhibit (PX) 1). Petitioner was treated conservatively with pain medications and physical therapy and was kept off of work. (PX 1; PX 2).

Petitioner was then referred to an orthopedic physician, Dr. John Wood. Dr. Wood first met with Petitioner on February 23, 2012, at which time he performed a physical examination and reviewed an MRI. Dr. Wood's plans at that time were for aggressive formal physical therapy. He placed Petitioner on work restrictions of no lifting greater than 5 pounds with the left arm, no lifting greater than 10 pounds with both arms, to avoid repetitive activities with the left arm, and to avoid climbing and overhead activities. Dr. Wood on that date also provided to Petitioner a left shoulder steroid injection. (PX 3). Petitioner returned to work on March 23, 2012. Petitioner was paid temporary total disability (TTD) benefits at that time.

After conservative treatment with Dr. Wood and continuing through physical therapy without relief, Petitioner was referred to Dr. Jeffrey McIntosh, an orthopedic surgeon. Petitioner first met with Dr. McIntosh on

May 2, 2012. After taking a history and performing a physical examination, Dr. McIntosh initially diagnosed Petitioner as having a strain to his shoulder. Dr. McIntosh provided another injection to Petitioner's shoulder and requested a follow-up appointment. Petitioner next saw Dr. McIntosh on May 30, 2012, at which time Dr. McIntosh recommended surgery. (PX 8; PX 11, Dep. Exh. 2).

On August 22, 2012, Petitioner was evaluated by Dr. Michael Nogalski at the request of the Respondent pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq*. (hereafter the "Act"). After performing a physical examination, Dr. Nogalski provided the impression of left shoulder pain, possible resolving capsulitis and generalized bicipital tendinopathy/bicipital physical exam findings. (RX 11, Dep. Exh. C). Dr. Nogalski testified that it was his opinion within a reasonable degree of medical certainty that Petitioner's accident was not the cause of his left shoulder condition. (RX 11, pp. 12-13). Dr. Nogalski also provided an AMA impairment rating of 3% of the upper extremity. (RX 12).

On September 17, 2012, Dr. McIntosh performed a left shoulder arthroscopy, debridement of a partial rotator cuff tear, debridement of a labral tear, and a biceps tenotomy and tenodesis. His post-operative diagnosis was a partial tear of the rotator cuff, a glenoid labral tear, and a biceps tendon tear. (PX 8; PX 11, Dep. Exh. 2). Dr. McIntosh referred Petitioner to physical therapy ,which Petitioner attended at Integrated Health, and ultimately plateaued. (PX 6). Petitioner last saw Dr. McIntosh on December 12, 2012, at which time he was released to return to work full duty with a note to return in six weeks to make sure Petitioner had made an appropriate transition to full duty. (PX 9).

After being released to full duty, Petitioner was terminated from his employment with Respondent on January 13, 2013, at which time Petitioner lost all group health insurance benefits. Respondent cited lack of available positions as its reasoning for terminating Petitioner. (RX 7). As Petitioner's case had been denied since April 26, 2012, the majority of Petitioner's medical expenses were paid by his group insurance through his employment. (See RX 9; RX 10). After losing his group insurance, Petitioner could not afford to follow-up with Dr. McIntosh as requested by the doctor in his December 12, 2012 office note.

On March 5, 2013, Dr. McIntosh's deposition was taken. Dr. McIntosh testified within a reasonable degree of medical certainty that Petitioner's complaints were causally related to the February 1, 2012 accident at work. (PX 11. Pp. 14-15). Dr. McIntosh outlined his opinion as to causation in a letter dated January 30, 2013. (PX 7).

Petitioner testified that he still experiences pain throughout his left arm, including his shoulder, bicep, and hand. He indicated that he experiences significant pain when lifting his arm overhead. Petitioner also testified that he is unable to perform many of the activities that he once could do before the accident, such as lifting weights and playing the guitar. Petitioner is currently prescribed pain medications by his primary care physician, which he continues to take on a regular basis for the pain associated with his left arm. Petitioner currently works at a car wash, where he makes change for customers and sprays tires with cleaning fluid.

Rebecca Weiss, Respondent's Asset Protection Manager at its Harrisburg location, testified that she reviewed extensive camera footage in the storage area Petitioner was working during the timeframe in question. She did not view any evidence of the incident as described by Petitioner. She believed there were cameras positioned in about 90% of the storage area aisles, but cameras were not always on both ends of the aisles. Petitioner testified that at the time of his work accident, candy was being stored in multiple aisles, and not just in the typical candy storage aisle, as Valentine's Day was approaching, and there was an abundance of candy in storage in preparation for that holiday. Ms. Weiss confirmed that Respondent sold a large amount of candy during the time leading up to Valentine's Day. Ms. Weiss also testified that if there was footage that existed and that was not reviewed that depicted Petitioner's accident, it would have been deleted by the time of trial. Petitioner viewed the surveillance in

question, and agreed that it did not show his accident. He testified that the storage area was quite large, and further confirmed Ms. Weiss' testimony that there were not cameras positioned on every aisle in the storage room.

CONCLUSIONS OF LAW

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

The Arbitrator finds the testimony of Petitioner to be credible. Petitioner testified that on February 1, 2012, at approximately 1:00-1:30 a.m., he injured his left shoulder while performing his work duties with Respondent. Petitioner testified that he was on a ladder in the storage area and was reaching into a box of candy. Petitioner indicated that the box was on an upper shelf and caused Petitioner to reach across his body and overhead in order to retrieve the items from the box. Additionally, Petitioner testified that the flaps of the box were positioned downward, causing friction when pulling the items out of the box. There were no witnesses to the accident and Petitioner's testimony regarding the accident was unrebutted.

Petitioner testified that he continued to work on that date but with pain. Petitioner testified that after the time of the accident his left arm began to draw up and use of his left arm became limited. Petitioner thereafter presented to his primary care physician and continued to treat for pain associated with his left shoulder up to the time of his release from Dr. McIntosh and physical therapy.

Respondent submitted various surveillance footage of the storage area in question on or about the date of the accident, none of which depicted the accident. The Arbitrator does not find the surveillance videos submitted by Respondent to be persuasive in denying that the accident as described by Petitioner occurred. Respondent's witness, Ms. Weiss, testified that the videos submitted were not exhaustive and there may in fact have been other videos from the date in question which were not submitted in to evidence and which potentially could have shown the accident as described by Petitioner. Petitioner's credible testimony, coupled with the medical evidence, reveals that an accident did in fact occur on February 1, 2012.

The Arbitrator concludes that the accident as described by Petitioner as occurring on February 1, 2012 was an accident which arose out of and in the course of Petitioner's employment with Respondent.

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The Arbitrator finds the opinion of Petitioner's primary treating physician, Dr. McIntosh, to be credible, and hereby adopts his opinions. Dr. McIntosh diagnosed Petitioner with a partial tear of the rotator cuff, glenoid labral tear and biceps tendon tear, and after conservative measures failed, Dr. McIntosh performed a left shoulder arthroscopy, debridement of a partial rotator cuff tear, debridement of a labral tear, and a biceps tenotomy and tendodesis. Dr. McIntosh opined that Petitioner's condition and the need for surgery that he performed were related to the accident of February 1, 2012.

The Arbitrator is not persuaded by the opinions of Respondent's examining physician in regard to the issue of causal connection. At the time Dr. Nogalski evaluated Petitioner, Dr. McIntosh had not yet performed surgery and had not provided his pre-operative diagnoses as indicated in his operative report dated September 17, 2012.

Based on the foregoing, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

The Arbitrator concludes that all of the medical treatment provided to Petitioner's left shoulder condition was reasonable and necessary, and that Respondent is responsible for payment of the medical bills associated therewith. Respondent shall therefore pay reasonable and necessary medical services as identified in Petitioner's Exhibit 15, as provided in Sections 8(a) and 8.2 of the Act.

Issue (K): What temporary benefits are in dispute? (TTD)

Petitioner was off of work from September 17, 2012 through December 12, 2012, for which he was not paid any TTD benefits. This period of time represents the date of surgery through the date of the full duty release by Dr. McIntosh. Based upon the finding that Petitioner's accident arose out of and in the course of his employment with Respondent and that Petitioner's condition of ill-being is causally related to said accident and that Petitioner's treatment was therefore causally related to said accident, Respondent shall pay to Petitioner TTD benefits for the aforementioned period. The parties stipulated that the credit Respondent asserted for TTD benefits paid was for a prior period of TTD, and not the period at issue. Therefore, no credit is applied to the foregoing TTD award.

Issue (L): What is the nature and extent of the injury?

Petitioner's date of accident falls after September 1, 2011, and therefore Section 8.1b of the Act shall be discussed concerning the permanent partial disability (PPD) award being issued.

Concerning Section 8.1b(b)(i) of the Act (reported level of impairment per the AMA Guides), Dr. Nogalski concluded Petitioner's impairment rating to be 3% of the left upper extremity. Some weight is placed on this factor when determining the permanency award.

With respect to Section 8.1b(b)(ii) of the Act (Petitioner's occupation), the Arbitrator notes that Petitioner worked as an inventory management employee for Respondent. Petitioner's duties would require him to move large boxes, get up and down off of ladders, and use his shoulder and arms on a regular basis. Petitioner has difficulty lifting his left arm overhead and still experiences pain in his left arm, shoulder, bicep and hand. Since his termination from Respondent's employ, Petitioner works at a car wash, where he makes change for customers and sprays tires with cleaning fluid. While Petitioner likely is using his arms much less with his current job versus his job with Respondent, he nonetheless uses his arms with his job duties, and the Arbitrator gives weight to this factor when determining the PPD award.

Concerning Section 8.1b(b)(iii) of the Act (Petitioner's age at the time of injury), Petitioner was 42 years old at the time of the accident. The Arbitrator considers Petitioner to be a somewhat younger individual and concludes that Petitioner's PPD will be moderately greater than that of an older individual because Petitioner will have to live and work with the consequences of the injury for a longer period of time. The Arbitrator places some weight on the factor of age in determining the PPD award.

Regarding Section 8.1b(b)(iv) of the Act (Petitioner's future earning capacity), Petitioner testified he currently works at a car wash. No evidence was established regarding whether Petitioner's earning capacity has been affected by this injury, and therefore no weight is afforded this factor.

Finally, with regard to Section 8.1b(b)(v) of the Act (evidence of disability corroborated by Petitioner's treating medical records), the Arbitrator notes that Petitioner has sustained permanent partial disability to the left shoulder. Petitioner had multiple injections to the left shoulder and attended physical therapy before ultimately

undergoing a left shoulder arthroscopy, debridement of a partial rotator cuff tear, debridement of a labral tear, and a biceps tenotomy and tenodesis. The post-operative diagnosis was a partial tear of the rotator cuff, a glenoid labral tear, and a biceps tendon tear. Petitioner testified that he currently experiences pain in his left arm, shoulder, bicep and hand. He is unable to lift overhead without difficulty and is unable to perform many of the activities that he once could before the accident, such as lifting weights and playing the guitar. As stated earlier, the Arbitrator found Petitioner to be a credible witness at trial who testified in an open and forthcoming manner. Great weight is placed on the foregoing factor when determining the PPD award.

The determination of PPS is not simply a calculation but an evaluation of all five of the aforementioned factors stated in Section 8.1b of the Act. In making a PPD evaluation, consideration is not given to any single factor as the sole determinant. Applying Section 8.1b of the Act, the Arbitrator finds that Petitioner sustained the 10% loss of use to the person as a whole as a result of his work injury.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF DU PAGE	)	

[X] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathleen Murray,

Petitioner,

vs. NO: 09 WC 34281

15IWCC0150

Globe Union Services, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 25, 2013, 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.

15IWCC0150

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,500.00. 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: FEB 2 6 2015
TJT:yl
o 2/2/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

MURRAY, KATHLEEN Case# **09WC034281**
Employee/Petitioner

GLOVE UNION SERVICES INC 15IWCC0150
Employer/Respondent

On 9/25/2013, 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 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1559 LAW OFFICE OF JAMES P LEAHY
1275 DAVIS RD
SUITE 131
ELGIN, IL 60123

2837 LAW OFFICES OF THADDEUS J GUSTAFSON
WILLIAM A DELANEY
2 N LASALLE ST SUITE 2510
CHICAGO, IL 60602

15IWCC0150

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 DECISION

Kathleen Murray
Employee/Petitioner

Case # 09 WC 34281

v.

Globe Union Services, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of Wheaton on June 5, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD

L. ☒ What is the nature and extent of the injury?

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other

15IWCC0150

FINDINGS

On **January 15, 2007**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $ **119,600.00**; the average weekly wage was $ **2,300.00**.

On the date of accident, Petitioner was **31** years of age, *single* with **2** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**0** 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 $ **41,125.37** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of $ 619.97/week for a further period of 125 weeks, as provided in Section 8(d)(2) of the Act, because the injuries sustained caused 25% loss of the person-as-a-whole.

Respondent shall pay Petitioner compensation that has accrued from 01-15-07 through 06-05-13, and shall pay the remainder of the award, if any, in weekly payments.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

09-23-13
Date

ICArbDec

SEP 25 2013

ARBITRATOR FINDINGS

Statement of Facts

Petitioner, Kathleen Murray, testified that she has been employed as a sales representative for the respondent bathroom fixture company for many years. On January 15, 2007 petitioner injured her low back while lifting a sample fixture weighing approximately 100 pounds. On January 22, 2007, a MRI of the lumbar spine showed a very large herniated disc at L4-5 with an extruded fragment causing nerve root impingement. On March 10, 2007, Dr. Christopher Bergin performed a laminotomy and discectomny at L4-5. Petitioner underwent physical therapy through May 31, 2007.

Petitioner returned to work a short time after the surgery, but was limited to working from home. By mid-May 2007, petitioner resumed her normal job, which requires extensive travel to China (4 times a year), Europe and North America. Petitioner has worked full-time, full-duty since mid-May 2007.

Petitioner returned to Dr. Bergin on September 25, 2007. Dr. Bergin noted that petitioner had been doing quite well until the last month or so when she had increasing back pain. Petitioner underwent nine physical therapy sessions between October 17, 2007 and November 17, 2007.

In June 2008, petitioner was seen by Dr. Alexander Ghanayem at Loyola for low back pain and completed nine physical therapy sessions at Athletico between June 27, 2008 and August 1, 2008.

On January 6, 2009, petitioner returned to Dr. Bergin complaining of severe and incapacitating low back pain. A MRI of the lumbar spine was completed on January 12, 2009 that showed significant interval improvement at L4-5. A discogram was completed on January 30, 2009. The discogram indicated that disc degeneration at L4-5 was contributing to the petitioner's pain complex. Petitioner returned to physical therapy on September 18, 2009 attending 13 sessions and missing nine through November 26, 2009

Petitioner's next treatment for her low back was between June 23, 2011 and September 8, 2011 when she underwent 20 physical therapy sessions and saw Dr. Bergin on August 16, 2011 at which time surgical options were discussed.

Petitioner has not returned to a doctor or physical therapy since September 2011.

Medical records submitted into evidence from before the January 15, 2007 work accident reveal that in March 2005 the petitioner developed low back pain radiating down the right leg with occasional numbness after a lifting a heavy object. In August 2005, petitioner visited the emergency room reporting that she had been experiencing low back pain after lifting her 29 pound daughter. On November 25, 2005, the petitioner complained of low back pain mentioning that she had intermittent flare-ups.

The first medical record following the work accident on January 15, 2007 notes that the petitioner has had right-sided low back pain radiating into her right buttocks for 3½ years with periodic flare-ups. On February 6, 2007, Dr. Bergin stated that the petitioner had low back pain radiating into both legs, right greater than left, for 1½ years. The problem worsened midway through a pregnancy in 2006 to the point where the low back pain became severe; she had difficulty walking and felt weakness in her right foot. Petitioner testified she gave birth to a child seven weeks before the January 15, 2007 work accident.

Petitioner did not contest the statements in the medical records concerning her back pain and problems before the work accident.

CONCLUSIONS OF LAW

Issue F: Is Petitioner's current condition of ill-being causally related to the injury?

It is the employee's burden to establish all the elements of his case by a preponderance of the credible evidence including whether Petitioner's current state of ill-being is causally related to the alleged work accident. Causal connection cannot be premised upon imagination, speculation or conjecture but must arise from the facts established by a preponderance of the evidence. *Illinois Bell Telephone Co. v. Industrial Commission*, 265 Ill.App.3d 681, 685, 638 N.E.2d 307, 310 (1st Dist. 1994).

The petitioner admits that she had significant low back pain and radiating problems into her right lower extremity dating back to March 2005. The petitioner's testimony and medical records show that petitioner has had periodic flare-ups of her low back pain since March 2005. The Arbitrator finds that the work accident of February 15, 2007 was an aggravation of her pre-existing conditions in the lumbar spine. With regard to the low back problems experienced by petitioner thereafter; the Arbitrator concludes that petitioner did not meet her burden of proving that her current condition of ill-being is causally related to the work accident.

Issue L: What is the nature and extent of the injury?

The Arbitrator finds that the nature and extent of petitioner's injury to her lower back is 25% loss of the person as a whole.

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☒ Affirm with correction of computational errors	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WINNEBAGO	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Julie Cassano,

Petitioner,

vs. NO: 13 WC 359

15IWCC0151

Lifetouch, 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 accident, causal connection, extent of temporary total disability, medical expenses and prospective medical care and being advised of the facts and law, corrects the computational errors 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 (1980).

The Commission notes that both Petitioner and Kristi Crosby testified that the cart they were moving just stopped. Mr. Crosby was pulling the cart and Petitioner was pushing the cart. When the cart stopped, the left side of Petitioner's body went one way and her right leg twisted, sustaining a right knee injury. It is unknown why the cart stopped. There is no question that Petitioner was a traveling employee and it was foreseeable she would be performing the specific function of her job when she was injured. Petitioner was performing a work related task when this occurred.

The Commission corrects the computational errors in the calculation of the TTD periods. The Arbitrator found TTD from December 19, 2012 through January 19, 2013 (a period of 4-4/7 weeks) and from February 4, 2013 through February 20, 2013 (a period of 2-3/7 weeks) and from January 13, 2014 through January 22, 2014 (a period of 1-3/7 weeks), The periods of TTD total 8-3/7 weeks, not the 11-1/7 weeks awarded. The Commission corrects the total TTD period to 8-3/7 weeks at $307.62 per week. The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 8, 2014 is hereby affirmed and adopted with the above noted computational corrections.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $307.62 per week for a period of 8-3/7 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 $3,755.68 for temporary partial incapacity for work under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $44,008.93 for under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical care and orders Respondent to authorize and pay for a repeat right knee MRI and all further treatment that may result or stem from that examination or test.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

15IWCC0151

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50.500.00. 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: FEB 2 7 2015
MB/maw
o01/22/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) DECISION OF ARBITRATOR

CASSANO, JULIE
Employee/Petitioner

Case# **13WC000359**

15IWCC0151

LIFETOUCH INC
Employer/Respondent

On 7/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1131 GESMER LAW OFFICES PC
BRAD A REYNOLDS
630 N CHURCH ST SUITE 201
ROCKFORD, IL 61101

2337 INMAN & FITZGIBBONS LTD
KEVIN DEUSCHLE
33 N DEARBORN SUITE 1825
CHICAGO, IL 60602

15IWCC0151

STATE OF ILLINOIS	)	
	)SS.	
COUNTY OF WINNEBAGO	)	

- ☐ Injured Workers' Benefit Fund (§4(d))
- ☐ Rate Adjustment Fund (§8(g))
- ☐ Second Injury Fund (§8(e)18)
- ☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JULIE CASSANO,
Employee/Petitioner

v.

LIFETOUCH, INC.,
Employer/Respondent

Case # 13 WC 00359

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 **Joann M. Fratianni**, Arbitrator of the Commission, in the city of **Rockford**, on **April 9, 2014**, and in **Woodstock**, on **May 7, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to Respondent?

F. ☐ Is Petitioner's current condition of ill-being causally related to the injury?

G. ☐ What were Petitioner's earnings?

H. ☐ What was Petitioner's age at the time of the accident?

I. ☐ What was Petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. ☒ Is Petitioner entitled to any prospective medical care?

L. ☒ What temporary benefits are in dispute?
☒ TPD ☐ Maintenance ☒ TTD

M. ☐ Should penalties or fees be imposed upon Respondent?

N. ☐ Is Respondent due any credit?

O. ☐ Other: ______________________

FINDINGS

On the date of accident, **December 11, 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 **$23,994.88**; the average weekly wage was **$461.44**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **1** dependent child.

Petitioner ***has in part*** received all reasonable and necessary medical services.

Respondent ***has in part*** 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, and under Section 8(a) of the Act.

ORDER

Respondent shall pay to Petitioner temporary total disability benefits of **$307.62/week** for **11-1/7** weeks, commencing **December 19, 2012** through **January 19, 2013,** again commencing **February 4, 2013** through **February 20, 2003,** again commencing **January 13, 2014** through **January 22, 2014,** as provided in Section 8(b) of the Act.

Respondent shall pay to Petitioner temporary partial disability benefits of **$230.69/week** for **16-2/7** weeks, commencing **January 20, 2014** through **February 3, 2013,** again commencing **February 21, 2013** through **May 18, 2013,** again commencing **March 9, 2014** through **April 19, 2014,** for a total amount of **$3,755.68,** as provided in Section 8(a) of the Act.

Respondent shall pay to Petitioner the cost of reasonable and necessary medical services, pursuant to the Medical Fee schedule, in the amount of **$44,008.93**, as provided in Section 8(a) and 8.2 of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for 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 JOANN M. FRATIANNI

June 30, 2014
Date

ICArbDec19(b)

JUL 8 - 2014

15IWCC0151

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

Petitioner works for Respondent as a photographer. Respondent's main location or headquarters is in Loves Park, Illinois. Petitioner testified she would frequent headquarters 4-5 times per week performing work on the computer, stopping in to pick up her job assignments, job bags and camera equipment. Petitioner testified her job duties included traveling from Respondent's headquarters. Such travel included trips to schools to take spring photos, class photos, sports team photos and special events photos. Petitioner testified she traveled as far as Waukegan, Illinois to take school photos. Respondent would pay Petitioner hourly while she traveled to and from her job assignments, and paid for gas for travel to and from her work assignments. Petitioner worked in such a capacity for Respondent for 8 years.

On December 11, 2012, Petitioner drove to Respondent's headquarters where she picked up her job bag, cart and camera equipment. Petitioner then drove from headquarters to Belvidere South Middle School where she was to take winter sports photos. Petitioner arrived at the school premises at 2:45 p.m. and parked in the visitor's lot. She then proceeded to load her cart with the camera equipment. Petitioner testified she met a co-employee, Ms. Kristi Crosby, at the school. Ms. Crosby assisted Petitioner in loading the cart with equipment and pushing it into the building. Petitioner testified she loaded two cameras, 2 car mono lights, 2 light stands and her moneybag onto the cart. The cart had 4 wheels and according to Petitioner weighed approximately 20 pounds empty. With the loaded equipment, she estimated the cart weighed between 100-150 pounds on that date. Petitioner testified it was easier to maneuver and push the cart with all the equipment by pushing it with one person in the front and the other in the back. Petitioner took photos and testified they accurately portrayed how much work equipment was loaded on her cart on December 11, 2012. (Px11)

Petitioner testified that she and Ms. Crosby completed the photo assignment at the school approximately at 4:00 p.m. After the job was completed, she gathered the money received into the moneybag and loaded up the cart with all the equipment that was previously brought inside. Petitioner and Ms. Crosby then pushed the cart outside into the visitor's parking lot area towards her car. Petitioner testified the job bag was over her shoulder and right arm and that the cart was being pushed on blacktop. The bag was filled with money and was 16 inches by x 12 inches in size. Petitioner testified she leaned over with her right hand on the cart touching the bar of the cart. The cart stopped suddenly and she fell to her left and twisted her right knee in the opposite direction. Petitioner testified her right knee felt like "rubber" and she experienced pain after she fell.

Petitioner testified the fall took place approximately 10 feet from where her car was parked. Petitioner testified it was dark outside when she and Ms. Crosby exited the building with the only lighting by the entrance to the gym. She described the parking lot as being poorly lit. There was no precipitation on the ground and the blacktop was flat. Petitioner testified she did not detect any holes. Petitioner testified the wheels had a locking mechanism in the front and would often lock up while being pushed. Petitioner testified she did not know what caused the cart to stop at the time of her fall.

Ms. Crosby then assisted Petitioner in getting up and drove her to the emergency room of St. Anthony's Hospital.

Ms. Crosby testified that she is a photographer employed by Respondent. She arrived at Belvidere South Middle School around 3:00 p.m. where she met Petitioner on December 11, 2012. Ms. Crosby then assisted Petitioner in loading the cart with 2 lights, 2 cameras, 2 bags and 2 light stands, and assisted her in taking the cart inside the school building. Ms. Crosby testified the photo session was completed around 5:00 p.m. After the cart was reloaded, Petitioner and Ms. Crosby pushed the cart outside and onto the blacktop. Ms. Crosby estimated the loaded cart weighed 100 pounds.

15IWCC0151

Ms. Crosby testified she was pulling the cart from the front and Petitioner was pushing from the back. Ms. Crosby testified the cart stopped suddenly and she turned around and saw Petitioner lying on the ground. Ms. Crosby testified she had her back towards Petitioner at the time of the fall and that it was dark outside at the time. The only lighting in the visitor's parking lot was by the gym door entrance. Ms. Crosby testified the fall occurred approximately 10 feet from Petitioner's car, and approximately 50 feet from the school building. Ms. Crosby testified she did not know why the cart stopped.

Based upon the above, the Arbitrator find that Petitioner sustained an accidental injury that arose out of and in the course of her employment with Respondent on December 11, 2012. It is undisputed that Petitioner's employment required her to travel. A traveling employee is defined as an employee who is required to travel away from the employer's premises in order to do his job, *Chicago Bridge and Iron, Inc. v. Industrial Commission,* 248 Ill.App.3d 687, 188 Ill.Dec. 573, 618 N.E.2d 1143 (1993). It is not necessary for an individual to be a traveling salesman or company representative who covers a large geographic area in order to be considered a traveling employee, *Wright v. Industrial Commission,* 62 Ill.2d 65, 338 N.E.2d 379 (1965). Petitioner in this case testified she spent 4-5 days each week on the road for Respondent driving to various schools in carrying out her job duties as a photographer. Respondent offered no evidence to contradict this testimony.

The Arbitrator also does not find it significant that the fall occurred after she left the school building and while on her way to her car in the visitor's parking lot so she could unload the equipment and then drive home. As a traveling employee, she is in the course of her employment from the time she leaves home until her return. The test is both reasonableness of her actions and whether such acts are foreseeable by her employer. Here, her actions in loading and pushing the filled cart cannot be considered unreasonable and it would be foreseen by a reasonable person that such activities in that location at that time could lead to an injury.

Even if the Petitioner were not considered a traveling employee, the Arbitrator would still find that she would have met her burden of proof in proving that she sustained an accidental injury that arose out of and in the course of her employment by Respondent on December 11, 2012. Respondent argues that no defect existed in the parking lot area where the fall occurred and that the fall was thus idiopathic in nature. Respondent further argues there was no increased risk to the Petitioner in this matter created by her work duties. The lack of identification of a defect in a dark parking lot while pushing a 100 pound cart is not fatal to this claim based on the facts presented during trial.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner incurred charges from the following medical providers after this accidental injury that she introduced into evidence:

Freeport Memorial Hospital	$38,280.03
FHN Physicians	$ 5,471.90
Orthopedic & Arthritis Clinic	$ 257.00

These charges total $44,008.93.

See findings of this Arbitrator in "C" above. The parties both stipulated that a causal relationship exists between the condition of ill-being complained of and this accidental injury.

15IWCC0151

Dr. Pietro Tonino performed an examination at the request of Respondent to the right knee of Petitioner on June 6, 2013. Dr. Tonino reviewed certain medical records including photographs of the surgery performed on January 23, 2013. Dr. Tonino was of the opinion that the medical treatment rendered to date was reasonable, necessary and appropriate for the clinical condition found. On April 28, 2014, Dr. Tonino performed a second examination at the request of Respondent and reached the same conclusions. (Px5)

Dr. Tonino noted medial joint line tenderness with equivocal McMurray test. X-rays revealed evidence of a fracture line and questionable bipartite patella. Dr. Tonino diagnosed right knee pain, possible meniscus tear and questionable patella fracture, and felt that she had not reached maximum medical improvement. Dr. Tonino recommended an updated right knee MRI with light duty restrictions that prohibited squatting, twisting, climbing, kneeling, and no lifting above 20 pounds.

Petitioner testified her right knee continues to bother her and describes pain as being 6 out of 10 at rest. She rates the pain at 8 while walking, kneeling or squatting. Dr. Draxsinger, her surgeon, has placed her on a light duty restriction of no standing for more than 4 hours daily effective March 13, 2014.

The medical evidence reflects that initial right knee arthroscopic surgery was performed by Dr. Draxsinger on May 23, 2013 in the form of an arthroscopic procedure consisting of a partial right lateral meniscectomy. On January 13, 2014, Dr. Draxsinger performed additional surgery in the form of an arthroscopy. During surgery he found evidence of osteoarthritis and a partial meniscal tear to the lateral side. Petitioner's treatment in addition to the two surgical procedures has primarily consisted of steroid injections and physical therapy.

Based upon said findings, Respondent is further found to be liable for the above medical charges, as they represent reasonable and necessary medical care designed to cure or relieve the condition of ill-being caused by this accidental injury.

K. Is Petitioner entitled to any prospective medical care?

See findings of this Arbitrator in "C" and "J" above.

Based upon the findings of Dr. Tonino, Respondent is ordered to authorize and pay for a repeat right knee MRI including all further treatment that may result or stem from that examination or test.

L. What temporary benefits are in dispute?

See findings of this Arbitrator in "C" and "J" above.

Having found accident in this matter, and based upon the medical evidence presented, the Arbitrator finds that as a result of this accidental injury, Petitioner is entitled to receive temporary total disability benefits from Respondent commencing December 19, 2012 through January 19, 2013, from February 4, 2013 through February 20, 2013 and from January 13, 2014 through January 22, 2014.

15IWCC0151

In addition, Respondent is found to be liable to Petitioner for temporary partial disability benefits commencing January 20, 2013 through February 3, 2013, from February 21, 2013 through May 18, 2013 and from March 9, 2013 through April 19, 2014. The Arbitrator finds that Respondent accommodated Petitioner's restrictions for these periods of time.

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

Anthony Navarro,
Petitioner,

vs.

NO: 97 WC 47524
97 WC 47525
04 WC 45847

Chicago Park District,
Respondent.

15IWCC0152

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 and permanency 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 exception noted below.

The parties are in agreement that the Arbitrator's award of $42,293.39 is in error and the correct amount is $39,536.39. The Commission further finds that Petitioner is entitled to any and all medical bills related to his back injury which arose out of the February 27, 1997 and April 28, 1997 work accidents. In turn, Respondent is entitled to any credit for the medical bills that have been pain in regard to Petitioner's back injury so long as the same is subject to Sections 8 and 8.2 of the Illinois Workers' Compensation Act. Petitioner is not entitled to any medical bills related to the alleged right shoulder injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 4, 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 in regard to Petitioner's back condition, 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: FEB 2 6 2015

MB/jm

O: 2/5/15

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NAVARRO, ANTHONY
Employee/Petitioner

Case# **97WC047524**
04WC045847
97WC047525

CHICAGO PARK DISTRICT AND DAN RUTHERFORD STATE TREASUER AND EX-OFFICIO CUSTODIAN OF THE RATE ADJUSTMENT FUND
Employer/Respondent

15IWCC0152

On 8/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

1747 STEVEN J SEIDMAN LAW OFFICE
TWO FIRST NATIONAL PLAZA
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

1946 CHICAGO PARK DIST LAW DEPT
LEON W PAWLYCOWYCZ
541 N FAIRBANKS COURT 3RD FL
CHICAGO, IL 60611

15IWCC0152

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

- [ ] Injured Workers' Benefit Fund (§4(d))
- [x] Rate Adjustment Fund (§8(g))
- [ ] Second Injury Fund (§8(e)18)
- [ ] None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Anthony Navarro
Employee/Petitioner

v.

Chicago Park District and
Dan Rutherford, State Treasurer and
Ex-Officio Custodian of the Rate Adjustment Fund
Employer/Respondent

Case # **97** WC **47524**

Consolidated cases: **97 WC 47525**

04 WC 45847

An *Application for Adjustment 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 **March 26, 2014 and April 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other

FINDINGS

On **February 27, 1997, April 28, 1997, and April 16, 2002**, Respondent *was* operating under and subject to the provisions of the Act.

On **February 27, 1997 and April 28, 1997**, an employee-employer relationship *did* exist between Petitioner and Respondent.

On **February 27, 1997 and April 28, 1997**, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of the accidents of **February 27, 1997 and April 28, 1997** *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accidents of **February 27, 1997 and April 28, 1997.**

In the year preceding the injury of **February 27, 1997 and April 28, 1997**, Petitioner earned $ **50,696.36**; the average weekly wage was $**974.93**.

On the dates of accident **February 27, 1997 and April 28, 1997**, Petitioner was **45** years of age, *single* with **1** dependent child.

Petitioner *has* received all reasonable and necessary medical services.

Respondent *has not* paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**572,355.84** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**572,355.84**.

Respondent is entitled to a credit of $**0** under Section 8(j) of the Act.

ORDER

No benefits are awarded for the claim filed under case number 04 WC 45847, because Petitioner did not give timely notice of his April 16, 2002 accident to Respondent.

Respondent shall pay Petitioner temporary total disability benefits of $**649.95**/week for **879 2/7**ths weeks, commencing **April 29, 1997** through **March 26, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **April 29, 1997** through **March 26, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $**572,355.84** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $**42,293.39**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for all medical benefits that have been paid.

Respondent shall pay Petitioner permanent and total disability benefits of $**649.95**/week for life, commencing **March 27, 2014**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) 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.

Milton Black
Signature of Arbitrator

August 4, 2014
Date

AUG - 4 2014

FINDINGS OF FACT

Case No. 97 WC 047524
Case No. 97 WC 047525

Petitioner Anthony Navarro is a male who was 45 years old when he re-injured a prior back injury at work on February 27, 1997. He was released back to work with restrictions when he suffered a second re-injury on April 29, 1997. (T. 64.)

Petitioner has had no subsequent accidents involving his back. (T. 58-59.) Petitioner's medical treatments prior to October 2007 were paid for by Petitioner's wife's health insurance carrier. (T. 67.)

A prior hearing on 97 WC 047524 and 97 WC 0475245 occurred on October 23, 2007. Past medical bills, TTD, maintenance, nature and extent and 8(j) credits were not before the arbitrator for adjudication at that time, as they were held in abeyance by stipulation of the parties. (A1 2007; A2 2007.) The parties stipulated that on both April 28, 1997 and February 27, 1997: (1) Petitioner and Respondent were operating under the Workers' Compensation Act; (2) Petitioner and Respondent had an employer-employee relationship; and (3) Petitioner sustained accidental injuries arising out of his employment. (A1 2007; A2 2007.) As it was an emergency proceeding on interim benefits, causal connection and prospective medical benefits were the only disputed issues to be decided at that time. (A1 2007; A2 2007.)

In a decision filed on December 12, 2007, the arbitrator found that Petitioner's condition of ill-being was causally related to his workplace accidents, and that he was entitled to prospective medical benefits including lumbar spine surgery recommended by Dr. Luken. (Decision of the Arbitrator, December 12, 2007.) This decision was affirmed and adopted in its entirety by the Commission on August 15, 2008.

Petitioner visited Dr. Luken on June 28, 2010. Petitioner continued to complain of considerable right groin and leg pain with any protracted sitting or other exertions, though Petitioner stated he did not have difficulty when walking considerable distances. Examination produced no clear change relative to past exams. Dr. Luken reviewed Petitioner's January 18, 2006 myelogram, and once again recommended lumbar reexploration and right-sided L4-L5 foraminotomy, subject to approval after consultation with Dr. Beck. (PX, 72.)

Petitioner underwent a lumbar x-ray on August 30, 2010, at Ingalls Memorial Hospital. The radiologist opined that there had been no change relative to Petitioner's x-ray of June 2, 2006. (PX, 81.)

At a final pre-operative visit with Dr. Luken on September 10, 2010, Petitioner's symptoms and clinical findings remained consistent. (PX, 71.)

On September 16, 2010, at Ingalls Memorial Hospital, Dr. Luken performed a lumbar re-exploration with right L4-L5 interlaminar laminotomy, partial facectomy, and foraminotomy with resection of ectopic ossification and L4 and L5 nerve root decompressions. Pre-operatively, Dr. Luken diagnosed Petitioner with right 5th lumbar compressive radiculopathy many years status post L4-L5 metallic cage interbody fusion. (PX, 216.)

In the operative report, Dr. Luken noted that he had recommended this surgery in the past due to suspicious results from Petitioner's contrast myelogram and CT scan of January 18, 2006, but that surgery was delayed due to difficulty obtaining authorization for the procedure, as well as from Petitioner's intercurrent cardiac problems necessitating a cardiac evaluation in January 2010. (PX, 217.)

Proceeding with the surgery, Dr. Luken exposed Petitioner's lumbar vertebrae and discovered "a large and impressive mass of bone within the neural foramen, consistent in appearance with either an exuberant osteophyte or ectopic ossification related to the patient's past fusion surgery." Dr. Luken removed the bone mass, leaving the L4 and L5 nerve roots free of mechanical impingement. Post-operatively, Dr. Luken added "Marked ectopic ossification within the right L4-L5 neural foramen" to Petitioner's diagnosis. (PX, 216-17.)

The next day, Petitioner underwent an acute physical therapy evaluation. Petitioner complained of soreness in his back, in the incisional area, and in his big toe; he was found to have limited active range of motion in his hips and knees bilaterally due to pain. (PX, 325.) Petitioner was assessed with upper extremity weakness, lower extremity weakness, impaired balance, gait impairment, and pain. (PX, 326.)

Petitioner was discharged on September 18, 2010 with extensive restrictions, including restrictions against bending or twisting, reaching overhead, pushing or pulling heavy objects, or sitting for more than 45 minutes consecutively. (PX, 345.)

Petitioner followed up with Dr. Luken on October 1, 2010. Petitioner described substantial relief of his agonizing, chronic right leg pain, particularly when rising from a sitting position. He reported lower back stiffness and soreness, which seemed to be steadily resolving. Dr. Luken kept Petitioner off work and referred him to physical therapy. He stated: "it remains to be seen whether a return to any sort of gainful employment is in his future." (PX, 70.)

Petitioner began physical therapy at Maximum Rehabilitation. (T. 26.) His initial evaluation occurred on October 21, 2010; Petitioner complained of frequent, sharp, aching, predominantly right-sided lower back pain and leg pain between 6/10 and 8/10; severe stiffness; and intermittent tingling from his right thigh to his right toes. Upon examination, Petitioner was tender to palpation along the lumbar paraspinals. He was found to be ambulatory without any assistive device, though he exhibited gait deviation with decreased stance on his right lower extremity. Petitioner exhibited muscle weakness in his core, with guarding during trunk movement. He was found to have decreased tolerance and endurance in daily activities due to pain and muscle weakness. (PX, 138-39.)

On November 29, 2010, Petitioner returned to Dr. Luken. He reported substantial relief of his right-sided sciatica post-surgery, with the ability to sit and drive for prolonged periods without incapacitating right buttock and leg pain. (PX, 69.)

The next follow-up with Dr. Luken occurred on February 18, 2011. Petitioner reported very gradual improvement with physical therapy. He reported that his sciatica was much improved since his surgery, but that he had significant recurring pain if he "overdoes it." Dr. Luken kept Petitioner off work. (PX, 67.)

Dr. Luken examined Petitioner on follow-up on April 22, 2011. (PX, 65.) Dr. Luken noted that Petitioner was continuing to attend physical therapy three times per week, with improved comfort and only modest residual back pain and variable right-sided sciatica. (PX, 65.) On examination, there was no clear change to Petitioner's clinical findings. (PX, 65.)

PT with Maximum Rehab ended on May 4, 2011. (T. 31.) At this final session, Petitioner complained of pain and stiffness in his back at 6/10 with sitting and bending. He also reported sharp back pain during prolonged walking at the mall the day prior, but stated that it subsided in the morning. The therapist recommended continued physical therapy to improve mobility, increase strength and decrease pain. (PX, 97.)

An FCE was performed at Accelerated Rehabilitation Centers on May 9, 2011. (PX, 471.) The results were deemed valid and reliable, with Petitioner classified at light-medium duty indicative of occasional two-handed lift/carry of 25 pounds from floor-waist level, and a frequent two-handed lift of 13 pounds from floor-waist level. (PX, 471.) The job of plumber requires occasional lifting of up to 100 pounds and frequent lifting of up to 50 pounds. (PX, 510.)

Petitioner last saw Dr. Luken on May 27, 2011. (T. 31.) Petitioner reported that his right-sided L4-L5 foraminotomy had been followed by significant (though incomplete) relief of his long-standing right leg pain. (PX, 63.) However, Petitioner stated that the exertions involved in his FCE produced significant recurrent right leg pain comparable in degree to how the leg felt pre-surgery. (PX, 63.) Dr. Luken noted no clear change in Petitioner's clinical findings upon examination. (PX, 63.) Dr. Luken suggested that Petitioner undergo a second FCE, and indicated that he would not declare Petitioner to be at MMI before one year had elapsed post-surgery. (PX, 63.)

On August 31, 2011, Petitioner was examined by Respondent's Section 12 examiner, Dr. Jay Levin. (PX, 476; RX 24.) Dr. Levin subsequently reviewed Petitioner's medical records and authored a report giving his opinions on September 27, 2011. (RX 25.) The first three or four pages of Dr. Levin's report consist primarily of Dr. Levin recounting the events depicted in a surveillance CD. (PX, 476-79.) The individual surveiled in that CD was not the Petitioner, however. (PX, 505.) The remainder of the report summarizes the contents of various medical records from 1989 to 2006. (PX 479-501.)

In an addendum, Dr. Levin noted that the surveillance video that began his prior report was of the wrong individual. (PX, 506.) Dr. Levin stated that this did not change any of his opinions. (PX, 507.) He opined that Petitioner did not sustain an injury on April 28, 1997. (PX, 507.)

Petitioner continued physical therapy periodically through 2012. (T. 27.)

Petitioner continued to treat with a Dr. Keshava, practicing at the Pullman Clinic in the Chicago Health and Family Center. (T. 65.) Petitioner currently treats with Dr. Keshava. (T. 65.) Respondent stopped paying for Petitioner's medical care; it now pays only for Petitioner's hydrocodone and gabapentin prescriptions. (T. 65.) Dr. Keshava's practice is a free service associated with the County. (T. 65.)

On November 22, 2011, Petitioner saw Susan Entenberg of Rehabilitation Services Associates in November 22, 2011. (T. 44; PX, 508.) He stated that he could sit for 15 to 20 minutes, stand for 25 to 30 minutes, walk for 15 minutes, drive for 15-20 minutes, lift as much as a gallon of milk close to his body, climb a small number of steps slowly, and squat (but not a deep squat). He reported not being able to sleep for more than 3 hour intervals. (PX, 509.)

Entenberg stated that the job of plumber is classified as heavy in terms of exertional level, with occasional lifting of up to 100 pounds and frequent lifting of up to 50 pounds. She noted that Petitioner had no transferable skills within his restrictions, and that he had been out of the work force for 15 years. She opined that Petitioner could not return to his past job as a plumber, that he was not a candidate for vocational rehabilitation, and that no stable labor market existed for him. (PX, 510-11.)

Petitioner has a high school education, and completed a plumbing internship. (T. 30.) Petitioner has no computer skills. (T. 47.) Petitioner can speak some Spanish, though he is not fluent. (T. 57.) Petitioner worked as a plumber for the Chicago Park District starting in 1984. (T. 30.) He became a plumber after graduating high school. (T. 56.) It was a very heavy job; one has to perform a lot of lifting, extended kneeling, and one has to be able to bend, crawl and contort one's body. (T. 30-31.) Petitioner's employment with Respondent was terminated on April 18, 2000. (T. 48.) Petitioner has not had occasion to work since December of 2007. (T. 24.)

After his interview with Ms. Entenberg, Petitioner searched for work. (T. 45.) Because Petitioner has no computer skills, his son helped him with online job searches. (T. 47.) Petitioner contacted the positions listed on MedVoc's labor market survey. (T. 46.) Petitioner has submitted job search logs covering his searches throughout 2012, 2013 and 2014. (T. 46.) Petitioner's electronically submitted job applications alone stretch across more than 400 pages of the record. (PX, 551-976.) Petitioner has not received any interviews or calls back from the jobs he applied for. (T. 47-48.)

On January 16, 2012, Petitioner saw vocational rehabilitation counselor Jackie Ormsby of MedVoc Resources, Inc. at Respondent's request. (T. 56; PX, 526.) Ormsby composed a report on January 27, 2012 recommending that Petition complete a labor market survey. (PX, 526, 30.) In a follow-up report of February 20, 2012, Ormsby surveyed counter and rental clerk, security officer, service advisor, and miscellaneous positions. (PX, 539.) These jobs paid an average wage of $10.72 per hour. (PX, 547.) Ormsby opined that Petitioner's main hindrance to obtaining employment in these positions would be his age, not his physical limitations. (PX, 547.)

Petitioner was prescribed Hydrocodone (three doses per day) and Gabapentin (two 300-milligram doses per day) post-surgery. (T. 28-29.) These were prescribed for his back. (T. 49.)

Petitioner wears a back brace; he experiences pain after sitting for more than 15 or 20 minutes, or standing for 20 to 25 minutes. (T. 37-38.) Petitioner's back prevents him from sleeping for more than three hours at a time. (T. 32.) He suffers from leg pain and back stiffness. It takes Petitioner roughly one and a half to two hours to get moving freely and correctly in the morning. (T. 33.) Petitioner has a valid driver's license

and can drive. (T. 57.) He can only drive in 20 minute stretches, however; after 20 minutes, his back starts to bother him and his leg "burns like crazy," and he has to get out of the car. (T. 44.)

Petitioner stated that his surgery of September 16, 2010 helped him; it relieved some of the constant burning and numbness in his toes. (T. 33.) Before the surgery, it was excruciating, comparable to a constant toothache. (T. 33.) Petitioner had difficulty walking. (T. 34.) After the surgery, he was able to walk. (T. 34.) Petitioner can now walk for 15 minutes at a time. (T. 38.)

Petitioner can lift things that don't hurt his back throughout the day. (T. 36.) Petitioner can bend and twist only very little; he might be able to bend to reach things as low as 6 inches off the ground if he bends his knees. (T. 38.) He can navigate stairs and stepladders. (T. 39.)

Respondent hired private investigator Paul Rybicki of Smith Surveillance to surveil Petitioner. (T. 71-72.) On October 21, 2011, Rybicki observed Petitioner for eight hours with a handheld video camera. (T. 72-73.)

Petitioner testified that his garage roof had been damaged during a storm and sprung a large leak. Petitioner asked a friend who does construction work to come repair the roof for him. On October 21, 2011, Petitioner's friend arrived and asked him to show where on the roof the leak was. Petitioner climbed a ladder and swept some debris off the roof with a plastic push broom so he could pinpoint the leak and his friend could perform the repairs. (T. 35-36.)

Rybicki's DVD recording begins at 11:29 AM. Thereafter, it depicts Petitioner standing one or two steps below the top of an A-frame ladder, using a brush broom to sweep a sloped roof with both hands. (T. 79, 85.) There was another individual with Petitioner. (T. 85.) Petitioner was able to extend both arms out from his body, but there was little to no raising of his arm above the shoulder. (T. 78.) That occurred at 11:36 AM or so. (T. 86.) At 11:37 AM or so, Petitioner put the broom away and walked away. (T. 86.) Petitioner came back and swept the ground between 11:37 AM and 11:42 AM. (T. 86.) Petitioner was somewhat bent at the waist while sweeping the ground. (T. 86.) The video stopped and started, and was not continuous. (T. 86.)

At the hearing before the Arbitrator, Respondent stopped playback once the DVD reached 11:49 AM. (T. 79.) That was the full extent of the sweeping activities; Rybicki stopped recording after that point. (T. 85.)

Rybicki testified that he had no knowledge of Petitioner's physical restrictions, medical treatment, profession, or any functional capacity evaluations. (T. 81-82.) There was another individual besides Petitioner shown in the recording, but Rybicki does not know anything about him or what he and Petitioner discussed. (T. 83-84.) Rybicki estimates that Petitioner's broom weighed maybe one pound. (T. 85.)

From 6:00 AM until 11:29 AM, Rybicki did not observe Petitioner doing anything. (T. 81.) He did not observe Petitioner doing anything at any point during his eight-hour surveillance other than the 16-minute period between 11:29 AM and 11:45 AM. (T. 81, 83.) Rybicki surveiled Petitioner again on December 10, 2011, but observed nothing. (T. 80, 83.)

Case No. 04 WC 045847

A prior arbitration hearing on this case occurred on October 23, 2007, but was held in abeyance by stipulation of the parties. (Decision of the Arbitrator, December 12, 2007.)

On April 16, 2002, Petitioner was 50 years old, married with one dependent child. Petitioner was undergoing treatment at the Fitness Point Therapy unit in Munster, Indiana on April 16, 2002. (T. 40.) He was sent there for treatment related to his Workers' Compensation claims. (T. 60.) While performing aquatic exercise therapy with resistance paddles, Petitioner felt something pop in his right shoulder. (T. 40-41.) Petitioner felt immediate shooting pain running from his shoulder up to the back of his neck. (T. 41.)

Petitioner visited Dr. Luken for treatment of his shoulder injury; Dr. Luken referred Petitioner to Dr. Carobene. (T. 41.) Dr. Carobene performed injections and gave Petitioner pain medication. (T. 41.)

Petitioner then went to see Dr. Fuentes for his shoulder injury. Dr. Fuentes ordered a CT scan, then ordered physical therapy for Petitioner's shoulder. (T. 42.) Other than physical therapy, Petitioner has had no treatment for his right shoulder in the past four years. (T. 44.)

During Petitioner's appointment with Dr. Luken of February 18, 2011, Petitioner reported continued, considerable pain in his right shoulder. Dr. Luken referred Petitioner to Dr. Joseph Thometz for right shoulder treatment. (PX, 67.)

Petitioner currently has minimal use of his right arm; he testified that periodically, his hands cramp so badly that he loses the ability to move his fingers. Those symptoms manifest up to his elbow. (T 42-43.) Petitioner has pain from his right elbow up to his right shoulder so intense that he cannot use the arm; he uses a compression wrap to relieve the pain. (T. 43.) Petitioner currently cannot raise his right arm over his shoulder. (T. 43.) Petitioner is right-handed. (T. 43.)

CONCLUSIONS OF LAW

04 WC 45847

Was timely notice of the accident given to Respondent?

Respondent disputes that Petitioner gave timely notice of his April 16, 2002 accident. Petitioner testified that he did not give notice of his April 16, 2002 accident to Respondent. (T 53.) Petitioner's Application for Adjustment of Claim was filed on September 23, 2004; Proof of Service of the same was dated September 22, 2004, well outside the 45-day statutory period for notice.

The Arbitrator finds that Petitioner did not give timely notice of his April 16, 2002 accident to Respondent.

The remaining issues regarding this case number are moot.

For the foregoing reasons, no benefits are payable under case number 04 WC 45847.

Is Petitioner's current condition of ill-being causally related to the work accident?

97 WC 47524 and 97 WC 47525

Respondent disputes that Petitioner's state of ill-being is causally connected to Petitioner's accidents of April 28, 1997 and February 27, 1997. In the prior proceeding of October 23, 2007, the Arbitrator found that Petitioner's state of ill-being was causally connected to Petitioner's accidents of April 28, 1997 and February 27, 1997. (Decision of the Arbitrator, December 12, 2007). Petitioner's unrebutted testimony establishes that he has had no subsequent accidents involving his back. (T. 58-59.) The Arbitrator finds Petitioner's testimony as to his ongoing symptoms remains credible and consistent with the medical evidence.

Respondent has procured a new Section 12 examiner, Dr. Jay Levin. Dr. Levin's first report of August 31, 2011 contains no opinions or recommendations--Dr. Levin concluded this report by remarking that he would issue those at a later date after reviewing Petitioner's medical history. (RX24.) Dr. Levin issued these opinions in a subsequent report dated September 27, 2011, as well as in an addendum the following year.

In his report and addendum, Dr. Levin never offers any opinion on the issue of causation; rather, Dr. Levin opines that Petitioner did not suffer a workplace accident on April 28, 1997. (PX, 503.) The Arbitrator notes that Dr. Levin's opinion notwithstanding, Respondent has stipulated that a workplace accident *did* occur on April 28, 2010, both in this adjudication and in the adjudication of October 23, 2007. (A1; A2; A1 2007.) Insofar as Dr. Levin's opinions appear to concern an issue that is not contested in this proceeding, they are afforded no weight.

Further, the Arbitrator notes that Dr. Levin's reports rely upon medical evidence that was already weighed in prior proceedings. In his report of September 27, 2011, Dr. Levin merely reviews the exact same medical records that were already scrutinized in the previous adjudication of October 23, 2007, beginning with records from 1989 (PX, 479) and ending with a record dated November 16, 2006 (PX, 501).

"Under the law-of-the-case doctrine, the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit." This doctrine applies to Workers' Compensation Commission decisions--once the Commission issues a decision, that decision becomes the law of the case and controls subsequent proceedings.

In the prior proceeding of October 23, 2007, causal connection was one of two disputed issues to be ajudicated by the Commission. (A1 2007; A2 2007.) In a Decision of the Arbitrator dated December 12, 2007, the Arbitrator reviewed all of the medical evidence in the record, weighed it, and found that Petitioner had proven causal connection. The Arbitrator stated as follows:

> The Arbitrator finds that the petitioner is credible. The Arbitrator finds that the petitioner's credible testimony is corroborated by the medical testimony and the medical records. Although respondent disputes causal connection, none of respondent's doctors have overcome Dr. Luken's convincing opinions. The Arbitrator finds that petitioner is entitled to surgery as recommended by Dr. Luken.

(Decision of the Arbitrator, December 12, 2007). This decision was then affirmed and adopted in its entirety by the Commission on August 15, 2008.

Thus, the Commission has already weighed the medical evidence from prior to October 23, 2007, and on that basis, decided that Petitioner's condition of ill-being as of October 23, 2007, was causally connected to his work accidents of April 28, 1997 and February 27, 1997. The Respondent now presents a Section 12 report that

relies upon the exact same medical records that were already scrutinized, weighed, and utilized in the Commission's decision in the previous adjudication. The Arbitrator lacks jurisdiction to re-weigh this evidence. The question of how to weigh that evidence is already settled by decision of the Commission. It is the law of the case, and the Arbitrator may not re-decide it.

Petitioner's unrebutted testimony establishes that there has been no new accident since April 28, 1997. (T. 58-59.) There is no evidence of any incident that could have plausibly broken the chain of causation between October 23, 2007 and the hearing of March 26, 2014, and the Arbitrator may not re-weigh the evidence from prior to October 23, 2007.

The Arbitrator notes that the post-October 23, 2007 medical records in this case support a finding of continued causal connection. In Dr. Luken's surgical notes of September 16, 2010, Dr. Luken characterized Petitioner's condition as a continuation of Petitioner's condition as it existed post-accident and prior to October 23, 2007. Under "Indications for Procedure," Dr. Luken stated:

> Approximately 11 years ago Mr. Navarro underwent an L4-L5 interbody fusion using threaded metallic cages, and subsequently he enjoyed substantial symptomatic gains, though he was never was able to return to gainful employment.
>
> For the last few years he has experienced considerable right groin and leg pain with any protracted sitting or other exertions, though walking significant distances seems to cause him particular difficulty.
>
> ...
>
> We reviewed together the report of Mr. Navarro's contrast myelogram and CT scan performed on January 18, 2006 at the Neurologic and Orthopedic Institute of Chicago, demonstrating a suspicious area of calcified foraminal encroachment on the right at the L4-L5 level.

(PX, 76-77.) The surgery of September 16, 2010 removed that encroachment, caused by what Dr. Luken characterized as an "impressive mass of bone within the neural foramen, consistent in appearance with either an exuberant osteophyte or ectopic ossification related to the patient's past fusion surgery." (PX, 78.) All of Dr. Luken's subsequent medical records, in turn, document Petitioner's slow recovery from the September 16, 2010 surgery. (PX, 63-70.)

The only piece of new evidence that Dr. Levin reviewed for his September 27, 2011 report was a surveillance video--a video which did not actually depict the Petitioner. (PX, 506.) Clearly, footage of someone who is not the Petitioner cannot support a finding of no causal connection. Subsequently, Respondent provided Dr. Levin with surveillance footage from October 21, 2011 (this time actually depicting the Petitioner). Dr. Levin referenced this footage in his July 19, 2012 addendum to his report, asserting that his opinions remained unchanged because this new footage was "discrepant" with Petitioner's reports of his capabilities. (PX, 505-07.) However, the Arbitrator has reviewed the footage, and finds that it merely shows the Petitioner performing activities consistent with his testimony and his medical restrictions.

The DVD recording, created by private investigator Paul Rybicki, begins at 11:29 AM. Thereafter, it depicts Petitioner standing one or two steps below the top of an A-frame ladder, using a brush broom to sweep a sloped roof with both hands. (T. 79, 85.) Petitioner was able to extend both arms out from his body, but with

little to no raising of his arm above the shoulder. (T. 78.) That occurred at 11:36 AM or so. (T. 86.) At 11:37 AM or so, Petitioner put the broom away and walked away. (T. 86.) Petitioner came back and swept the ground between 11:37 AM and 11:42 AM. (T. 86.) Petitioner was somewhat bent at the waist while sweeping the ground. (T. 86.) The video stopped and started, and was not continuous. (T. 86.) Rybicki estimated that Petitioner's broom weighed maybe one pound. (T. 85.)

In short, the video shows nothing inconsistent with Petitioner's testimony about his own capabilities. Petitioner testified that he can lift things that don't hurt his back throughout the day. (T. 36.) Petitioner testified that he can bend and twist only very little; he might be able to bend to reach things as low as 6 inches off the ground if he bends his knees. (T. 38.) He testified that he can navigate stairs and stepladders. (T. 39.) He gave similar, consistent reports of his capabilities to his medical providers and to Susan Entenberg. The video does not contradict the Petitioner's accounts of his capabilities, and it in no way justifies a finding that Petitioner's back injuries are not causally related to his work accidents.

The Arbitrator further notes that this video footage showing 16 minutes of very mild physical activity was selected from numerous hours of footage. From 6:00 AM until 11:29 AM, Rybicki did not observe Petitioner doing anything. (T. 81.) Rybicki did not observe Petitioner doing anything at any point during his 8-hour surveillance other than those 16 minutes shown on the DVD. (T. 81, 83.) Rybicki surveiled Petitioner again on December 10, 2011, but observed nothing on that day. (T. 80, 83.)

The Arbitrator finds that Petitioner's current condition of ill-being is connected to his workplace accidents of April 28, 1997 and February 27, 1997.

Is the Respondent liable for unpaid medical bills?

97 WC 47524 and 97 WC 47525

In the prior proceeding of October 23, 2007, the Commission awarded Petitioner prospective medical benefits for 97 WC 47524 and 97 WC 47525.

The parties have stipulated that unpaid medical bills for 97 WC 47524 and 97 WC 47525 from prior to February 1, 2006 total $39,536.39. Additionally, Petitioner has submitted bills showing an additional balance of $2,757.00 outstanding for Petitioner's treatment between February 1, 2006 and October 23, 2007 at The Hammond Clinic and The Community Hospital. These bills were incurred as a result of treatment prior to the earlier decision, and held in abeyance by stipulation of the parties.

The parties have stipulated that there is no credit due to the Respondent for medical expenses.

The Arbitrator finds that the Petitioner's treatments prior to October 23, 2007 were reasonable and necessary. The Arbitrator awards Petitioner medical expenses totaling $42,293.39.

What temporary benefits are in dispute?

97 WC 47524 and 97 WC 47525

Respondent disputes that it owes Petitioner TTD benefits in 97 WC 47524 and 97 WC 47525. In each case, the parties have stipulated that the Petitioner earned $50,696.36 in the year preceding the injury, with an average weekly wage of $974.93. Petitioner claims that Petitioner has been temporarily totally disabled for 879 and 2/7 weeks (from April 29, 1997 to the date of hearing: March 26, 2014); Respondent contends that Petitioner reached MMI on July 19th, 2012 when he was examined by Dr. Levin.

As noted above, Dr. Levin opined that Petitioner did not suffer an accident, a position advocated by neither of the parties to this case. As such, the Arbitrator does not find his conclusions as to whether Petitioner required medical treatment for injuries suffered in said accident credible. The Arbitrator finds that Petitioner is entitled to the claimed TTD benefits for 879 and 2/7 weeks, for a total of $571,491.75 ($649.95 X 879 and 2/7 weeks). The parties have also stipulated that the Respondent has paid $572,355.84 in TTD, for which it is due a credit. The Arbitrator so finds.

What is the nature and extent of Petitioner's injuries?

97 WC 47524 and 97 WC 47525

The medical evidence establishes that Petitioner has been unable to work full duty since his date of accident, and that his disability is permanent in nature. This is consistent with Petitioner's credible testimony.

Petitioner was kept off work continually following his surgery of September 16, 2010. On October 1, 2010, Dr. Luken kept Petitioner off work and remarked: "it remains to be seen whether a return to any sort of gainful employment is in his future." (PX, 70.) With each examination after February 8, 2011, Dr. Luken stated that he was unable to demonstrate any clear change in Petitioner's condition. (PX, 63, 65.) Dr. Luken kept Petitioner off work as of his final visit on May 27, 2011, 8 months post-surgery. (PX, 63.)

Petitioner testified that he currently wears a back brace; he experiences pain after sitting for more than 15 or 20 minutes, or standing for 20 to 25 minutes. (T. 37-38.) Petitioner's back prevents him from sleeping for more than three hours at a time. (T. 32.) He suffers from leg pain and back stiffness. It takes Petitioner roughly one and a half to two hours to get moving freely and correctly in the morning. (T. 33.) Petitioner has a valid driver's license and can drive. (T. 57.) He can only drive in 20 minute stretches, however; after 20 minutes, his back starts to bother him and his leg "burns like crazy," and he has to get out of the car. (T. 44.) Petitioner was prescribed Hydrocodone and Gabapentin post-surgery; he takes these three times per day and two times per day, respectively. (T. 28-29, 49.)

It is undisputed that Petitioner has only a high school education and no computer skills. (T. 30, 47.) Petitioner began to work as a plumber for the Chicago Park District soon after graduating high school. (T. 56.) Petitioner has not had occasion to work since December of 2007. (T. 24.) Susan Entenberg credibly opined that Petitioner cannot meet the physical demands of his old position as a plumber, that he has no transferable skills within his restrictions, and that no stable labor market exists for him. (PX, 510-11.)

Although Jackie Ormsby opined that Petitioner could apply for counter / rental clerk, security officer, service advisor, and miscellaneous positions with an average wage of $10.72 per hour, Ormsby herself noted that Petitioner's age would hinder his ability to obtain employment in these positions. (PX, 539, 547.) Further, Petitioner's unrebutted testimony establishes that he did not receive any interviews--or even so much as a single

response--to his voluminous documented attempts at securing employment in these areas over the course of several years.

Therefore, the Arbitrator finds that Petitioner is totally permanently disabled.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐	Affirm and adopt (no changes)	☐	Injured Workers' Benefit Fund (§4(d))
☐	Affirm with comment	☐	Rate Adjustment Fund (§8(g))
☐	Reverse	☐	Second Injury Fund (§8(e)18)
☒	Modify down	☒	None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Myles Dubuclet,

Petitioner,

vs. NO: 12 WC 27449

15IWCC0153

W.E. O'Neil,

Respondent.

DECISION AND OPINION ON REVIEW

Respondent appeals the Decision of Arbitrator Hegarty in a §19(b) proceeding finding that as a result of accidental injuries arising out of and in the course of his employment on July 9, 2012, Petitioner was temporarily totally disabled from July 11, 2012 through May 27, 2014, the date of arbitration, a period of 98 weeks at $867.49 per week. The Arbitrator gave Respondent credit of $62,890.88 that was paid in TTD benefits. The Arbitrator found Petitioner entitled to prospective medical care and ordered Respondent to authorize and pay for a prescribed cervical fusion. The issue of medical expenses was reserved by Petitioner for a subsequent hearing. The issues on Review are whether Petitioner sustained accidental injuries arising out of and in the course of his employment, whether a causal relationship exists between those injuries and Petitioner's current condition of ill-being and if so, the extent of temporary total disability and whether he is entitled to prospective medical care. Respondent also reviewed on objections of record, evidentiary rulings and denial of a continuance. The Commission, after reviewing the entire record, modifies the Decision of the Arbitrator finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on July 9, 2012, that a causal relationship exists between those injuries and Petitioner's current condition of ill-being regarding his hernia, but not his low back and neck, that he was temporarily totally disabled from July 11, 2012 through December 27, 2012, a period of 24-2/7 weeks, that he is entitled to medical expenses that are related to treatment for his hernia, but not for his low back and neck, that he is not entitled to prospective medical care and affirms the Arbitrator's

evidentiary rulings and denial of a continuance for the reasons set forth below. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327, 399 N.E.2d 1322 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 51 year old concrete laborer, testified that on July 9, 2012, he was employed with Respondent as a concrete laborer (Tr 8). Petitioner started as a concrete laborer in 1983 with James McHugh. He has been working consistently as a concrete laborer from 1983 until July 9, 2012, a period of 28 years (Tr 9). Petitioner was asked if he ever filed a workers' compensation claim before July 9, 2012 and stated that he never really got injured (Tr 9). He did not ever have any prior neck injuries and had no prior neck treatment (Tr 9). He never had any prior back injuries (Tr 10).

Prior to July 9, 2012 with respect to his abdomen, Petitioner had a hernia or knot and it was a small bulge in the second row of his abs (Tr 10). It had started maybe 6 or 7 months before July 9, 2012 (Tr 10). The Northwestern Hospital job had started when he left the University of Chicago job (Tr 10). Petitioner did not have treatment for the knot prior to July 9, 2012 (Tr 11).

On July 9, 2012, a Monday, Petitioner was transferred from another job as Respondent wanted him in the concrete that day (Tr 11). Petitioner stated he had a prior drug past and treatment at a Methadone clinic (Tr 12). He has been clean and sober for 4 to 5 years now, at least 2 to 3 years prior to July 9, 2012 (Tr 12-13). Petitioner did not tell any of his doctors about his prior drug past because he was not proud of it and he was clean (Tr 13). On July 9, 2012, Petitioner had started work that day at Northwestern Hospital and that morning he was transferred to DePaul University at Racine and Fullerton to pour cement (Tr 14). Normally Petitioner's job activities are on the truck, down on the pump with the buckets, but on July 9, 2012, he was put in the concrete on the hose (Tr 14). The hose was on the roof (Tr 14). Petitioner was on the roof at a construction project at DePaul University with the concrete hose (Tr 14). Petitioner testified as to what happened on July 9, 2012: "We have what we call anchors for window washers, and they're about four or five feet in height. And when we got to one, we have to raise it up. And the pump was still going, running, and it twisted – as I got it up it twisted me because it was still in the high speed; and that's when I felt a strain in my scrotum and my stomach." (Tr 15). Petitioner was asked what happened to his body when he was holding the pump as he was lifting the anchors up (Tr 15). Petitioner testified, "Well, I'm a little guy, but I got it up over the anchor, and with it still running it twisted my back. And if I would have held on to it, it probably would have broke my leg because it's like six inches in diameter." (Tr 15). Petitioner told labor foreman Ralph and superintendent Randy Johnson that he had

injured himself in this activity (Tr 15-16). The main symptoms Petitioner was having at the scene of the incident were his back and scrotum (Tr 16). He continued working that day and was told to go downstairs and scrape up the spillage that comes down on the floor (Tr 17).

Petitioner reported for work on July 10, 2012 and was assigned to work with the carpenters (Tr 18). That day, Petitioner lifted a 4' X 8' piece of plywood and got the sharp pain again (Tr 18). He went to Randy Johnson and told him that the bulge had gotten larger in his stomach and his testicles were killing him (Tr 18). Petitioner stated that Mr. Johnson told him he had to go to the doctor about 11:00 a.m. (Tr 18).

Petitioner testified he went to Ingalls Memorial Hospital on July 12, 2012 and told ER personnel what happened at work and what his symptoms were (Tr 19). Petitioner followed-up with Dr. Vandenberg, who referred him to Dr. Rudnicki, a surgeon (Tr 19). On December 19, 2012, Dr. Rudnicki performed surgery consisting of an open repair of a hernia (Tr 19). Prior to that, Petitioner came under the care of Dr. Pye, an occupational medicine doctor that was recommended by a friend who had injured herself (Tr 19-20).

Petitioner testified he is also claiming injury to his neck (Tr 20). Petitioner explained that he was having pain in his shoulder at first, then it started going down his arm (Tr 20). About a week from there, his neck problems began and he could not get out of bed and he was beginning to get tingling in his fingers (Tr 20-21). His neck started hurting (Tr 21). As of July 11, 2012, Petitioner was taken off work and he has not returned to work (Tr 22). Petitioner stated that his doctors have told him to stay off work until he had surgery (Tr 25-26). He was authorized off work on July 12, 2012 (Tr 26). Dr. Pye referred him to Dr. Slack, an orthopedic specialist (Tr 27). At some point, Dr. Slack referred him to Dr. Fisher. Petitioner first saw Dr. Fisher on May 15, 2013 and last saw him on August 14, 2013 (Tr 27). Dr. Fisher has recommended a cervical fusion from level C3 to C6 and has authorized him off work pending the surgery (Tr 27).

Petitioner currently noticed he has pain in his neck and is getting headaches (Tr 28). When he leans back, his neck pops and it hurts (Tr 28). He has not been able to get his prescription because his money was taken away (Tr 28). His left hand fingers are numb (Tr 28).

On cross-examination, Petitioner testified he was not having any back pain until about 4 or 5 days after the accident; he then stated the neck pain (Tr 30). Petitioner acknowledged that he filled out an incident report two days after the accident (Tr 31). The incident report was marked as Rx1 (Tr 31). Petitioner acknowledged that when he filled out Rx1, the only thing he indicated on the report was a hernia (Tr 31). Petitioner then stated he filled out 3 papers where he indicated the nature of the injury was a hernia and his back (Tr 31). He acknowledged that the incident report does not say anything other than low back and groin and does not say neck (Tr 32-33). At the time of the incident report, Petitioner was not having any neck or upper back pain (Tr 33).

15IWCC0153

Petitioner did not tell the doctors about his heroin use because it is nothing he was proud of and he was clean (Tr 33-34). When he went to Illinois Bone & Joint, there was an intake form that asked if he had a history of illicit drug use and Petitioner put no on there; it is correct that Petitioner knew when he wrote that down that that was a false statement (Tr 34). It is not correct that he was in a Methadone Treatment Program during the same period of time that he was treating with the doctors for his work injury (Tr 34-35). Petitioner stated he was off methadone when the following history was noted by Ingalls Memorial Hospital in August 2012: "Fifty-one year old male presents with past medical history of heroin abuse/use two to three years ago, currently attends Methadone Clinic, presents with headache at the top of my head." (Tr 35). This was marked Rx4 for identification (Tr 35). Petitioner was at Ingalls Memorial Hospital ER on August 25, 2012 for complaints of headaches (Tr 36). At that time, Petitioner was through with the Methadone Treatment Program (Tr 37). Petitioner was through with the Methadone Treatment Program before the beginning of 2012 (Tr 37). The nurse wrote that down wrong; he was off the Methadone and had passed a drug test (Tr 37-38). The other doctors did not ask Petitioner about drug use; Dr. Fisher was the only doctor that asked him (Tr 38). Petitioner denied he was selective about what he told the other doctors (Tr 38-39). Petitioner would not say he lied to Dr. Fisher; he just did not really feel it was necessary because he was not on it anymore and was clean (Tr 39). He told Ingalls Memorial Hospital ER personnel the truth (Tr 39).

Before this claimed work accident, Petitioner freely admitted he already had a bulge in his abdomen (Tr 39). The bulge in his abdomen got larger after the July 9, 2012 accident (Tr 40). He had showed the bulge to Randy Johnson (Tr 41). Petitioner testified that a month before the accident, he was at the ER and the nurse examined the bulge and told him it was a hernia, that he better watch it and if it got larger to have it corrected; he was not sure of the date he was at the ER before the accident (Tr 42). At that time, Petitioner was working at Northwestern University job on the bucket (Tr 42). Petitioner thought it was the ER at the University of Chicago that he went to (Tr 42). He went to the ER because a small knot was bulging out of his abdomen and he was told it was an umbilical hernia (Tr 43). Petitioner did not have any of those records with him (Tr 43). Respondent's attorney requested a continuance to obtain the records from the University of Chicago and that he was totally taken by surprise by this (Tr 43). Petitioner's attorney indicated that Respondent's attorney knew the hernia was preexisting, that the ER records say the hernia had been there a while, and the IME doctor testified the hernia was preexisting; therefore, there was no surprise to him (Tr 45-46). The Arbitrator overruled Respondent's attorney's request for a continuance (Tr 46).

Petitioner denied having any conversations in June 2012 with somebody at Respondent about when his employment was ending (Tr 46-47). Petitioner did not know when the job he was on was scheduled to end; he was taken off that job (Tr 47). He did not have another job lined up. Petitioner was taken to the Northwestern job and from there he went to the DePaul University job (Tr 47). Petitioner did not have any conversations with a supervisor or anybody at Respondent regarding what his assignment would be after July 2012 (Tr 47-48). He was not told if there was work into August 2012 (Tr 48). Petitioner would say he did have work lined up

for July and August 2012, but they don't tell him, just like they did not tell him he was going to DePaul University job that day (Tr 49). They never tell him when a job is ending; they say you go here, go there (Tr 49). There was never any conversations in which he was advised that he was not going to have any assignment after that; it never happened (Tr 50). There is no one who saw the hernia before the accident and after the accident (Tr 52). The only person that could testify that the hernia was larger after the accident would be Petitioner (Tr 52).

When he was in the Methadone Program, Petitioner was not told that if he went to a doctor he had to tell the doctor he was on Methadone so he would not prescribe Vicodin for him (Tr 53). From July 9, 2012 through the date of this hearing, Petitioner was prescribed Vicodin one time (Tr 54). A lot of prescriptions Petitioner did not take because they were not doing anything for him (Tr 55). Petitioner was prescribed OxyContin one time and the doctor told him to stop taking it (Tr 55). Dr. Pye prescribed OxyContin for his neck pain. Dr. Pye knew about his heroin use and Petitioner was not on Methadone at the time (Tr 56). Dr. Fisher did not prescribe narcotic medications; he used a different type of drug (Tr 58). Dr. Fisher prescribed Neurontin (Tr 59). None of the prescription medications really worked, so Petitioner was not finishing them (Tr 59). Dr. Fisher's records also indicate that he prescribed Vicodin and Flexeril in addition to Neurontin. Petitioner took Vicodin, but did not get refills (Tr 60). He did tell Dr. Fisher that he was not taking Vicodin anymore; Dr. Fisher had told him to stop taking Vicodin if it was not working; Debbie Nelson from Zurich also told him to stop taking Vicodin if it was not doing anything (Tr 64). Petitioner had taken about half the bottle of Vicodin (Tr 65).

2. Timothy McErlean testified that he is employed with Respondent and has been so for 24 years. He has been superintendent for maybe 10 years (Tr 68). During his employment with Respondent, he has been a laborer, laborer's foreman, laborer superintendent and then superintendent (Tr 69). His duties include keeping a job on schedule and he supervises employees and contractors (Tr 69). Mr. McErlean knows Petitioner as a laborer who worked for him (Tr 69). He believed Petitioner was working for Respondent in January and July 2012. Petitioner worked at the Northwestern Hospital garage job and the DePaul University job (Tr 70). Both jobs were winding down at that time (Tr 70). There were a lot of employees on those jobs previous to that and work was getting slow. There were roughly 100 employees and maybe went down to 10, 15 employees (Tr 71).

Mr. McErlean testified that during 2012, he had multiple conversations with Petitioner regarding the availability of work; he did not know how many conversations there were (Tr 71). The conversations were in person (Tr 72). The last conversation was at the Northwestern garage and no one else was present (Tr 73). This was towards the end of the job and they were loading out; the job ended after July 2012 (Tr 74). Petitioner asked him about work that was coming up, if Respondent had anything (Tr 74). Mr. McErlean told Petitioner he did not know of anything happening; the guys were going to work 2, 3 days a week and there was nothing for sure coming up right after this (Tr 74). It is typical that when a job is winding down that the employees will approach him about getting their next assignment (Tr 74-75). It was more than typical for Petitioner at the end of his job (Tr 75). Petitioner was somebody that was very aggressive and

Mr. McErlean was uncomfortable by how many times Petitioner asked; every time he saw Petitioner on the job more than once in one day, he would ask (Tr 76). Petitioner was just always questioning if Respondent had more work coming, where they were going next, what was the next job (Tr 76). Petitioner was still asking even after being told there was nothing after the Northwestern job (Tr 77). He believed Petitioner worked the DePaul University job a couple days. Petitioner might have been one of the guys that was not full-time (Tr 77). Mr. McErlean was informed of Petitioner's alleged work accident (Tr 77). He had no direct knowledge of anything that may or may not have happened (Tr 77).

On cross-examination, Mr. McErlean testified that construction can often be seasonal or have ebbs and flows. Respondent is not always at 100% capacity all the time (Tr 78). There are times there is a big job where it is busy for a while and there are times when things slowed down (Tr 78). Often times employees are laid off and then brought back (Tr 78). In the construction industry, the union scale workers, if they are laid off, they will either look for another job out of the union hall or often times they will get unemployment benefits until the next job comes around (Tr 79). After his last conversation with Petitioner where Mr. McErlean said he did not know what was coming down the pipeline, Petitioner started working at the DePaul job (Tr 79).

On re-direct examination, Mr. McErlean testified that in addition to unemployment, some people sometimes do not go off on workers' compensation when the work slows down (Tr 80).

3. James Smith testified he is employed with Respondent as the risk manager (Tr 82). He knows Petitioner was a laborer for Respondent (Tr 82). He knows Petitioner has alleged a work injury in July 2012 (Tr 82). Mr. Smith was responsible for handling work injuries for Respondent in July 2012 and still is responsible (Tr 82-83). Part of his duties include administering workers' compensation cases (Tr 83). He participates in getting medical records from time to time and statements and working both with defense counsel and the insurance company (Tr 83). In this case, there was an IME performed by Dr. Bernstein (Tr 83). It is his understanding that at the time of Dr. Bernstein's IME, the defense did not have all the medical records that had been requested (Tr 83). Petitioner's attorney waived his *Ghere* objection to Dr. Bernstein's opinions regarding the hernia only (Tr 86). There was a reduction in the amount of employees that was done in June and July of 2012; there was a slowdown in self-performed concrete work and there were no new jobs coming in (Tr 88-89). That slowdown would have affected Petitioner (Tr 89). In the first 6 months of 2012, Respondent averaged over 100 full-time union employees. By the end of 2012, Respondent was down to less than 10 full-time union employees (Tr 89).

No cross-examination was conducted (Tr 89).

4. The emergency room records of Ingalls Memorial Hospital, Px7, Px1, show that Petitioner was seen at this facility on July 11, 2012 by Dr. Saluja. The following was noted: "Chief Complaint: Patient presents to the ED with c/o anterior abdominal wall pain that started yesterday. As per patient he has to pour concrete at work and yesterday started having anterior

abdominal wall pain which extends all the way from the xiphisternum to the groin. denies testicular pain, penile discharge. Pain is relieved by rest but worse on stretching backwards." Examination of the neck found normal range of motion. Examination of the abdominal area found the abdomen tender, moderate intensity; tenderness over the abdominal wall along the rectus abdminis muscle; no inguinal hernia; no femoral hernia; no umbilical hernia present; no ventral hernia; no incisional hernia; testicles were normal with no hernia. Examination of the back found normal inspection. Examination of the upper extremity found normal inspection and normal range of motion. Dr. Saluja noted: "Patient has no hernia, testicular torsion or tenderness over the epididymis, will discharge with analgesics." Petitioner was given care instructions for a pulled muscle/muscle strain. He was prescribed Flexeril and Motrin and discharged.

5. In an undated Incident Investigation Form, Rx1, a Date of Incident of July 9, 2012 is listed. The following Description is noted: "Picking up concrete hose." The following Extent of Injury is noted: "Pain in my growing, low back." The Commission notes that although this document is undated, Petitioner testified that he filled out Rx1 two days after the accident.

6. According to Dr. Vandenberg's records, Px1, Petitioner was seen on July 12, 2012. Dr. Vandenberg noted: "Pt here for pain in testicles + above stomach from injury at work Monday July 9th. Pt went to ER 7/11/12." The rest of his Progress Note is unreadable. In a Slip that date, Dr. Vandenberg noted: "Mr. Dubuclet is to be off work until further notice. He will be re-evaluated on 7/24/12." In his July 24, 2012 Progress Note, Dr. Vandenberg noted: "follow-up + Pt still c/o pain in stomach area + testicles. c/o LBP." The rest of his Progress Note is unreadable. The Commission notes that the July 24, 2012 Progress Note is the first mention of low back pain in the medical records.

7. The records from HTP & Associates Occupational Medicine Physicians, Px3, indicate Petitioner saw Dr. Pye on August 1, 2012. Dr. Pye noted that Petitioner presented there from a recommendation of his postal carrier. Dr. Pye noted the following history: "Pt works as a laborer and on 7/9/12 (DOI) he was lifting a pipe approx. 300 lbs was unable to completely lift and dropped subsequently felt pulling in abd and groin and pain in his lower back." Dr. Pye noted the ER visit. Petitioner informed him he had reported what happened to his supervisor. Dr. Pye noted: "From what I can gather he was then supposed to f/up with another physician per job and did not. He has obtained a lawyer who supposedly is coming over to his house to discuss the case. Appears he has private insurance but not sure if active will have staff inquire." Dr. Pye noted Petitioner's subjective complaints of 1) low back pain; 2) neck pain; 3) hand numbness. On examination of the low back, Dr. Pye found SI joint tenderness and paraspinal tenderness. On examination of the cervical spine, Dr. Pye found limited neck range of motion, cervical tenderness and trapezius tenderness. It was Dr. Pye's assessment was: 1) sprain and strain of lumbosacral (joint)(ligament); 2) cervicalgia; 3) pain in hand joint, more so numbness. Dr. Pye ordered x-rays and prescribed medications. The Commission notes that this August 1, 2012 office visit with Dr. Pye is the first mention of neck pain in the medical records.

8. Dr. Rudnicki's records, Px2, indicate Petitioner was seen on August 4, 2012 on a referral for a second opinion. Dr. Rudnicki noted the following history: "While lifting a heavy load, he experienced a sudden pain in epigastric area liking something ruptured in his upper abdomen. He also felt like having sudden pain in lower abdomen in area of his scrotum. Since the accident, he noticed having a small bulge in upper midline abdominal area that continues to be tender to palpation. He also has blunt pain on the right side of his scrotum, towards the perianal area. The patient has also history of neck and lumbar problems for which he is scheduled with orthopedic surgeon next week." Dr. Rudnicki noted Petitioner subjective complaints of 1) epigastric bulge that appeared after lifting heavy load at work; 2) lower abdominal and scrotal pain that appeared after lifting heavy load at work; 3) also pain in the neck, sometimes he feels like having numb hands. On his musculoskeletal examination, Dr. Rudnicki noted chronic pain in the lumbar and neck areas, with some intermittent numbness of both arms; joint pain; joint stiffness; he has a hard time to stand upright because of pain in the lumbar area. On examination, Dr. Rudnicki found there was a 2 cm bulge in the upper abdominal midline, elevating the skin up to 1 cm; palpation in that area showed a 2 cm bulge that was not reducible and not mobile in relation to the underlying tissues; also there was palpable tenderness of the right side of his scrotum, particularly during palpation of the right spermatic cord; right testicle seemed less tender; no inguinal hernia; significant tenderness of perineum towards the anus; DRE showed a very tender prostate. Dr. Rudnicki's assessment was: 1) unbilical hernia without mention of obstruction or gangrene; 2) unspecified prostatitis; 3) degeneration of lumbar or lumbosacral intervertebral disc. Dr. Rudnicki noted Petitioner had an epigastric midline hernia that needed to be treated with surgery. Dr. Rudnicki referred Petitioner to an urologist for consultation for his prostate and tender right scrotum. Dr. Rudnicki noted that an orthopedic consultation had already been scheduled for his neck and lumbar spine problems.

9. Dr. Pye authorized Petitioner off work on August 9, 2012. On August 15, 2012, Petitioner saw physical therapist Ellen O'Donnell for an initial evaluation. Ms. O'Donnell noted the following history: "Pt is a concrete laborer 7-9-12 lifted a pipe full of concrete, felt a pop in his groin, first but couldn't drop the pipe, and then he strained his back and neck." She noted his work status as off work. Petitioner complained of neck pain on the left of 7/10. He reported his neck pain increased if he tried to raise his arm. He had difficulty turning his head to drive. He had numbness in the ulnar distribution of his bilateral arms. Petitioner rated his low back pain at 4-9/10. His low back pain felt better when sitting in a flexed position. He could not tolerate sit-to-stand. He was sleeping propped up on a couch. It was painful trying to go to the bathroom. Ms. O'Donnell recommended physical therapy 3 times a week for 4 wks.

Petitioner saw Dr. Pye on August 16, 2012 and reported he was sleeping in a chair due to the pain in his back. After examination, Dr. Pye's assessment was: 1) lumbar sprain and strain; 2) neck sprain and strain; 3) thoracic sprain and strain; 4) rotator cuff (capsule) sprain and strain. His plan for Petitioner lumbar area was physical therapy to improve his posture and electric stimulation. He also prescribed medications. On August 23, 2012, Ms. O'Donnell noted that Petitioner reported that hernia surgery was put off because of a problem with his heart and he was seeing a cardiologist. In a slip that same date, Dr. Pye had Petitioner remain off work.

10. Ingalls Memorial Hospital records, Px7, Rx4, indicate Petitioner was seen in the emergency room on August 25, 2012 for complaints of headache for 2 days. A past medical history of heroin abuse was noted, the last use 2-3 years ago. Petitioner was given medication and later that day he was discharged as improved.

11. On September 13, 2012, Petitioner complained to Dr. Pye of low back pain. On examination, Dr. Pye found tightness in the lumbar spinal muscles and tenderness in gluteals/hips. Dr. Pye's assessment was compressions to the gluteals, muscle stripping to pararspinal muscles, lumbar region, rocking of hips. His plan was to continue massages 1-2 times per week. That same day, Ms. O'Donnell noted Petitioner complained of neck pain at 7/10 and constant headaches. He rated his low back pain at 6/10. In a slip dated September 14, 2012, Dr. Pye had Petitioner remain off work.

In his September 28, 2012 Progress Note, Dr. Pye noted a Date of Incident of July 9, 2012. Dr. Pye noted the following history: "On incident date, he was pouring concrete on the roof at a DePaul University building. He lifted a concrete hose filled with wet cement, weighing 200-300 lbs., approximately 4 ft. over a metal barrier and felt sudden pain in his neck, left shoulder, abdomen and low back." The Commission notes that neck pain and low back pain were not mentioned in the ER records. Dr. Pye noted that Petitioner also complained of numbness and tingling in both hands, which he reported had noticed since being off work and have been present intermittently for several months. Petitioner rated his neck pain at 4/10, which increased with turning his head or bending. Petitioner reported numbness and tingling in both hands, non-radiating from the neck. Petitioner denied any prior history of neck pain. Dr. Pye noted that a cervical MRI was done on August 29, 2012 and demonstrated Grade 1 retrolisthesis C3-7 and multilevel degenerative changes. Petitioner also complained of headaches to the back of his head which he reported had been present for several months and seemed improved with presecribed medications and physical therapy. Petitioner reported left shoulder pain at 4-5/10, which increased with raising his left arm and with sleep. He denied any prior history of left shoulder pain. Dr. Pye noted that a left shoulder MRI done on August 29, 2012 demonstrated a supraspinatus tendinosis and Petitioner was receiving physical therapy for this. Petitioner reported he had left-sided chest pains intermittently for months and was seen by cardiologist on September 25, 2012 and a stent placement was scheduled for October 4, 2012. Dr. Pye planned a left shoulder cortisone injection, but put that on hold due to Petitioner's cardiac condition.

Dr. Pye noted Petitioner reported abdominal pain at 6/10, which increased with lifting objects, bending and changing positions. An abdominal MRI done August 29, 2012 was normal. A ventral hernia was found on examination. Petitioner rated his low back pain at 5/10, which increased with bending, reaching, prolonged standing and use of stairs. Dr. Pye noted that a lumbar MRI done August 29, 2012 demonstrated multilevel degenerative disease and Petitioner receives physical therapy for this. Petitioner complained of left hand pain at 3/10, which increased with use, gripping, squeezing; numbness and tingling; pain and numbness awakens him at night. Petitioner complained of right hand pain at 3/10, a burning sensation to his palm occurred with frequent use; numbness and tingling; symptoms for several months; he was not

15IWCC0153

sure what symptoms were until recent increase with occurrence at night and during the day; right hand dominant. On examination of the neck, Dr. Pye found a slight decrease in extension, full flexion, decreased left lateral motion; palpation tenderness bilaterally in the paracervical soft tissue and trapezius. On examination of the left shoulder, Dr. Pye found full range of motion; tenderness over the bicipital groove; tenderness over the proximal humerus; stability tests were negative. On examination of the left hand, Dr. Pye found tenderness of 1st dorsal compartment; full grip; strength intact; positive Tinel's and positive Phalen's. On examination of the right hand, Dr. Pye found tenderness in the 1st dorsal compartment; full grip; strength intact; positive Tinel's and positive Phalen's. On examination of the lumbar spine, Dr. Pye found full range of motion; tenderness bilaterally in the paravertebral lumbar soft tissue; negative straight leg raises; he was able to stoop and squat. Dr. Pye's assessment was: 1) lumbar sprain and strain; 2) sprain and strain of lumbosacral (join)(ligament); 3) cervicalgia; 4) rotator cuff (capsule) sprain and strain; 5) pain in hand joint; 6) carpal tunnel syndrome; 7) hernia. Dr. Pye prescribed medications, continued physical therapy and kept Petitioner off work. Dr. Pye referred Petitioner to a general surgeon for evaluation of hernia repair.

On October 15, 2012, Dr. Pye noted Petitioner was seen for complaints of neck pain rated at 8/10 and low back pain rated at 6/10. Dr. Pye noted Petitioner had been off physical therapy due to a recent cardiac catherization. Petitioner had a follow-up with his cardiologist scheduled for October 31, 2012 and would need clearance from him to resume physical therapy. Dr. Pye noted Petitioner awaited hernia repair surgery pending cardiac clearance. Dr. Pye's assessment was: 1) cervicalgia; 2) lumbar sprain and strain; 3) hernia. Petitioner was to remain off work and restart physical therapy once he received cardiac clearance.

Petitioner was seen by Dr. Pye on November 28, 2012 for complaints of neck pain rated at 8/10 and low back pain rated at 7/10. Dr. Pye noted that Petitioner had cardiac clearance. Dr. Pye's assessment was: 1) cervicalgia; 2) lumbar sprain and strain. Dr. Pye restarted physical therapy and prescribed medications. In a slip that date, Dr. Pye noted sedentary duty only. In a slip dated December 13, 2012, Dr. Pye noted Petitioner was to remain off work. (Px3).

12. Petitioner saw Dr. Rudnicki on December 19, 2012. Dr. Rudnicki noted: "The patient came to my office complaining of epigastric bulge that developed after lifting a heavy load at work. On physical exam, he had an incarcerated epigastric hernia." Dr. Rudnicki recommended surgical repair. On December 21, 2012, Dr. Rudnicki performed an open repair of the epigastric hernia. Petitioner followed-up with Dr. Rudnicki on December 27, 2012. On examination, Dr. Rudnicki found the wound healing well without infection. His assessment was a good recovery after hernia repair. Dr. Rudnicki noted that no further care was needed and Petitioner was to be seen as needed. (Px2).

13. Petitioner saw Dr. Pye on January 17, 2013 and complained of pain in his neck and low back. On examination, Dr. Pye found tenderness in the trapezius muscles, paraspinals and some tightness in gluteals. His assessment was compression to the gluteals, light trigger point therapy to upper and mid trapezius, levator and paraspinals. He continued massages 1-2 times per week.

On January 25, 2013, Dr. Pye noted the ventral hernia was repaired on December 19, 2012. Petitioner complained of low back pain, spinal pain and upper back/neck pain. On examination, Dr. Pye found tenderness in the thoracic paraspinals; tightness in the cervical, thoracic and lumbar paraspinals. His assessment was compression to the gluteals, muscle stripping and light trigger point therapy to the paraspinals and upper trapezius muscles. Petitioner was to continue massages 1-2 times per week and remain off work. (Px3).

14. The records from Illinois Bone & Joint Institute, Px4, indicate Petitioner saw Dr. Slack on February 6, 2013 on referral from Dr. Pye for consultation. Dr. Slack noted the following history: "This patient stated that while doing concrete work as a laborer, he was on the roof of one of the buildings at DePaul University on July 9, 2012. There was a hose pumping concrete up to the roof, and at one point he attempted to move the hose and developed pain in his ventral abdominal area, having developed a ventral hernia, and also, with twisting maneuver that occurred when he was trying to deal with this concrete moving through the hose, he also sustained pain in his neck and his lower back which has been persistent." The Commission notes that there were no complaints of the neck or low back to the ER on July 11, 2012. Dr. Slack noted Petitioner's current treatment. Petitioner also complained of posterior occipital headaches as well as a heaviness sensation to his left arm and numbness and tingling radiating into his 4th and 5th fingers. Dr. Slack noted the December 21, 2012 ventral hernia repair. On exam of the lumbar spine, Dr. Slack found Petitioner was forward flexed at about 20 degrees; further forward flexion to about 50 degrees caused complaints of low back pain; extension towards neutral also caused low back pain and neck pain; supine straight leg raises on the right at 45 degrees caused right-sided low back pain; supine straight leg raises on the left at 55 degrees caused low back pain; seated straight leg raises were negative. On examination of the cervical spine, Dr. Slack found flexion caused posterior neck pain; extension caused more severe posterior neck pain; tenderness to palpation over the left posterolateral neck; upper extremity muscle strength was intact; reflexes were decreased on the left compared to the right.

Dr. Slack reviewed the August 29, 2012 cervical MRI scan and noted Petitioner appeared to have a C3-4 posterior left-sided disc herniation with some foraminal narrowing along with disc osteophyte complex with some foraminal narrowing at C4-5, C5-6 and C6-7. Dr. Slack reviewed the August 29, 2012 lumbar MRI scan which showed at L5-S1 level severe degenerative disc changes with moderate to severe facet arthritis changes and moderate to severe bilateral foraminal narrowing; the L4-5 level also showed degenerative disc changes with moderate facet arthritis and moderate to severe foraminal narrowing; mild facet arthritis was noted at L3-4. Dr. Slack's assessment was persistent left cervical radiculopathy with a C3-4 left sided disc protrusion and degenerative disc disease C4-5 through C6-7 and persistent lumbar derangement with degenerative lumbar disc and facet disease. Dr. Slack suggested cervical epidural steroid injection, Neurontin and physical therapy for his neck and low back. Petitioner was to remain off work.

On February 19, 2013, Dr. Cupic of Cupic Pain Management gave Petitioner a cervical epidural steroid injection. Petitioner saw Dr. Slack on March 7, 2013 and reported that after

epidural steroid injection, he had continued to have persistent neck pain with intermittent numbness in his 4th and 5th left fingers, which occurred at any time without specific association of position or activity. He also complained of headaches. Dr. Slack noted Petitioner was attending physical therapy. Dr. Slack's assessment was persistent cervical and lumbar derangements associated with symptomatic aggravation of his degenerative disc and facet disease. Dr. Slack increased Neuronton dosage and prescribed Flexeril. Petitioner was to continued Vicodin for break through pain. He was to continue physical therapy and remain off work.

Petitioner attended physical therapy through March 28, 2013. (Px3). Petitioner saw Dr. Slack on April 4, 2013 and reported persistent severe posterior left lateral neck pain, numbness and tingling in his 4th and 5th fingers and a cold sensation in his right hand. Petitioner also reported he gets some bilateral posterior leg pain and low back pain, which felt somewhat better. He also reported a flare-up of pain in the area where he had his hernia repaired. Pain was now radiating down into his scrotum area and above from the area of his hernia repair. Dr. Slack noted Petitioner was seeing the surgeon who did the repair. Dr. Slack's assessment was persistent symptomatic aggravation of his cervical and lumbar degenerative disc disease. Dr. Slack noted that in spite of treatment including two cervical epidural steroid injections, physical therapy and prescribed medications, Petitioner continued to have severe persistent neck pain. Dr. Slack requested Petitioner be seen by Dr. Fisher, his associate, to evaluate for possible cervical spine surgery. Dr. Slack continued physical therapy, prescribed medications and continued Petitioner off work.

Petitioner saw Dr. Slack on May 9, 2013 and reported his low back pain was somewhat better, but his neck pain had been persistent with headaches in the posterior head and he had ongoing intermittent numbness in his left 4th and 5th fingers, especially when getting out of bed in the morning. Turning his head quickly to the left increased his symptoms of neck pain and finger numbness. Petitioner informed Dr. Slack that the hernia repair surgeon gave him antibiotics as he had some prostatitis. Dr. Slack's assessment was persistent symptomatic aggravation of his cervical disc disease with left arm radiculopathy and low back derangement and aggravation of lumbar degenerative disc disease. Dr. Slack again recommended Petitioner see Dr. Fisher. He continued Petitioner off work and continued the prescribed medications. (Px4).

15. Petitioner saw Dr. Fisher from Illinois Bone & Joint Institute on May 15, 2013. Dr. Fisher noted the following history: "Mr. Dubuclet states that in July 2012, he was working with a hose, pouring concrete on the roof of a building when it jerked, and he experienced neck pain, back pain and abdominal pain." The Commission notes that there were no complaints of the neck or low back to the ER on July 11, 2012. Dr. Fisher noted that Petitioner's hernia was repaired. Petitioner complained of left sided neck pain and recurrent numbness to the 4th and 5th digits of his left hand. Dr. Fisher noted that the cervical MRI scan revealed disc herniations, although there was reported motion artifact. Dr. Fisher noted that epidural steroid injections provided no improvement. On neck examination, Dr. Fisher found tenderness to the paraspinous

of the left from C3 to the left trapezius muscle; extension was 25 degrees, flexion was 30 degrees, lateral bending was 10 degrees left and right, rotation was 75 degrees left and right. On upper extremity examination, Dr. Fisher found 5/5 strength throughout with decreased sensation in the left ulnar nerve distribution; negative Tinel's at the cubital tunnel. Examination of the lower extremities was normal. Cervical x-rays taken this day showed mild degenerative changes with normal lordosis. Dr. Fisher's assessment was: 1) cervicalgia; 2) cervical disc herniation; 3) left upper extremity radiculopathy v. cubital tunnel syndrome. Dr. Fisher ordered a repeat cervical MRI.

A cervical MRI was done on May 20, 2013. The radiologist's impression was: 1) diffuse cervical and upper thoracic spondylosis with multilevel degenerative disc disease; there was mild Grade 1 retrolisthesis from C3-C4 through C6-C7; 2) there were posterior disc osteophyte complexes at all levels from C3-C4 through C6-C7.

Petitioner saw Dr. Fisher on June 5, 2013 and had the same complaints. Dr. Fisher reviewed the May 20, 2013 cervical MRI scan. Dr. Fisher's assessment was: 1) cervical spondylosis with facet arthropathy and herniated nucleus pulposus; 2) left cubital tunnel syndrome. Dr. Fisher injected Petitioner's left cubital tunnel. Petitioner was to continue home exercises. Dr. Fisher noted that he would send Petitioner for a left C4 through C7 facet injection. On June 25, 2013, Dr. Cupic gave Petitioner cervical facet injections from C3/4 through C6/7.

On July 18, 2013 Petitioner reported to Dr. Fisher that the left cubital tunnel injection did not change his symptoms. Petitioner reported that the third neck injection made his neck numb at first, but it did not last. The decreased sensation in his 4th and 5th toes resolved in two days. Petitioner complained of pain in his neck and recurrent numbness down to the 4th and 5th fingers of his left hand. Aggravating factors included any activity. Dr. Fisher's assessment was: 1) cervicalgia; 2) cervical disc herniations and spinal stenosis. Dr. Fisher requested a CD of the cervical MRI scan. Dr. Fisher ordered a cervical aspen collar and continued the exercise program.

Petitioner saw Dr. Fisher on August 14, 2013 and reported no relief with the injections. Petitioner reported continued neck pain and recurrent radicular symptoms. Dr. Fisher noted that Petitioner wanted to proceed with cervical surgery as his symptoms have been present for over a year and have been affecting his daily living and ability to work, sleep and exercise. Petitioner brought the CD of the cervical MRI and Dr. Fisher reviewed same, which revealed C3-4, C4-5 and C5-6 broad-based disc herniations with spinal stenosis of 7.8 mm for the spinal cord in AP direction measured on the sagittal images at C3-C4 and C5-6. Dr. Fisher's assessment was C3 through C6 disc herniations and spinal stenosis. Dr. Fisher recommended surgery consisting of C3 through C6 ACDF procedure (anterior cervical discectomy fusion). Dr. Fisher noted that Petitioner wanted to proceed with the recommended surgery. (Px4).

16. In his December 9, 2013 deposition, Px6, Dr. Fisher testified he is a board certified orthopedic spine surgeon. Dr. Fisher stated that Dr. Slack only does low back surgery and not

neck surgery and that is why he referred Petitioner to him (Dp 8). Dr. Fisher recited from his records, noted above. Petitioner was currently off work pending surgery (Dp 18). Dr. Fisher opined causal connection, aggravation of a preexisting cervical condition, resulting in neck symptoms and recurrent radiculopathy. Dr. Fisher opined that Petitioner's need to be off work is related to those symptoms (Dp 19). Dr. Fisher opined causal connection for the recommended cervical surgery (Dp 19-20).

On cross-examination, Dr. Fisher testified that in this case it seems Petitioner did not have any symptoms before the July 9, 2012 accident, then had symptoms after (Dp 21). His treatment recommendations would be the same no matter what caused Petitioner's condition (Dp 22). Dr. Fisher also relied on Dr. Slack's notes along with what Petitioner told him (Dp 22). He did not review any other medical records, accident reports, or any other records (Dp 24). Dr. Fisher did not have in his notes that he asked Petitioner if he had neck pain before his accident (Dp 25). Dr. Slack's notes do indicate that Petitioner did not report any prior neck pain (Dp 25). Dr. Fisher was shown the incident report (Rx1) (Dp 28). Dr. Fisher agreed that the report does not mention a neck injury and that it mentions a hernia and low back strain (Dp 29). Respondent's attorney recited the history noted in Dr. Rudnicki's August 4, 2012 notes (Dp 33-34). Dr. Fisher stated that note could be reasonably interpreted as Petitioner's neck problems are unrelated to the work accident and preexisting (Dp 36).

17. At Respondent's request, Petitioner saw Dr. Bernstein on October 13, 2013 for a §12 evaluation. In his October 13, 2013 report, Rx3, DepExRx6, Dr. Bernstein noted that Petitioner denied any history of prior neck or back problems. Dr. Bernstein noted the following history: "He reports that he was involved in a work related incident on July 9, 2012. He reports that he has been pouring concrete since 1983. On the date of incident, he was working at DePaul University. Concrete was being pumped up to the roof. He reports that the hose carries a pressure of about 5,000 pounds per square inch. He was holding onto the pump when things apparently shifted. He twisted, and he suffered an abdominal hernia...The patient also had complaints of neck and low back pain." Dr. Bernstein noted Petitioner's treatment. Petitioner complained of neck pain aggravated by extension and physical activity. On examination, Dr. Bernstein noted Petitioner had markedly decreased active range of motion of the cervical spine. However, Dr. Bernstein noted that as he walked about the room and changed position while Petitioner was distracted, Petitioner moved his head and neck smoothly without any pain guarding whatsoever. Dr. Bernstein reviewed the medical records. Dr. Bernstein reviewed the August 29, 2012 cervical MRI report, but not the films/scans. Dr. Bernstein noted Dr. Fisher's August 14, 2013 note recommending cervical surgery.

It was Dr. Bernstein's assessment that Petitioner's objective findings did not support his subjective complaints. Dr. Bernstein noted Petitioner has a degenerative condition of both the cervical and lumbar spine. Dr. Bernstein noted there is evidence of symptom magnification and exaggeration on his examination. He noted Petitioner is completely normal neurologically. Dr. Bernstein opined Petitioner can return to work full duty. Dr. Bernstein opined that it is possible

that Petitioner suffered sprains and strains or even an aggravation of a degenerative condition, however, he opined Petitioner should be able to function without any difficulty whatsoever.

18. In his January 31, 2014 deposition, Rx3, Dr. Bernstein testified he is a board certified orthopedic surgeon. Dr. Bernstein recited from his report, noted above. Dr. Bernstein opined there was no causal connection for the hernia, indicating there is a medical record that the bump or knot in his abdomen had been there for quite some time (Dp 13). Dr. Bernstein noted Petitioner's past medical history of being a heroin abuser and that he uses methadone (Dp 13). Dr. Bernstein was shown the incident report and noted Petitioner did not mention any cervical or upper back complaints (Dp 17). Dr. Bernstein felt this speaks against a neck injury occurring on July 9, 2012 (Dp 18). Dr. Bernstein opined that at the time of his §12 evaluation, Petitioner was not in need of further medical treatment (Dp 18). Dr. Bernstein opined Petitioner did not have any permanent disability as a result of the injury he reported (Dp 18). Dr. Bernstein opined that no treatment Petitioner had was related to the work accident he described (Dp 18).

On cross-examination, Dr. Bernstein testified he does not treat hernias (Dp 22). He did not review any diagnostic films (Dp 23). Dr. Bernstein acknowledged there are times a patient has pain in one area of the body that due to the degree of pain, masks other areas and as time goes by they develop symptoms in those other areas (Dp 24). It is a possibility that he cannot rule that out in Petitioner's case (Dp 25). Dr. Bernstein opined that it is a possibility that Petitioner had a severe amount of pain in his abdomen and his low back and that might account for why he did not initially complain of neck pain within the first day or two of this accident (Dp 25).

On re-direct examination, Dr. Bernstein opined that within 48 hours is a reasonable period of time to recognize that Petitioner had a cervical injury (Dp 27). By the time Petitioner filled out the incident report two days later, a cervical injury would have been noticed by then by Petitioner (Dp 27).

Based on the record as a whole, the Commission modifies the Decision of the Arbitrator finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on July 9, 2012, that a causal relationship exists between those injuries and Petitioner's current condition of ill-being regarding his hernia, but not his low back and neck, that he was temporarily totally disabled from July 11, 2012 through December 27, 2012, a period of 24-2/7 weeks, that he is entitled to medical expenses that are related to treatment for his hernia, but not for his low back and neck, that he is not entitled to prospective medical care and affirms the Arbitrator's evidentiary rulings and denial of a continuance.

The Commission affirms the Arbitrator's finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on July 9, 2012. Petitioner testified as to what occurred on that date. A version of events that day is noted in the medical records of all the treaters. However, the Commission modifies the Arbitrator's causal connection finding to

find that an accident occurred on July 9, 2012 with injury to Petitioner's groin and abdominal hernia. The Commission finds that Petitioner failed to prove that a causal relationship exists between those injuries sustained on July 9, 2012 and his condition of ill-being for his low back and neck. There was no mention of low back or neck complaints in the July 11, 2012 ER records (Px1). Examination in the ER of the neck and back was noted as normal. There is mention by Petitioner in the Rx1 incident report of the groin and low back. However, there are no complaints of low back pain until July 24, 2012 to Dr. Vandenberg (Px1). There are no complaints of the neck until August 1, 2012 to Dr. Pye (Px3). There was no mention of left shoulder complaints until September 28, 2012 (Px3). Both low back and neck complaints are delayed, as noted above. Dr. Fisher opined causal connection for the neck condition, but this was based on Petitioner's reporting to him that he had neck pain immediately after the July 9, 2012 accident, which if that were the case, Petitioner presumably would have informed the ER staff. The Commission gives more weight to the opinions of §12 Dr. Bernstein as he had reviewed Petitioner's medical records.

The Commission finds Petitioner was temporarily totally disabled from July 11, 2012 through December 27, 2012, a period of 24-2/7 weeks. Dr. Rudnicki on December 21, 2012 performed an open repair of the epigastric hernia. Petitioner followed-up with Dr. Rudnicki on December 27, 2012. On examination, Dr. Rudnicki found the wound healing well without infection. His assessment was a good recovery after hernia repair. Dr. Rudnicki noted that no further care was needed and Petitioner was to be seen as needed. The Commission finds Petitioner is entitled to medical expenses that are related to treatment for his hernia, but not for his low back and neck, based on the causation findings. The amount of these medical expenses is to be determined in a subsequent hearing. The Commission finds Petitioner is not entitled to prospective medical care, also based on the causation findings. The Commission affirms the Arbitrator's evidentiary rulings and denial of a continuance, which was at her discretion. The Commission affirms all else. 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 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $867.49 per week for a period of 24-2/7 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 shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury. The Commission notes that Respondent shall have credit of $62,890.88 that was paid in TTD benefits. Respondent shall have credit of the resulting overpaid amount against any subsequent determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

15IWCC0153

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision.

There is no bond for the removal of this cause to the Circuit Court by Respondent as the amount of credit exceeds the amount awarded. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 7 2015
MB/maw
o01/22/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF LASALLE	)	☐ 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

City of Chicago,
Respondent,

15IWCC0154

DECISION AND OPINION ON REVIEW

Petitioner appeals the decision of Arbitrator Steffen finding Petitioner failed to prove he sustained an accidental injury arising out of and in the course of his employment on February 3, 2011. The issues on Review are whether Petitioner sustained an accidental injury arising out of and in the course of his employment on February 3, 2011 and whether a causal relationship exists between Petitioner's current condition of ill-being and the alleged February 3, 2011 accident, and/or need for current and prospective medical expenses, and if so, the extent of Petitioner's temporary total disability and the nature and extent of Petitioner's permanent disability. The Commission, after reviewing the entire record, affirms the Arbitrator's decision and addresses some additional issues related thereto.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified he is currently retired. For eight years, he was the Assistant Superintendent of the Forestry Department for the City of Chicago. In addition to spending 70 percent of his time outside and running a chain saw 3-4 times a week, his job duties entailed releasing 185 drivers of trucks and chippers from the garage every morning. The number of trucks that were turned on at the same time varied. There would be a maximum of 20-25 trucks there every day.

2. Petitioner testified that on February 3, 2011 at 5:55 a.m. he was standing next to Mike Brown, his boss, at the garage waiting for the trucks and equipment to pull out. While hearing protection was available, they did not wear it in the garage. The garage was closed except for a door in the back. Someone started a truck and it was very loud. Petitioner testified he started getting woozy and thought he was going to fall. He lost

his equilibrium/balance and the hearing in his left ear. It felt like there was water in his ear. This lasted for 15-20 minutes. Since he already had a doctor's appointment scheduled with Dr. Mathur prior to February 3, 2011 he went to that pre-scheduled appointment. Petitioner testified that he saw Dr. Mathur on either February 3rd or 4th, but he does not have his records from that appointment with him at the hearing. Petitioner testified he told Dr. Mathur that he was dizzy, his equilibrium was not right and he had lost hearing in his left ear. Dr. Mathur referred him to Dr. Chang-Yan Wang, an audiologist, who prescribed some tests.

3. On February 7, 2011 Dr. Wang recorded Petitioner's medical history and noted that Petitioner had a brain ischemic four years ago. He has had some problems since then. One of the problems was listed as a balance problem for 1-1/2 years. While he reported his hearing was okay in both ears, he felt like there was water in his ear. Petitioner agreed that he had a stroke three years ago that affected the left side of his body, but he denies experiencing any dizziness, vertigo or left hearing loss or receiving any treatment for these conditions at that time. Petitioner testified if the medical records indicate that he was experiencing dizziness prior to February 3, 2011 he did not believe them.

4. The February 14, 2011 Audiological Evaluation and Videonystagmography (VNG) report indicated that the reason for the referral was Petitioner was experiencing intermittent episodes of subjected vertigo on the left. Petitioner reported the first episode was approximately three years ago following working in high temperatures after Hurricane Katrina in Louisiana. Petitioner reported he had a stroke after returned to Illinois that affected the left side of his body. He experienced an episode every couple of weeks, but the episodes decreased recently to every couple of months. The episodes last from seconds to minutes and are not accompanied by nausea, tinnitus or hearing loss. He feels as though there is water in his left ear during the episodes. The episodes occur primarily when he is standing. Petitioner has been taking Lasix for seven months and was advised to continue taking it for this testing. Dr. Wang noted that Lasix may cause tinnitus, hearing loss or vertigo. However, the patient denied experiencing these symptoms since he began taking it. Petitioner was diagnosed with a mild hearing loss above 6000 Hz. Screened acoustic reflexes were absent at 1000 and 2000 Hz in ipsilateral conditions. An abnormal VNG was indicative of a peripheral lesion. After the evaluation Petitioner was instructed to follow up with Dr. Wang, consider referral to vestibular rehabilitation and utilize cawthorne exercises to assist with hearing loss compensation.

5. Petitioner testified that the audiological evaluation showed a 15% loss of hearing and a 90% nerve damage in the left ear. Petitioner testified that he might have told the audiologist that he experienced some dizziness three years ago when he was working after Hurricane Katrina since it was 119 degrees in Louisiana and they were working 16-17 hour days. He then stated that if the February 14, 2011 audiologic report says he

had dizziness every couple of weeks that decreased to every couple of months after the Louisiana trip that would be correct, but then he stated that that February 3, 2011 work episode was different than before. Currently, he takes Allopurinol for gout, Lisinopril for his blood pressure and Lasix, which is a water pill. Petitioner testified he has been taking the water pill on and off for eight years. He denies that anyone told him that Lasix causes tinnitus, hearing loss, or vertigo and he denied experiencing any dizziness or vertigo when he was on Lasix.

6. On February 17, 2011, Dr. Wang noted that Petitioner is not dizzy anymore. On February 24, 2011, Dr. Wang completed a Family Medical Leave Act (FMLA) form in which he indicated that Petitioner was unable to perform driving function. He noted Petitioner's diagnoses was vestibular unilateral weakness on the left side with a 90% p.s. noise induced high frequency sensurneural hearing loss. While the March 2, 2011 treating records from Dr. Wang are somewhat illegible, it appears Dr. Wang had prescribed Meclizine for the Petitioner and the Petitioner reported the medication was making him drowsy. It also appears that at that time Dr. Wang diagnosed Petitioner as having vertigo, a vitamin D deficiency and sleep apnea.

7. On March 10, 2011, Petitioner saw Dr. Diadula at Mercy Works. In the history portion of the examination, the doctor noted that Petitioner is an assistant superintendent who states he became dizzy while standing directing the crew out of the garage. Petitioner had dizziness that lasted for 15 minutes. He has hearing loss of the left ear. Once every other day he feels dizzy for 10-15 minutes. He previously had a cerebrovascular accident six years ago during which he developed left sided weakness. At that time Petitioner was diagnosed as having vertigo and left-sided hearing loss. Dr. Diadula noted that Petitioner is off duty due to non-work related condition and he needs medical clearance from his private doctor prior to returning to work. Petitioner was discharged and given instruction to follow up with his family doctor.

8. On March 10, 2011, Petitioner completed an Application for Adjustment of Claim for the Commission in which he claimed he sustained injuries to his left ear and other parts of the body while working. He listed the nature of injury as hearing loss and ascertainable nerve damage. On March 11, 2011, Petitioner completed an accident report in which he reported that on February 3, 2011 he was working as an assistant superintendent in a garage about 6:20 a.m. when he experienced a dizzy spell. He notified his supervisor and he was advised to go to MercyWorks but instead he went to his private doctor who sent him to an ears, nose and throat (ENT) specialist the same day. Petitioner reported that on March 10, 2011 MercyWorks placed him on a non-work relate duty disability.

9. On March 14, 2011, Petitioner again saw Dr. Wang who noted at that time that Petitioner reported that the Meclizine was causing him serious drowsiness and he could not function. On May 19, 2011, Petitioner reported to Dr. Wang that he gets dizzy 2-3

times a week and he may go back to work if the dizziness is under control. On June 20, 2011, Dr. Wang noted that Petitioner's dizziness has been under control for the last two weeks. He released Petitioner to return to work full duty starting July 1, 2011. On July 6, 2011, Dr. Mathur noted that Petitioner's vertigo has resolved and he has been released by the ENT. On July 25, 2011, Petitioner reported to Dr. Mathur that he had no dizziness. On December 1, 2011, Dr. Wang noted that Petitioner's dizziness was under control.

10. On December 24, 2012, Petitioner was evaluated by Dr. Horwitz, a board certified otolaryngolist. The doctor noted that Petitioner reports he underwent an ENG in 2009 because of persistent dysequalibrium which showed a marked left ear hypo-function but he says no one gave him a diagnosis at that time. In the history given at the ENG he denied hearing loss or tinnitus. An audiogram was completed on February 14, 2011 and it showed left sided hearing loss at 6000-80000Hz at 35 db. Given this result, Petitioner has a very mild high frequency sensorineural hearing loss in the high frequencies which is slightly worse in the left ear. However, his function hearing is very good and the percentage of hearing loss is zero. Whether his condition is related to work is hard to determine for sure. While he said he was exposed to loud noise at work, this seems to be intermittently related to particular jobs. The decibel level and the time of exposure are poorly documented. Furthermore he is claiming loss only for the last 2-3 years. Presumably the noise exposure would have been ongoing for much of his career. He had an abnormal left ear finding at the time of the 2009 ENG with a documented hearing loss at that time. While the February 14, 2011 audiogram shows very mild loss at 4000 Hz, the 4000 Hz notch can be suggestive of noise induced hearing loss but is definitely not diagnostic of it and the notch certain can be present in other otologic diseases including presbycusis (hearing loss with aging) and vascular disease. Dr. Horwitz noted once again that the percentage of hearing loss is zero and he opined that Petitioner is not in need of any treatment. He further opined that from a hearing standpoint Petitioner certainly can work, although his imbalance and left sided hemiparesis (weakness) may be limited. Lastly, he opined that Petitioner has reached maximum medical improvement.

11. On February 1, 2012 Petitioner once again saw Dr. Mathur who noted that Petitioner had seen an audiologist who was recommended by Respondent and he was advised to go on neudexta for a diagnosis of pba for pseudobulbar effect. Currently, on physical examination his ears show no external otitis, no discharge and no inflammation of PM. He noted that Petitioner has normal hearing and he has no new problems.

12. On February 21, 2013, Petitioner underwent an evaluation with Dr. Gross who noted Petitioner worked for Department of Streets and Sanitation for 30 years. During this time Petitioner reports he was exposed to loud equipment noise while working outdoors. He did not wear hearing protection and was not required to do so.

On February 3, 2012, in association with a loud truck noise, Petitioner experienced a loss of equilibrium, felt dizzy and thought he was going to fall. He was sent to Mercy Works and then he saw Dr. Mathur, his doctor, who suggested he see Dr. Wang, an ear specialist. He was referred for an audiological evaluation on February 14, 2011 due to intermittent vertigo. He was told he had a 20% hearing loss in the left ear and 90% nerve damage, which was noise related. He has episodes of vertigo every couple of weeks, which then decreased to every couple of months. He felt as though there was water in his left ear during the episodes. Meclizine was prescribed, which helps stabilize his equilibrium but it causes him to sleep too much and once he falls asleep it is hard for him to get up. He retired due to the injury. He complains of decreased hearing and states he had to quit work as a result. He states that if he does not take his medication he has vertigo and is unstable.

On examination there is a decrease in the hearing on the left as compared to the right. Dr. Gross diagnosed Petitioner as having a hearing loss, vertigo and residual neurological deficits which were related to a prior unrelated stroke. He noted that from the patient he obtained a history of sudden onset of vertigo and speech difficulty on October 19, 2002. He was rehabilitated and he returned to work for nine years then in 2011 he experienced a sudden loss of equilibrium when a truck started next to him. He had an electronystagmogram and audiogram done in 2009. He related a gradual onset of hearing loss on the left side over many years which worsening when exposed to noise. He operated a chipper at O'Hare airport for seven years and drove every day as a supervisor. He has had mild tinnitus (ear dysfunction leading to perception of extraneous noise by the patient) for many years. He is retired principally due to his vertigo/disequilibrium symptoms, which appeared in 2002 but resolved sufficiently to allow work until 2011. After that he had a pattern of vertigo every couple of weeks which decreased to every couple of months. Understandably, it is difficult for him to work or drive and the somnolence caused by the Meclizine also made it dangerous for him to drive or be around machinery which his job required. During his attacks, he felt fullness or water in his left ear. Dr. Gross opined that to a probable degree of medical and surgical certainty, Petitioner developed hearing loss due to noise exposure at work and vestibular damage has resulted.

13. Petitioner testified he saw a doctor at Mercyworks who removed him from work on March 10, 2011. Either Dr. Wang or Dr. Mathur subsequently released him back to work on July 1, 2011. He returned to work in July and retired in September since the Meclizine made him sleepy and he could not do his job. He last saw Dr. Wang two months ago. He agreed that he told Dr. Wang that he did not have dizziness while he was taking the Meclizine. He takes the Meclizine on a daily basis. If he does not take the Meclizine he gets dizzy and his balance is not right.

The Commission notes that in Petitioner's Application for Adjustment of Claim (AAC), Petitioner contends that as a result of the February 3, 2011 work accident he sustained

injuries to his "left ear and other parts of the body". He further lists the nature of injury as hearing loss and ascertainable nerve damage. The Commission finds that the second portion of the language contained in the AAC is somewhat vague while the other portion addresses a clearly defined claimed alleged hearing loss injury. Given the vague nature of the claim along with the testimony/exhibits submitted into the record and in order to err on the side of over inclusion, the Commission reviews the symptoms of alleged hearing loss, vertigo and dizziness.

The Arbitrator found Petitioner failed to prove he was exposed to noise for a period of time significant enough to cause a permanent impairment to noise levels in excess of the statutory noise levels provided by either the Workers' Compensation or Occupational Diseases Act. More specifically, he failed to prove he sustained a hearing loss arising out of and in the course of his employment on February 3, 2011. Moreover, the Arbitrator found Petitioner's prior medical condition is likely the cause of his current hearing loss and all the doctors have documented histories of Petitioner's prior vertigo, dizziness and loss of balance conditions.

On Review, Petitioner's attorney conceded that Petitioner did not meet the standard for a hearing loss under the Act, but still claims Petitioner sustained injuries that resulted in vertigo and dizziness on February 3, 2011 and these conditions are causally related to said accident. Given Petitioner's attorney's concession, the Commission finds Petitioner did not preserve the hearing loss issue on Review.

In terms of the vertigo/dizziness conditions, the Commission noted that these symptoms are only generically referred in the AAC. However, in order to thoroughly address these conditions, the Commission notes that these symptoms and/or their connection to Petitioner's work on February 2, 2011 need to addressed.

Based on a review of the evidence, the Commission finds there is no question that Petitioner had a pre-existing vertigo/dizziness condition going into the alleged February 3, 2011 work accident. While Petitioner testified that these conditions were short lived after his stroke, it appears that these conditions might have been ongoing leading into the alleged February 3, 2011 work accident. Petitioner testified on direct examination that his vertigo/dizziness conditions were asymptomatic leading up to the alleged work accident. However, on cross-examination it appears that Petitioner contradicts himself by stating that he might have told the audiologist he was dizzy prior to the alleged February 3, 2011 work accident and his cross-examination testimony is supported by the February 14, 2011 audiological report that said Petitioner reported that he initially was dizzy every couple of weeks and then every couple of months after the Louisiana trip. Petitioner tried to differentiate the February 3, 2011 work experience from the Louisiana experience by claiming that the former was different from the later. Based on Petitioner's testimony as a whole, the Commission finds that Petitioner's testimony internally contradicts itself and Petitioner is not credible. Additionally, the Commission finds that the medical records

support the fact that Petitioner was experiencing intermittent episodes of vertigo and/or dizziness prior to the February 3, 2011 alleged work accident. The Commission finds that the Arbitrator also needed to determine whether the alleged February 3, 2011 work accident aggravated Petitioner's pre-existing condition. Having reviewed the evidence, the Commission finds that there was no aggravation of the ongoing condition. There is no indication that there was any difference between the vertigo/dizziness Petitioner experienced both before and after the alleged February 3, 2011 work accident. Assuming arguendo that there was a difference, it appears that Petitioner's condition after the alleged February 3, 2011 work accident was temporary in nature and it constitutes a "flare-up" of the prior condition that quickly dissipated shortly thereafter with the use of Meclizine. While there is some contradictory evidence as to how long Petitioner was taking Lasix, the water pill for an unrelated condition, the evidence clearly shows that he was taking it prior to the alleged February 3, 2011 work accident and that Dr. Wang commented that one of the side effects of Lasix may be vertigo. Based on Dr. Wang's comment, the Commission draws an inference that Petitioner's vertigo was a side effect of the Lasix medication and by virtue of Petitioner taking the medication prior to and leading up to the alleged work accident, Petitioner's vertigo/dizziness it is not related to the February 3, 2011 work accident.

In the end, the Commission affirms the Arbitrator's finding that Petitioner failed to prove he sustained an accidental injury on February 3, 2011 resulting in vertigo/dizziness. The Commission finds Petitioner is not credible and, in addition to the Arbitrator's findings, that Petitioner's current condition is ongoing from his pre-existing stroke condition, the incident which took place on February 3, 2011 did not rise to the level of a work accident and Petitioner's pre-existing condition was not aggravated by the same. As such, the Commission also finds that Petitioner's current condition of ill-being is not causally related to the alleged February 3, 2011 work accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he sustained accidental injuries arising out of and in the course of his employment on February 3, 2011, his claim for compensation is hereby denied.

The party commending the proceedings for review in the Circuit Court shall filed with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: FEB 2 7 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/jm
O: 2/5/15

43